Overview report

A Domestic Homicide Review concerning the death of Sarah (pseudonym)

(January 2023)

Author – Jackie Dadd

Date completed – November 2023

Family tributes to Sarah

My Mum

My mum was a beautiful woman. I'll always remember her that way.

To her, her looks were everything. She was stunning on the outside but with my mum she didn't just have a beautiful face her soul beamed with beauty, so when it came to reputation it was a big thing, she would always keep her problems to herself and always told me our business is no one else's.

She never wanted anyone to know that she was breaking. So, as my mum put this mask up of her life not allowing many people to pass it, she would hide the trauma that she went through all her childhood. My mum was an independent woman. She didn't like to be told what to do because she was independent, she also dealt with her problems by herself, she's the strongest person I know but even mum couldn't handle it on her own which just shows the terrible things she's been through.

Sarah was my mum, my best friend, my hairdresser, my hero, she was a survivor. Too many things were against her which is shame because she felt the world was so against her, she started to become against it herself fighting off any type of help. My mum loved yoga she did it every morning. She stopped for a while but always tell me how she needs to do her yoga she was amazing at it; it was a big part of her. She also loved doing hair as a kid she'd always want to do mine. I'm her only girl and fortunately for her I have very long hair, I hated her doing my hair because at the time I was more of a "Tom boy" but now all I wish is for her to be here doing my hair. She didn't deserve anything that happened to her, she lived a life where no matter how hard she tried everything seemed to be against her, she fought so hard I don't blame her for the way she reacted to us sometimes, many people would hear my story and feel bad for me for the way my mum would have treated us at times but they would have a very different approach if they heard my mums.

My mum was an amazing mum, time was just against me and her.

<u>My Mum</u>

As her cackle echoes through my ears

I remember the nights

Our conversations would go on for hours

Her beauty as Elegant as a flower

Yet her eyes held power

Because as much as my mum looked as an angel

If she had to protect us

The outcome would be fatal

Because my mums a survivor in an angel's body

My mum is my hero

And always will be

My Dearest Sister, words will never be enough to explain what you truly meant to me. Not only were you my big sister but you were also my best friend. I feel so lost in this world without you but I find the strength through our children. My heart breaks that I couldn't save you but now I know you are at peace. So, rest now my beautiful girl and remember it's never a goodbye but an until we meet again. I love you a million bits of love. Fly high beautiful and shine xx

Mummy will forever keep you alive and tell me with a smile on her face that "when mummy said no, Auntie ALWAYS said yes." I miss your 'big fat kisses and squishes.' I love you so much – Your Niece xx

I will never be able to listen to certain songs and not think about the times you used to sing them to me before bed when I was younger. Love you forever and always – Your Nephew xx

The Domestic Homicide Review Panel and the members of the Cambridge Community Safety Partnership would like to offer their sincere condolences to the family of Sarah, who have lost their loved one in tragic circumstances, and which has caused this Review to take place. They have been left with a huge gap in their lives.

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Preface

The key purpose of any Domestic Homicide Review (DHR) is to examine agency responses and support given to a victim of domestic abuse prior to their death and to enable lessons to be learnt where there may be links with domestic abuse. For these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future. The victim's death in this case met the criteria for conducting a DHR according to Statutory Guidance1 under Section 9 (3)(1) of the Domestic Violence, Crime, and Victims Act 2004. The Act states that there should be a "review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death".

The Home Office and the Domestic Abuse Act 2021 define domestic abuse as:

Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if—

(a)A and B are each aged 16 or over and are personally connected to each other, and

(b)the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following—

(a)physical or sexual abuse;

(b)violent or threatening behaviour;

(c)controlling or coercive behaviour;

(d)economic abuse (see subsection (4));

(e)psychological, emotional or other abuse;

and it does not matter whether the behaviour consists of a single incident or a course of conduct.

"Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to—

(a)acquire, use or maintain money or other property, or

(b)obtain goods or services.

For the purposes of this Act A's behaviour may be behaviour "towards" B despite the fact that it consists of conduct directed at another person (for example, B's child).

Controlling behaviour is:

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

Coercive behaviour is:

An act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim. The term domestic abuse will be used throughout this review as it reflects the range of behaviours encapsulated within the above definition and avoids the inclination to view domestic abuse in terms of physical assault only.

Recommendations will be made at the end of this report, however, there has been an ongoing action plan introduced by the panel, parallel to this review to ensure that the areas that can be immediately addressed have not incurred unnecessary delay.

NB: Any quotations or submissions from family and friends have been kept as a direct copy to ensure its authenticity.

Section 1 - Introduction

1.1 The commissioning of the review

1.1.1 This review is into the death of Sarah, a 44-year-old female, who was found hanging by her partner in January 2023 at her home address. The Police have investigated the circumstances and have submitted a report to the Coroner with a finding that the death was non-suspicious and the cause was suspected suicide by hanging. The Coroner's inquest has been opened and adjourned awaiting the completion of this review.

The Police made a referral to Cambridge CSP on 15th January 2023 due to the number of previous incidents and domestic abuse that had been recorded over a number of years involving Sarah. Following a meeting held on the same day with representatives from a number of authorities and voluntary sector, a decision was made to undertake a Domestic Homicide Review as the definition in Section 9 of the Domestic Violence Crime and Victims Act (2004) had been met.

1.1.2 Contributors to the review

Agency	Contribution
Cambridgeshire Police	IMR, Panel member
Cambridge and Peterborough NHS Foundation Trust (CPFT)	IMR, Panel member
Cambridge City Community Safety Partnership	Oversight
Cambridgeshire County Council IDVA Service	Summary report, Panel member
Cambridge and Peterborough MARAC	Summary report, Panel member
Cambridgeshire Public Health	Panel member
NW Anglia NHS Foundation Trust	Panel member
East of England Ambulance service NHS Trust	Panel member
Cambridgeshire and Peterborough DASV Partnership	Co-ordination, Panel member
NHS Cambridgeshire and Peterborough Primary Care Integrated Care Board	Summary report, Panel member
Cambridgeshire Women's Aid	Scoping, Panel member
Change Grow Live - CGL	IMR, Panel member
Cambridgeshire Children's Social Care - CSC	IMR, Panel member
Cambridgeshire Adult Social Care - ASC	IMR, Panel member
Department of Works and Pensions - DWP	Scoping, Panel member
Cambridgeshire Education	Information from schools
Cambridge City Council	Scoping, Panel member

1.1.3 Review Panel

The following agencies/organisations/voluntary bodies have contributed to the Domestic Homicide Review by the provision of reports and chronology. Individual Management Reviews (IMRs) have been requested and supplied.

1.1.4 – The panel comprised of the following: -

Name	Area of responsibility	Organisation
Vickie Crompton	Domestic Abuse and Sexual Violence partnership manager	Cambridgeshire County Council
DCI Jenni Brain	Public Protection Lead	Cambridgeshire Police
Angie Stewart	Chief Executive Officer	Cambridge Women's Aid
Emma Foley	Peterborough City Hospital – Adult Safeguarding Practitioner	NW Anglian NHS Foundation Trust
Linda Coultrup	GP practice representative. Named Nurse Safeguarding Adults Primary Care	Cambridgeshire & Peterborough Integrated Care Board (ICB)
Keryn Jalli	Community Safety Manager	Cambridge City Council
Rachel Robertson	Advanced Practitioner Safeguarding and Domestic Abuse Lead/AMHP	Cambridge and Peterborough NHS Foundation Trust (CPFT)
Deirdre Reed	Operational Manager/MARAC Chair	Cambridgeshire County Council
Lisa Barraclough	Advanced Customer Support Senior Leader	Department of Works and Pensions (DWP)
Rebecca D'Cruze	Ambulance service strategic safeguarding specialist	East of England Ambulance service NHS trust
Jim Bambridge (2nd panel meeting onwards)	MCU Review officer	Cambridgeshire Police
Joseph Davies	Suicide Prevention Manager	Public Health department – Cambridgeshire County Council
Claire Saggiorato	Designated Nurse Safeguarding Children	NHS Cambridgeshire and Peterborough Integrated Care Board

1.1.5 - All members of the panel and authors of the IMRs have complete independence from any subject in this review. The Review Chair and Panel gave due consideration for the content of the DHR and it was agreed that reports, chronologies, IMRs and other supplementary details would form the basis of the information provided. Thanks goes to all who have assisted and contributed to this review with their valued time and cooperation.

1.1.6 – Author of the Overview report

The chair of the review panel and author of this report is Mrs Jackie Dadd, an independent consultant who is independent of the organisation and agencies contributing to this report. She has no knowledge or association with any of the subjects in this report prior to the commissioning of this review. She is a retired Detective Chief Inspector with Bedfordshire Police with vast experience of safeguarding and domestic abuse related issues and has been involved in the DHR process since its inception in 2011. She has completed the Home Office online training, the Continuous Professional Development accredited AAFDA DHR Chair training and is a member of the AAFDA DHR network, regularly attending the monthly forums for CPD and discussion. Mrs Dadd has completed and had published, several DHRs.

1.2 Purpose of the review

1.2.1 - The purposes of a DHR are to:

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

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

c) Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

d) Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.

e) Contribute to a better understanding of the nature of domestic violence and abuse; and

f) Highlight good practice.

1.2.2 - DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners' and criminal courts, respectively, to determine as appropriate. DHRs are not specifically part of any disciplinary inquiry or process. Part of the rationale for the review is to ensure that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and domestic abuse. The review also assesses whether agencies have sufficient and effective procedures and protocols in place which were understood and adhered to by their staff.

1.2.3 - The death of Sarah has been presented to the Coroner as potential suicide. This review will ascertain whether domestic abuse could have been the cause or a contributory

factor to this. It is not to apportion blame, but to view the circumstances through the eyes of Sarah.

1.3 Timescales

1.3.1 – Cambridgeshire Police made a referral for consideration of a DHR to Cambridge City CSP on the 15th of January 2023 due to the history of domestic incidents held on their records.

1.3.2 – The same day, Cambridge City CSP, in accordance with the December 2016 Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews commissioned this Domestic Homicide Review. The Home Office were notified the following day.

1.3.3 - Mrs Jackie Dadd was commissioned to provide an independent Chair and Author for this DHR on 16th January 2023. Three separate panel meetings then took place. The completed report was handed to the Cambridge Community Safety Partnership on 02/11/23.

1.3.4 – Table outlining timeline of review

15/01/2023	Police referred incident for consideration of DHR to Cambridge City CSP
15/01/2023	Decision to commission a DHR made by Cambridge City CSP and partners
16/01/2023	Home Office notified of decision to commission DHR
16/01/2023	Mrs Jackie Dadd commissioned as Chair and Author
31/03/2023	First panel meeting
10/05/2023	Second panel meeting
17/07/2023	Third panel meeting
02/11/23	Completed report handed to Cambridge CSP by Author

Home Office guidance states that the review should be completed within six months of the initial decision to establish one. Delays occurred with the provision of information, particularly with one provider due to capacity issues and the complex structure of the organisation. There was also a further delay to ensure the family were content with the report prior to submission and changes were made to accommodate this.

1.4 Terms of Reference

1.4.1 The full Terms of Reference can be found in Appendix A at the conclusion of this report. The Terms of reference were discussed and agreed upon during the first panel meeting on 31st March 2023.

1.4.2 - It was agreed that the main areas of focus would be based on:

a) Domestic abuse in any form had been the causation or a contributory factor to Sarah taking her own life
b) The effectiveness and response of agencies in a collaborative approach to supporting those with multi-complex needs that include DA
c) The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home
d) Services and agencies provisions to suicide and those contemplating taking their own life within the Cambridgeshire area

1.4.3 - It was agreed by the panel that the scoping dates would take place from January 2017 until the date of Sarah's death. This would maintain focus on the factors involved in Sarah's life and pressures she may have faced leading up to this time.

1.5 Subjects of the review/Family and friends' involvement

1.5.1 - In accordance with Home Office guidelines to ensure confidentiality, pseudonyms have been utilised throughout this report for the following: (All ages are recorded at the time of Sarah's death).

Sarah – A 44-year-old white British female.

Leon – Estranged husband of Sarah. A 43-year-old white British male.

Daniel – Eldest son of Sarah and Leon. A 21-year-old white British male. lives with epilepsy and Cerebral Palsy.

Anton – Son of Sarah and Leon. A 19-year-old white British male.

Sophie – Daughter of Sarah and Leon. A 13-year-old white British female.

Lucas – Youngest son of Sarah and Leon. A 7-year-old white British child.

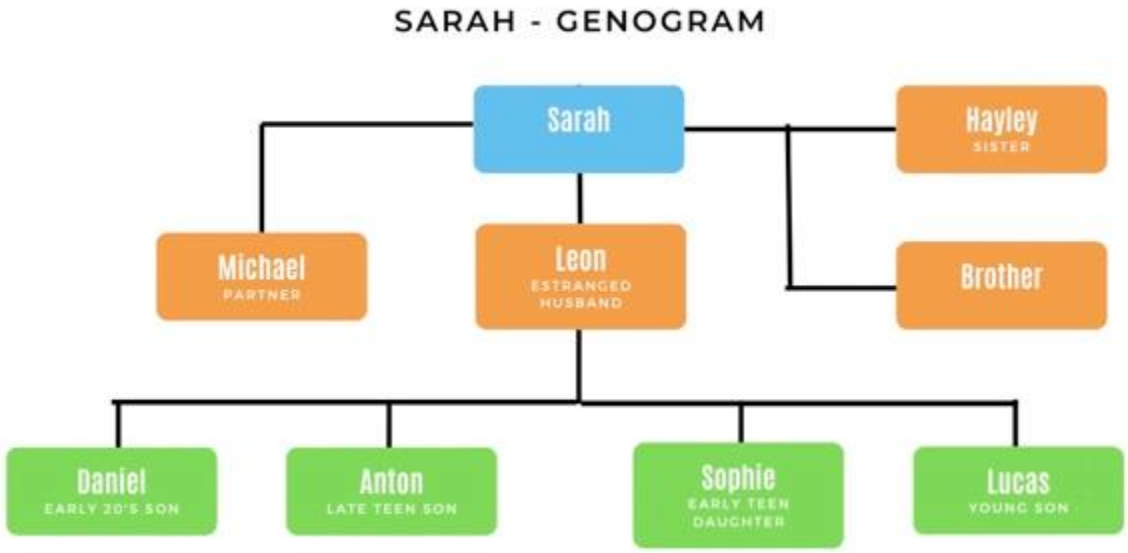
Hayley – Younger sister of Sarah.

Debbie – Close friend of Sarah.

Michael – Partner of Sarah. A 41-year-old white British male.

Address – Name of area provided as Cambridge

All pseudonyms were chosen by the author at random and verified by Hayley and Leon, as was their preference.



Leon and Hayley have been the agreed family representatives for this DHR.

Both Leon and Hayley wished to be fully engaged with the review and the Author would like to express their gratitude for the significant contribution and assistance provided throughout. With the permission of Leon, the voice of the child was heard by Sophie and her lived experience, as she spoke and wrote her thoughts down with her Auntie to pass on to the author with her permission. The Voice of the child has also been heard from Lucas, who spoke to AAFDA specialist child advocate and asked her to inform the author of what he had said. The Author spoke in person at length to both Leon and Hayley and frequently liaised with them via text, phone, email and Teams meetings. AAFDA details were provided and advocacy was provided to Leon and Hayley with a specialist Child advocate for the two youngest children.

Hayley and Leon attended the second panel meeting via teams with advocacy present, where they asked a number of prepared questions. Those that could not be answered were given as actions from the author to reply to following the meeting. The majority of these were answered and a face-to-face meeting has been facilitated with a senior officer of Children's Services to respond to the outstanding matters in person.

They have both received a copy of the report and had the opportunity to review the content. They are happy that it portrays Sarah's life and the multi-complex needs that she and their family faced. They are pleased with the conclusion and the recommendations. There are certain parts of reports from agencies that they do not believe are accurate accounts of what took place and these are outlined at 3.1.1.

1.6 Parallel reviews

1.6.1 - The Coronial process is taking place parallel to this review.

Sarah's death was reported to the Coroner by the Police and a file was opened. The report submitted stated that the death was considered to be non-suspicious and was treated as a sudden and unexplained adult death, indicative of a suicide by hanging.

A Post-mortem was subsequently held.

The result of that post-mortem examination was that the death was unnatural, due to: -

1a. Fatal pressure on neck

There were no injuries or trauma to the deceased indicating or suggesting any third-party involvement in the death. Toxicology tests show significant high levels of alcohol were present in the blood and urine, cocaine was also present. Therefore, the deceased was under the influence of alcohol and cocaine at the time of death.

The coroner has suspended the coronial inquest pending the outcome of this review.

1.6.2 Death following Police contact

On the same date as Sarah's death, the Bedfordshire, Cambridgeshire, and Hertfordshire Professional Standards Department (PSD) referred the death and serious injury occurrence (DSI) to the Independent Office of Police Complaints (IOPC) Cases where police officers have engaged with individuals who suffer serious injury or death following contact are referred under compulsory or voluntary arrangements with the IOPC. This referral was on a voluntary basis, the referral was assessed by the IOPC which responded:

"Although we acknowledge that [Sarah] was located deceased following police contact and a referral was appropriate, we are not persuaded that there is a necessity to direct investigation. This is on the basis of a lack of evidence to indicate a causal link."

"It is accepted that concerns were noted about Sarah's mental health and police tried to engage with her. However, Sarah refused to engage with officers or accept any help, despite this, officers made a referral in regard to her welfare. In addition, the evidence does not suggest that Sarah made any direct threats to harm herself to officers which would suggest that police were unaware of a real or immediate risk to life. Due to this, along with her refusal to engage with officers, it is unclear what more could have been done with the police powers available to them in the circumstances. Due to this, we are of the view that this matter can be referred back to the force."

The Professional Standards Department (PSD) investigation has been finalised with no conduct issues identified or learning.

1.7 Equality and Diversity

1.7.1 - The review gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010 and found sex, age and disability to be relevant to this case. It was considered that Sarah's sex was relevant to the review as 3-10 women a week die of suicide where they have suffered domestic abuse and in 2017, eighty-three per cent of victims reporting coercive control to the police were female (Office for National Statistics, 2017). Sarah's role as a mother and the sense of responsibility as a parent of a child through to adulthood that has additional caring needs is to be acknowledged in this report as her natural protectiveness of her child through nurture did not always protect her from the stress and abuse she received and was not recognised as domestic abuse.

1.7.2 Disability is relevant to this review due to:

Sarah had mental health issues which manifested through self-harming, alcohol abuse and eventually drug abuse. These could be seen as coping mechanisms of both the current stresses she was facing and also the adverse childhood experiences (ACES) that went on to affect her in adulthood.

It is valid to review whether these issues overshadowed the DA matters that were present when speaking with professionals.

Also, the disabilities that Daniel presented and the frustrations that this brought, which may have been a factor in the Adult Child to Parent Abuse and the influence this may have on the police response when a criminal act has occurred.

1.7.3 Sarah's age was considered by the panel as the highest age group for female suicides in England and Wales between 1981 and 2023 was those aged between 45 to 64 years[1] in which Sarah was just short of her 45th birthday. Also, according to the latest statistics on drug misuse, the median age of people in treatment for opiate use in England is 44 years old.[2]

1.7.4 Although not listed within the Equality Act 2010 as a 'protected characteristic,' questions have to be asked in relation to the role of Sarah as a carer as she was not recognised as such as she was his mother and records were kept separately on each individual rather than cross referenced as a family.

Equality is about ensuring everybody has an equal opportunity and is not treated differently or discriminated against because of their characteristics. **Diversity** is about taking account of the differences between people and groups of people and placing a positive value on those differences.

[1] ONS 2023

[2] https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report

1.8 Dissemination

Recipients who received copies of this report prior to publication:

Relevant staff of Cambridge City CSP

Panel Members (listed in 1.1.4)

Family Members and associated advocates

Coroner's office

Cambridgeshire Office for the Police and Crime Commissioner

Domestic Abuse Commissioner

1.9 Contextual background

1.9.1 Cambridge City is a university city with several universities attracting students from all over the world and is the County town in Cambridgeshire. It covers 15.71 square miles and has a population of 145,700 with a significant number who are transient due to their student status.[3]

The Cambridge Community Safety Partnership has the statutory responsibility for DHRs within their area. In April 2021, the Domestic Abuse and Sexual Violence (DASV) partnership took over a centralised DHR process for Cambridgeshire and Peterborough. This enables them to analyse issues across Cambridgeshire and Peterborough for wider implementation and uniformed processes.

Suicide rates in all districts within Cambridgeshire and Peterborough are statistically similar to England for the three-year period 2017-19. However, all have seen an increase in suicide rates from 2015-17 to 2017-19.

In Cambridgeshire and Peterborough, since May 2018, fourteen suicides relating to domestic abuse have been considered as requiring a DHR across 6 Community Safety Partnerships.

1.9.2 This review will consider the impact on a parent who cares for their child, no matter what their age when there are additional needs due to medical conditions and also the additional vulnerability this can place on them in regard to domestic abuse.

The Care Act 2014 put in place significant new rights for carers in England including:

- A focus on promoting wellbeing

[3] Cambridge population change, Census 2021 ONS

- A duty on local authorities to prevent, reduce and delay need for support, including the needs of carers.
- A right to a carer's assessment based on the appearance of need.
- A right for carers' eligible needs to be met.
- A duty on local authorities to provide information and advice to carers in relation to their caring role and their own needs.
- A duty on NHS bodies (NHS England, clinical commissioning groups, NHS trusts and NHS foundation trusts) to co-operate with local authorities in delivering the Care Act functions.

Research has been conducted by Thien Trang in relation to Adult Child to Parent Abuse as part of a fully funded PhD at the Anglia Ruskin University as it has been widely recognised that there is a dearth in research around adult family violence[4], and in particular around Adult Child to Parent Abuse. This will assist in the gap at present to understand the period of transition from adolescent to parent violence in which research has been conducted and generally has an upper age limit of 17 years [5].

1.9.3 The DASV worked alongside Public Health to review the correlation between suicide and domestic abuse. These outcomes were shared with key stakeholders working on Suicide prevention in Cambridgeshire and Peterborough. Cambridgeshire County Council published a Suicide Prevention Strategy in January 2023.

Research showed:

1. Domestic Abuse is a factor in around 12.5% of female suicide attempts
2. 25% of those in Domestic Abuse services have felt suicidal due to the abuse
3. Domestic Abuse victims are 8x more at risk of suicide than the general population
4. 50% of Domestic Abuse victims who attempt suicide will undertake further attempts within a year
5. 20% of DA Victims attempting suicide are pregnant
6. A third of female suicides are subject to domestic abuse
7. "Suicidal acts…… are more likely where feelings of defeat and entrapment exist alongside beliefs that neither rescue or escape are possible" Williams (2001)
8. 3-10 women a week die by suicide where they have suffered domestic abuse[6]

[4] Sharp-Jeffs & Kelly, 2016
[5] Miles & Condry, 2015
[6] hoping to help: Identifying and responding to suicidality amongst victims of domestic abuse - Vanessa E Munro, Ruth Aitken, 2020 (sagepub.com)

Section 2 – The Facts

2.1 Background information

2.1.1 Information from Sarah's early life has kindly been provided for the review by her sister Hayley.

Sarah was born in Peterborough living with her mum, brother and her father, who was violent to her mum in front of her and he was a heroin addict. Her mum left him when Sarah was 2-3yrs old, taking Sarah and her brother with her.

Sarah's mum then began a relationship with a man who she had known for a long time and Sarah's sister, Hayley was born. They all lived together until Sarah was five when the relationship ended. This is the man Sarah regarded and referred to as her Dad through life. Hayley remembers how good Sarah was at gymnastics.

When Sarah was 8 years old, her mum began a relationship with another male, D, who moved in to live with the family. Hayley recalls how he was horrible to all three siblings. He nailed their bedroom windows shut and when their mum was at work and he was supposed to be home to look after them after school, he would go out and lock the doors, leaving them on the doorstep in the rain. Sarah witnessed him hurt her mum both emotionally and physically and had the disruption of moving. Her mum would leave him but then go back time and again. She began to drink to help cope with the situation but would then be horrible to Sarah and her siblings when drunk. Both sisters were close to their brother as he protected them.

2.1.2 Sarah was dyslexic and struggled academically at school but was popular with students. She just wanted to be loved and accepted by everyone. When she was 12 years old, a cousin from her mum's side began to come and stay on a weekend and would sexually abuse Sarah. Her sister knew but she told her not to tell anyone so her mum never knew. Sarah ensured Hayley was safe by making her mum send Hayley to her Dads when he came to stay in order to protect her, but by not telling anyone what he was doing to her, Sarah didn't get the protection she needed.

At 13 years old, her mum left D and they moved to Southampton. Sarah was in secondary school and this was the happiest her sister had ever seen her. She became settled, enjoyed school and got a job at a hair salon where she started to learn about the profession and was really good at it.

D then started to come and visit and then married her mum so the family moved back to Cambridgeshire until D broke her mum's arm and they finally separated for good.

It was at this time that Sarah became rebellious. She would have been about 15/16 years old and always seemed to be angry. She shared a bedroom with her sister and began to self-harm by cutting her wrists for the first time. She went to stay with her Dad for a short while but not for long and in years to come, sexual abuse from that time was mentioned but the details are not known.

When she was 17 years old, Sarah started to see an older male who used to physically assault her and threw her out of the house naked on one occasion. She always had bruises. She was with him for a couple of years. She had qualified as a hairdresser, working at a hairdresser's whilst studying at college. She loved it and excelled at it and shared houses with friends for a while before moving to Southampton where she ran a salon. She seemed free, cut her hair short and didn't have a serious boyfriend. She stayed there a couple of years before moving back to Cambridgeshire where she got her own home and worked at the salon that had originally trained her.

2.1.3 (Information relating to the relationship outside of official records has been provided by Hayley and Leon). When Sarah was 20 years old, she met Leon at a Halloween party. They immediately 'clicked' and married on Sarah's 21st birthday and then went travelling for nine months around Europe with Leon working as a waiter to help fund it. It was during this time that Sarah began to drink a lot as she spent time on the beach whilst Leon worked. One evening, they were in a bar when Leon saw Sarah kiss a male he described as a 'wrong'un.' In anger, he left the bar and went home. Sarah did not return until 24 hours later covered in bruises and bites and disclosed that she had been raped and that the male had a gun.

Her drinking slowed down after that with Sarah not speaking about it apart from saying she had made a mistake. She returned to England just after the Christmas with Leon following on shortly after.

2.1.4 Sarah fell pregnant with Daniel in 2001 and immediately stopped drinking and smoking. He was born with Cerebral Palsy which meant a lot of appointments at Great Ormond Street Hospital in London. Sarah is described by Leon as an amazing, loving mother who gave up her hairdressing job to look after Daniel. Anton was born a couple of years later and although there was concern of Daniel's health, there were no issues and they had a good marriage according to both Leon and Hayley.

Daniel had his first seizure when he was about 8 or 9 years old. Leon secured a good job in London and moved to Edgeware ahead of Sarah whilst he found them somewhere to stay. Sarah became lonely and by the time they had a place to live, Daniel's behaviour had started to become worse. It was impossible to get him to school. He would have tantrums and Sarah found it hard to manage him. He was diagnosed with epilepsy and the medication he received seemed to heighten his behaviour and make him worse. Leon stated that this was when all the trouble between him and Sarah started as they were under a lot of stress.

Leon and Sarah started to have issues between them. Sarah began to drink again and had numerous affairs. She would often accuse Leon of having an affair. Leon states that the only thing he ever did wrong was to punch a wall or a door in frustration and knew it would annoy Sarah as she cared about how the house looked. He states that there is a possibility the children may have seen this.

Sophie was born during this time. Leon and Sarah had a joint bank account. They continued to ask for help with Daniel but had never had dealings with the authorities before and found it frustrating as not a lot of help was offered through the years and if it was, it was a bad

experience and dwindled. Even down to claiming benefits as they were unsure what to claim for and were not given advice by Social services when they asked.

2.1.5 Following her having an affair, Sarah moved back to Cambridge with the children without telling Leon and emptied the bank account. They spent some time in temporary accommodation but then secured a permanent address. Leon started seeing Sarah again and they got back together. Hayley recalls that Leon became possessive, kept calling her and checking her phone as he was insecure but "he was a nice guy and would never harm her."

In 2015, Lucas was born and Sarah seemed happy for a while as she loved being a mum again but then started to have affairs. She had not self-harmed in a long time or had any suicidal tendencies and having grown up with her mum who was a functioning alcoholic, she always said that she would never do that to her children.

The relationship with her two elder boys became strained due to Daniel's behaviour and Anton witnessing it and also not getting as much attention due to the demands of Daniel. The boys would argue as Anton stuck up for his mum and also had arguments with men who came to the address whilst his Dad was at work, he has since disclosed. They tried to get Daniel into anger management through Social Services but this never happened.

Children's services (CSC) first became involved with the family in 2013 with Early Help. In 2017, they made a home visit as Anton was not at school and was found to be looking after Lucas at 14 years old. A family worker was allocated as they informed them of the difficulties that they were having with the behaviour and demands of Daniel. Later that year, Sarah lost her mother through suicide by an overdose of beta blockers and took it really badly, not being able to accept it. Her mental health began to deteriorate and she was drinking a lot more and would be horrible to all her family members apart from the two youngest children when she was drunk. She started to cut herself which Hayley knew was a cry for help as she couldn't cope.

2.1.6 In 2018, Daniel (17yrs) was living at home with Leon, Sarah and his three siblings and his seizures were frequent and overtime, the author's analysis from Sarah's comments to professionals show that there was some correlation between the violence and anger he showed being just prior to a seizure, but not always. A pattern emerged where Daniel would be violent and damage something within the house, Sarah would contact the police who were called on four separate occasions, attended and then asked for him not to be arrested and she would not make a complaint as neither her nor Leon wanted him criminalised. Daniel's siblings would often be in the house at the time and Sarah frequently had to contact Leon if he was not at home to come and help as Daniel was now of the body and strength of an adult. Each time, a DASH was completed but no referrals were made for support provisions for domestic abuse and there were no MARAC referrals in relation to child to parent abuse.

CSC received three referrals from the Police and a hospital referral, all in relation to Daniel's violent behaviour. Daniel asked for anger management but did not receive this. A family worker was allocated and information was passed to Early Help (EH). Sarah requested bereavement counselling due to her mother passing recently.

Sarah frequently contacted Children's Services requesting assistance with there being short periods of time where a family worker or Early Help would be allocated but then the case would be closed again. It was frequently noted on Police records of how Sarah had voiced her concerns and struggles. Sarah and Leon often discussed the situation over Daniel being arrested by the Police which happened on few occasions with no action taken against him.

In March 2019, Sarah was seen by the Liaison Psychiatry Service at hospital following an overdose. They subsequently made a referral to Change Grow Live (CGL), an alcohol abuse support service and also to Children's Social Care for Daniel to be assessed so the family could have some respite and closed their file. Sarah spoke with them and outlined her main issue was support for her son. She declined a routine assessment by the Cambs North assessment team.

CPFT received eleven third party referrals regarding damage caused by Daniel and concern for neglect of the children due to Sarah's overdose.

A domestic incident occurred between Leon and Sarah whilst three of the children were in the home. Police were contacted but no action taken as Leon went to stay elsewhere for 24hours.

Daniel was referred to the Physical Disability team but there were significant delays in a social care assessment being completed. Daniel was eventually seen in the October where a plan was put in place for a further carers conversation and assessment. During the visit, Daniel became increasingly angry and following the Social Worker (SW) leaving, Daniel became violent causing damage and had a seizure prior to police arrival.

Further incidents at home involving Daniel were attended and recorded by the Police. Daniel was arrested on one occasion for criminal damage and assault on Lucas but no further action was taken as Sarah would not support a prosecution as she did not want him criminalised. No Child safeguarding referrals were submitted.

Sarah had self-referred to CGL for support with reducing her alcohol but after a few months, felt that she no longer required support and withdrew.

2.1.7 Through the remainder of her years, Sarah would frequently explain her reasons for her self-harm as being the loss of her mother and mainly, the strain of coping with Daniel's behaviour. The first multi-agency meeting by Children's Social Services took place in the July 2019 in which Sarah admitted she was scared of Daniel.

In 2020, A number of attendances by the Police were recorded and, in the August, it was noted that there had been 15 incidents of DA in the past twelve months including three in the past 90 days. The majority of these were in relation to Daniel either damaging or assaulting someone in the household. They continued after this and although he was arrested in the October, no further action was taken as it was deemed it would not be in the public interest to proceed due to his medical condition although expert medical advice on this had not been sought.

Daniel was admitted to hospital for his seizure and then discharged back to Sarah.

Sarah's SW changed back to Daniel's SW as it was deemed no longer appropriate to have a separate one. Daniel was not taking his medication and a conversation took place over the phone with Sarah over the risk Daniel poses and what support he needed. A formal carers assessment took place over the phone during which she stated that she did not really wish to speak to Talking Therapies. She agreed to be put in touch with Caring Together.

Daniel and Leon moved out and were eventually provided with temporary accommodation. Sarah disclosed that she was finding things overwhelming and took an overdose in the July.

Daniel's case was closed and re-opened as he had injured Leon and continued to visit Sarah's address where the police were called.

On 3rd January 2021, Anton called his Dad, Leon, late at night as his mum, Sarah had been drinking and was self-harming, cutting herself and he could not get her to stop. Leon went straight round where Sarah was hysterical and smashed a wine bottle and began to cut her neck. Leon began to restrain her to stop her causing any more harm in the presence of Anton whilst Lucas hid in a wardrobe and Sophie rang the police from her bedroom as she could hear what she thought was an argument. Blood was on the walls and the bed. Once the Police had arrived and spoke to Sarah in which she made suicidal comments to their questions, they spoke to her for some time and Sarah eventually agreed to attend the hospital voluntarily but then became aggressive, striking Leon and assaulting the police officer when they restrained her and was arrested. Leon had been requesting the Police to section her against her will as he told them she would leave straight away if she went voluntarily but they informed him that she had 'capacity' and could not do this. This is an area that caused the family frustration and is outlined at 3.5.52.

2.1.8 Sarah received a conditional caution for the assault on the police officer, which due to her having consumed alcohol at the time had conditions for her to engage with CGL. At this point, there had been 21 calls to the address by the police in twelve months and the first MARAC referral was made. However, the MARAC was ineffective in discussing the incidents surrounding Daniel.

In June 2021, Daniel was again arrested following a common assault on Leon and the CPS requested further actions that the Police did not complete prior to closing the investigation. Leon stopped living with Sarah permanently as the relationship had become too volatile and being in a family unit was making it worse for everyone. Over the next couple of years, Anton would separately move and visit between the houses as Leon lived close by to be near the younger children.

Daniel continued to have violent episodes and received a conditional caution later in the year for criminal damage to Leon's car. The Police also received a call from Anton, later that year asking how he could 'get someone removed from his house' as he had found his mum 'entertaining a visitor.'

Childrens Services received two referrals in relation to Sarah self-harming and overdosing during the year and due to other incidents in the home that they were aware of, Lucas and Sophie were placed on a Child Protection Plan as there were concerns of emotional harm.

Referrals were made for Sarah in relation to CGL and Mental Health but no contact was made with Sarah in relation to these for some months. (See recommendations 9 & 11)

The Child Protection Plan continued and altered when further referrals and information were received. Part of these were the distancing of Daniel and Anton from Sarah to alleviate incidents occurring in front of Lucas and Sophie and to reduce Sarah's stress as she had disclosed that both her elder sons caused her stress but more so, Daniel.

Sarah was taken to hospital in November following her self-harming and CPFT were made aware but Sarah had stated that she did not want help from the mental health team.

Sophie began receiving support from the Acorn Project.

2.1.9 At the beginning of 2022, Daniel and Anton were living with Leon and Sophie and Lucas were living with Sarah. Anton would stay at Sarah's occasionally.

In April, Anton called the emergency services as Sarah was drunk and suicidal. She had razor blades and a broken glass had been taken from her. Lucas was at home as this was the middle of the night.

A strategy meeting took place and it was agreed that Anton and Daniel would not stay over as they had been causing damage. Leon reported to CSC that Sarah had a number of boyfriends at the house and was frequently intoxicated with the children upstairs. Sarah admitted self-harming but also showed that she was black and blue from her boyfriend (identity not known). It was decided that unannounced visits would take place by CSC.

During the summer of 2022, Sarah began a relationship with Michael. Up until this point, Sarah had maintained a close relationship with her family and friends for support but they immediately noticed a distancing from them after this relationship started. She stopped going to beauty treatments with Hayley and neighbours told Hayley of drug taking, alcohol and noise into the night from Sarah's garden. When Hayley did spend time with her, Sarah received constant phone calls from Michael, asking where she was and what she was doing and Sarah appeared to have to defend herself even though she was not doing anything wrong.

Friends and family raised concerns over her with the Police and Social Services as they felt that Michael was controlling her. There was a noticeable change in her appearance with weight loss and her not taking as much care of how she looked as she always had done. Officers attended and described the house as 'very messy' and 'there wasn't much floor space to walk upon due to clothes strewn about the rooms and toys and furniture in the way.' Sarah continued to self-harm, causing herself injuries.

A Social Worker completed an unannounced visit but did not take Michael's details or discuss any concerns at the request of Sarah.

2.1.10 In October 2022, Sarah received head injuries, a black eye and an injured wrist from Michael after he had thrown her into the street. He had strangled her rendering her unconscious just before this and shouted at Lucas. Sarah fled to a friend's house and it later transpired that Sarah had confided in a few friends that Michael had placed his hands round

her neck previously. Sarah stayed in hospital overnight and Michael was arrested the following day but refused charge following the Crown Prosecution Service (CPS) decision not to prosecute as Sarah did not support police action.

Following this, an Initial Child Protection Conference (ICPC) determined that Sophie and Lucas should move to Leon's and it was agreed that this should be maintained during further strategy meetings.

The police conducted a welfare check at the request of CGL in November as they could not contact Sarah and she was at home with Michael and stated her phone had been broken.

During the December, CGL were still unable to contact Sarah. They had received information that Sarah was consuming two bottles of wine a day, there were suspicions of drug taking and she was back in the abusive relationship with Michael.

Over the course of Christmas, Hayley received several voicemail messages from Sarah, some where she was tearful and regretful and some where she was angry. Sarah did not see her children over Christmas.

2.2 Circumstances of the death of Sarah

Early in January 2023, Leon called the Police as Sarah had been banging on the front door for forty minutes. She was erratic in her behaviour and intoxicated as she was upset that she had not seen the children and was saying that she wanted to give Lucas 'one last cuddle.' A unit was not initially dispatched but on review, an officer was sent to locate Sarah to check on her welfare and found her at her home address. She was tearful at times whilst speaking to the police and told them how her own mum had taken her life and asked the officers how long it would take to die from hanging before telling them she knew it would take fifteen minutes to 'take your own life, you really have to want to'. There were no injuries that could be seen and when the officers enquired about support, Sarah politely asked them to leave. The officers deemed her not to be at immediate risk and left her address.

Later that day, Michael attended Sarah's home and left his dad waiting outside in the car. He found the front door open and allowed himself in. As he got to the bottom of the stairs, he found Sarah slumped to the right of the stairs slumped down with a cord around her neck. He called his dad and they began CPR whilst waiting for the ambulance to arrive. Sarah was pronounced deceased at the scene.

The police took a statement from Michael in which he stated that he had an argument with Sarah the previous evening as he was late home from work and she had kicked him out. She had a facetime call with him earlier that morning but he had not heard from her since.

The death was not deemed suspicious and a file was prepared for the Coroner.

2.3 Individual management reviews (IMRs) inc: Good Practice

2.3.1 – Sarah had frequent contact with a number of agencies from 2018 onwards. IMRs were requested from the following organisations because they had come into direct contact with Sarah and her family. They were lengthy due to the amount of information held and have been summarised where appropriate. Some direct quotes are utilised from reports and correspondence to provide context at that time.

2.3.2 Cambridgeshire Police

Throughout this IMR, the author has paid due regard to contextual issues, such as competing calls for service at the relevant time of each incident reported to the police, with reference to resource availability, response priorities and the recall of practitioners in respect of specific incidents, a number of which dates back several years. For context, the Constabulary responds on average to 1,400 reported domestic incidents monthly.

Within the period of the parameters of this review, there have been changes to how the Cambridgeshire Constabulary responds to incidents of domestic abuse under policy, practice, legislation and use of recording databases and operating systems. Responding to domestic abuse is a dynamic process and is under continual refinement to ensure that the key priority of the Constabulary to safeguard the most vulnerable, is prioritised whenever possible. Part of the time frame under review in this case is also recognised as being within the period of emergency legislation and guidance imposed during the Covid-19 pandemic, which may have had some influence on both the call-handling and the response to incidents.

The chronology is extensive with 80 separate entries and is therefore summarised.

26/03/18 – Police responded to a 999 call to a domestic incident involving Sarah and her son Daniel, whereby it was alleged Daniel had punched and broken a light switch following a verbal confrontation between them over Daniel's expected exam results.

Daniel was noted as having a number of healthcare conditions, notably referenced on the incident as Cerebral Palsy and Epilepsy and was reported as suffering from frequent seizures. Sarah reported that he had regular outbursts of temper which were often accompanied by him causing damage to items within the household. Daniel was 16 years old at this time.

Officers completed a DASH referral, which included the completion by officers of the child safeguarding and adult at risk forms (101 and 102) which narrated that Daniel's Cerebral Palsy and Epilepsy has been getting worse which resulted in his having to give up cycling due to him collapsing, on occasions, several times a day. This had caused him to feel extremely frustrated with his personal limitations and he took his frustration out on his mother by throwing things around the house and shouting at her. His school was aware of the episodes.

Officers spoke to all parties involved and it was noted that Daniel was having a '*difficult time both medically and emotionally.'* He felt that everyone around him was heading somewhere, and he had significant life limitations primarily because of his medical conditions. He had never been violent towards his parents or any other family members, but there was an apparent concern that due to his physical size, he was a threat with his behaviour and potentially difficult for his parents to physically control.

2.3.3 Sarah did not want any police action regarding the damage to the light switch but according to the narrative the reporting officers noted that she, '*seemed a little desperate for help.'* Sarah was reported as being frustrated with the situation involving Daniel, that she felt that she could not cope with his behaviour any longer with him and wanted more support. Although she declined to answer the DASH question set, the DASH risk assessment was completed by the officers and identified that there were no concerns for any of the other children present in the household and described their general welfare as appearing to be '*excellent*.'

The Integrated Mental Health Team (IMHT) operating within the force control room were consulted and confirmed that the subjects were not open to mental health services, which was good practice to check.

A significant incident marker[7] was added to the STORM command and control system for the address and a crime report raised. No further action was taken concerning the allegation of criminal damage following a review by a supervisory officer, due to no support from Sarah as the victim and as a consequence the associated lack of evidence. Although the incident and associated referrals identify the family were being encouraged to seek further support, it is not apparent what, if any other agency or support signposting was given to the family by officers.

Referrals were made for both safeguarding children in respect of Daniel and adult safeguarding referral for Sarah. The domestic incident was risk-assessed as being standard risk.

30/03/18 – Four days later, the police were called to a domestic incident involving Sarah and Daniel, whereby it was alleged Daniel had caused damage within the house, punching a mirror, causing a cut to his hand. He then smeared the blood from his injury over the living room walls. This had occurred during an argument where Leon had stopped Daniel's internet access after he refused to go to bed for the night. The attending officers spoke to the younger children at the address, and Daniel's behaviour was a common event, although they did not seem phased by what had happened. In stark contrast, Sarah had got to the

[7] This is an incident reference created on the STORM computerised system which immediately alerts control staff to previous incidents of DA (or other warning signals) for proportionate response.

point she no longer knew what to do with Daniel other than calling police as she was unable to intervene due to his size and aggression for fear of making the situation worse.

Officers graded the DASH as a medium risk and a crime report was raised for criminal damage, but no further action was taken due to Sarah not wanting to take any formal action against Daniel to prevent him being criminalised. A child at risk referral was made by officers, citing concerns in respect of Daniel, in particular his medical issues, but there were no concerns raised in respect of the other children present within the household.

When Sarah responded to the DASH question concerning about the worsening and escalation of situation – She responded - *"Before, his medication was an excuse, but now, he knows what he is doing. It's like he wants to hurt himself, hurt me, hurt his family. It's like he just wants to vent his rage at his life."*

Following a fourth incident with police attendance in May 2018, a nurse practitioner from Daniel's GP requested information from the MASH regarding safeguarding issues and was forwarded information from the officer in the case showing good collaborative working and information sharing, although the MASH did not forward any information as they did not have an open case.

Concerns outlined – *'Daniel has been having anger issue and has smashed the front room up. He has become more intimidating towards Sarah and is very abusive and controlling. Violent episodes have become worse recently and his mother is very afraid of his behaviour. There are several younger siblings at the address who are witnesses to this behaviour. Although no assaults or threats have been made concerns over the younger children being injured accidentally during these violent episodes have warranted a medium risk. No injuries but mother feels his mental health is deteriorating and she is living in fear of these violent outbursts.'*

16/03/19 – The police attended a domestic incident following a phone call by Sarah whilst having a verbal dispute with Leon. There was a delay before any resources became available for despatch to the incident and twenty minutes after the initial call, Sarah made a further emergency telephone call and said that she was now outside the address [with Leon] who could clearly be heard in the background by the call-taker. The argument appears to have re-ignited concerning Sarah not willing to stop her habitual drinking as was overheard in the background by the call-taker Sarah said she did not now require the police to attend, however the operator appropriately identified that Sarah's telephone contact with the police seemed to be escalating the situation between her and Leon and she was distressed and in immediate proximity to the alleged perpetrator. The call-taker ended the call and offier attended to find the situation was calm and Leon had left the location.

Indications were that the relationship between her and Leon was breaking down as Sarah had also admitted to having had an affair several months previously and although they had reconciled, Leon had read her text messages on her phone when she was asleep, discovering she had been speaking to an unknown male 'friend.'

No formal action was taken against either party as Sarah and Leon had already separated by mutual consent, with Leon finding temporary alternative accommodation for at least 24 hours. The domestic risk was graded as medium on the DASH. This was the first occasion that a domestic incident between Sarah and Leon had been recorded by the police. It was noted that there were three children at the address at the time but Sophie was not identified as being present. She regularly slept over at her friends.

March 2019 – Following incident reported to Police, disclosure of numerous altercations, some causing injury between Daniel and his brother Anton came to light. A crime report for Affray was raised but no DASH completed.

14/11/19 – This was the first incident of Daniel causing damage as an adult. Sarah stated that he was having multiple fits per day and his medication may cause some of his personality traits. An adult at risk referral was made to the MASH as Daniel was now aged 18 and was shared with the CPFT and IMHT. Although the other younger siblings were present at the time, no separate child safeguarding referrals appear to have been made by the attending officers. The DASH risk was standard.

06/12/19 – Police were called as Daniel had caused damage and as he slammed the door, it had rebounded on Lucas. Sarah was reluctant to pursue any prosecution against Daniel, however she pleaded to officers for some sort of help. In intervention response, Daniel was removed from the house to give everyone some space and for him to calm down and was taken to a friend who lived nearby. Sarah indicated that she had been trying to get help for Daniel to move into supported independent living however, he was not willing to engage with support services and took out his frustration on her, effectively bullying her. An adult at risk referral was made along with a child at risk referral in respect of Daniel's siblings, present in the household at the time.

Two crime reports were raised in respect of the criminal damage and assault on the sibling. Sarah again declined to make any formal complaint and would not support prosecution concerning the alleged common assault on Lucas. Although Sarah declined to support any formal action by the police, it does not appear that she was advised that by addressing the problem directly there were opportunities to have led to diversionary actions and support from a multi-agency perspective. Daniel was initially arrested but refused charge due to lack of evidence and returned home to Sarah.

Two days later, a review by an experienced supervisory detective concluded that in respect of the assault on the sibling, the parents were not supportive of prosecution and the sibling's welfare was not of concern, had suffered no injury and cited the difficulties of formal action in respect of *"Daniel's disability affecting his brain function."* The temporary relocation of Daniel was noted as not being a long-term solution.

The investigations were closed with no further action taken. It does not appear that a Child safeguarding referral was completed as should have been expected in respect of the assault against Lucas.

01/04/20 – Daniel arrested following further damage in which neither Leon or Sarah supported police action. He was refused charge and the crime report commented,

'*Over the period of one year the suspect is alleged to have caused damage on separate occasions to seven televisions. The victim has provided a statement but due to the time that has elapsed since the alleged offences there is no other supporting evidence. The suspect has provided an account when interviewed in which he gave a vague account that he could not remember the dates of the alleged damage and that he may have damaged one item by accident previously but could give not specific details on this. There is no other supporting evidence in this case.'*

There was a pattern of offending herein and given the nature of the allegations of Daniel having destroyed several television sets, this could have been evidentially led based on similar fact evidence and evidence gathered in the previous attendances by the police. This may have provided compelling grounds for diversionary actions.

Numerous further incidents occurred involving Daniel and following a further arrest in August 2020, the primary report commented,

"Due to the amount of incidents & the fact this is family related Domestic Abuse, positive action needs to be taken to address this ongoing situation." Some 15 incidents of domestic abuse and associated recorded crimes were identified as having occurred within the previous twelve months.

An out of court disposal was agreed by way of a conditional caution as Sarah and Leon did not want Daniel to be criminalised but were nevertheless supportive of the positive action being taken by the police.

2.3.4 The Inspector authorising the proposed diversionary action determined, *"In my opinion a Conditional Caution is the best course of action at this stage because it will assist the suspect in getting the support that he needs to address his pattern of offending against his parents. This is also what the parents want. They have previously withdrawn support because they do not want their son to be criminalised."*

Comment: On 1st September 2020, Daniel was issued with a conditional caution for offences of criminal damage and assault in respect of the culminative occurrences of August 2020. However, although the respective records identify a conditional caution was formally given, there is no corresponding record of this within Daniel's PNC record, which indicates that the process is or was incomplete. It transpires that an NFA result was appended to the closing crime report whereas the record should have identified that a conditional caution was issued to Daniel.

Daniel failed to comply with his conditions to engage with Outside Links, a referral project, but no formal conclusion appears to have been reached and by June 2021, Daniel's casefile record identifies that the Liaison and Diversion Services (LaDS) had remained unable to

contact him. LaDS is an NHS mental health triage service initiated whilst in police custody. (Recommendations can be found at the end of this report in relation to this)

There is no record of the conditional caution of September 1st, 2020, appearing on Daniel's PNC record.

Police refer to LADS for anyone deemed vulnerable and in the CJ system. (the criteria is vulnerable, not mental health). This can be in custody and so an individual does not need to go to the custody suite. The nurse has up to 21 days to contact the person and do the assessment and put a plan in place if appropriate. Daniel only needed to talk to the nurse and answer some of the assessment questions to meet the condition.

13/10/20 -Police were contacted by an emergency telephone call made by Sarah, stating that Daniel had punched Leon in the face. Daniel had been at Sarah's home temporarily due to him having a significant epileptic seizure earlier in the day. Leon had asked Daniel to use his tablet to get his grandfather's electricity supply arranged but this wasn't completed, and Leon had then told the grandfather that Daniel was the reason he was unable sort the electricity out. Daniel took immediate offence to what Leon was saying and reacted by punching him to the face. Consequently, Sarah then locked Daniel, Leon, and Anton outside in order to keep her and her other children, Sophie, and Lucas safe. Daniel proceeded to kick Leon to the face causing an eye injury at which point Daniel suffered a severe epileptic seizure.

Daniel was arrested at the scene by officers for assault occasioning actual bodily harm but in view of his seizure, he was taken directly to hospital but was then de-arrested[8] as he was required to remain at the hospital for monitoring, overnight.

Sarah was contacted by officers and stated that she was happy for Daniel to return to her address on his release from hospital on the basis that the matter would be investigated and dealt with appropriately. The inter familial domestic incident was graded as being a standard risk. Leon was supportive of prosecution; however, it was initially deemed disproportionate in a crime review by a supervisory officer, due to Daniel's medical issues. However, this was based on information from his parents, not a medical practitioner.

Leon was concerned about this decision as Daniel's current behaviour left him feeling like he had no other options, and he could not continue to contend with his offending. Leon was of the strongly held viewpoint that Daniel's behaviour was being continually excused by blaming his epilepsy and that the actual events were not considered in isolation.

2.3.5 As a consequence, the incident and circumstances were independently reviewed by a Public Protection Department (PPD) Detective Inspector, who recommended further avenues be explored in the first instance as this was "*a family subject of both frequent and*

[8] Officers are empowered to de-arrest individuals without the requirement to take the suspect into a police custody facility where circumstances make this a proportionate response. There will be no corresponding custody record reference other than the officer's notes/rationale if applicable.

repeated occurrences of domestic abuse and was centred on an individual's behaviour towards members of the family." Specifically, it was determined that further enquiries should be made in order to consider an out of court disposal and that appropriate independent advice should be sought once the facts were established.

Officers spoke to Sarah, who stated she did not wish to support any official prosecution action as she did not wish to criminalise her son, assuring the investigating officers that she was receiving more support than had previously been the case, although she gave no details concerning this. She did indicate that Daniel was due to have a mental health assessment, but that he had also suffered a considerable number of epileptic seizures which affected his behaviour.

The Out of Court Disposal team were tasked to review the case. The outcome was that the team did not support a conditional caution, citing that as such, it would be disproportionate and achieve nothing for the family and that Daniel's GP should be consulted if the behaviour was considered to be linked to his current medication. The conclusion was that in order to find proof (mens rea) this was potentially obscured by the chemical and physiological reaction to his medication. The referral to an NHS pathway was considered as the most appropriate way forward.

Further contact made with Sarah and Leon found them both to be non-supportive of taking any formal action against Daniel as they did not wish to criminalise him. Daniel was de-arrested at hospital and not taken into police custody.

The Crime report states that, *"there has been diversionary, educational and/or intervention activity against the suspect and therefore it is not in the public interest to take any further action. NHS/Lads. NHS best placed to assist as [Sarah] not engaging."*

Comment: Whilst the review is cognisant of the narrative on the crime report made by the Out of Court Disposal team (OoCD), Daniel had previously been subject of a diversionary process of a conditional caution in September 2020, but this does not appear on the PNC record of Daniel. With no obvious previous record, this diluted the positive action that could have taken place, and this was an opportunity missed to get Daniel and thereby other family members, intervention other than by prosecution and with other agencies and professional's support, given he was already within the judicial system. Although the victims declined prosecution, there was evidence of damage and injury seen by officers that could have led to an evidence-based case being prepared. The omission of the conditional caution dating from 01/09/2020 on Daniel's PNC record is likely to have been a contributory factor in the overall decision-making process and in itself should have triggered the preparation of a casefile for decision making.

19/12/20 - Police were called by an emergency telephone call made by Sarah who was requesting the attendance as soon as possible to her home as Daniel had assaulted Leon and was damaging the house. This had occurred after Daniel was asked to have a shower by

Leon following him making a mess cleaning the toilet. This escalated when Daniel punched the walls causing damage to a picture and frame. Sarah had indicated that her two youngest children, Sophie and Lucas were present, and officers attended in immediate response.

On arrival and as on previous occurrences, Sarah asked the officers to assist in removing Daniel, but she informed the officers that she did not wish for any action to be taken against him.

In order to de-escalate the situation, officers decided to take Daniel to his home. The incident had clearly affected the two other children in the house at the time, and officers made a safeguarding referral for them. Leon stated that despite the fact that Daniel was living independently in accommodation that the family paid for, he would frequently visit Sarah's home and cause issues and he felt that Daniel actually needed supported living accommodation where he could be supervised as there remained significant concerns for his mental health and he needed to be seen by healthcare professionals.

On this occasion, Leon stated he would make a formal complaint if this was to lead to a Conditional Caution for Daniel as his behaviour was a constant cause for concern and they no longer wanted him to attend their home because of the issues that he caused.

The Protecting Vulnerable Persons Department Detective Inspector added a senior officer's review identifying the considerable number of calls to the address in the previous twelve months and that the problems were repeated and not being dealt with, and repetitive issue was clearly a defining factor in the calls for service.

2.3.6 The review requested that the investigating officer secured statements from Sarah and Leon in order for the case to progress for diversionary action and that to date no support or implementation appeared to have been made for Daniel because of the lack of formal progress by any agency. "*This is a repeat Family Related Violence address, with 18 previous calls to the address. A number of assault and damage investigations have been raised during this time - the family are unsupportive of prosecution as they do not want to criminalise their son. Whilst I fully understand this, we are simply not dealing with the problem longer term. Please can we approach the family with a view to obtaining a statement to support a conditional caution - we can then seek an appropriate out of court diversion (such as anger management, something he [Daniel] clearly has issues with) to try and prevent recurrence in the future."*

The investigation notes identify that the investigating officer should – *"…speak to OoCD and get their advice on what can be put in place."* This action does not appear to be documented further and the investigation was closed within two weeks, and it appears without statements being obtained from Leon and Sarah or a further supervisory review. The allocated officer closed the report as follows, *"I have completed a full review of the crime and I do not believe there to be a realistic prospect of conviction; all reasonable lines of enquiries have been completed."*

IMR author's Comment: The review counters the conclusion reached in this particular investigation and identifies that the investigation was not conducted in accordance with the senior detectives' observations and directions and not all lines of enquiry were completed. No further work was conducted. This will be referred back for supervisory officers to consider words of advice to the allocated officer and determine if there has been a conduct matter.

04/01/21 - Police were called by Sophie in an emergency telephone call, stating her parents were arguing and a glass had been broken. The child told the call-taker she was ending the call so she could comfort her younger sibling Lucas, who was distressed.

Sophie had told the call-taker that she had told Leon she was calling the police and that her mum, Sarah, had a cut from a broken glass, but the circumstances were otherwise unclear. On arrival, officers were met and given access to the house by Sophie who told them that her parents were in an upstairs bedroom.

Officers found Leon restraining Sarah, who had a cut to her hand which required medical attention and who had been threatening self-harm, after she had been consuming alcohol during the evening demanding Leon fetched her more which he had refused. Sarah was worried she would use the broken glass to cut herself, hence his restraint of her which in turn created the disturbance.

Following extensive negotiations with Sarah by the attending officers, Sarah agreed to voluntarily attend the hospital emergency department, but then stated she would abscond if she was taken voluntarily. She became aggressive and attempted to strike Leon. Officers intervened, restraining her, during which time she assaulted one of the officers and was arrested for assaulting an emergency worker.

She admitted that her behaviour was affected by her misuse of alcohol and that this was a problem for her.

2.3.7 An out of court disposal by way of conditional caution was given for her to engage with CGL[9] for the assault against emergency worker and no action was taken in respect of the common assault on Leon although there was body worn video which captured the occurrence had an evidential prosecution been considered, but Leon did not wish to have any action taken. A Domestic Violence Protection Notice (DVPN) was considered but did not meet the proportionality threshold requirements in order to seek a superintendent's authority.

A MARAC referral was made on professional judgement of a Detective Inspector from the Public Protection Department who had noted the *considerable number* of calls for service to the family in the preceding twelve months and the lack of support to positive action by those affected, by the behaviour of Daniel. The comment in support of the referral was, *"I*

[9] Change, grow, live. Cambridgeshire Drug and alcohol service.

really feel that multi-agency support is required with this family due to their multitude of issues."

Sophie appeared to have taken a mature approach by comforting Lucas during the incident and remarkably, she presented as very calm to officers, but she raised concerns that she would like to speak to someone about what was happening in the house as it was affecting her wellbeing. A child safeguarding referral was made in respect of both Sophie and Lucas.

01/06/21 - Daniel was arrested following a common assault against Leon. Daniel made admissions in interview stating it was not his intention to hurt his dad, but he had done so in order to "*make him feel how shit I feel inside*." A Supervisory officer's disposal management note on the custody record identified that a conditional caution was to be sought in order for Daniel to complete an online anger management course.

However, as Daniel had previously been referred for a conditional caution a case file was in fact sent to the Crown Prosecution Service for a decision. The supervisor's case review was "*There is a realistic prospect of conviction in this case, and it is in the public interest to prosecute for the following reasons: [Daniel] has had Out of Court Disposals, there is a continued pattern to his poor behaviour, it is thought [Daniel] will not comply with conditions placed on him outside of a court setting*".

However, the CPS referred the case back for further enquiry with the family and for more information to be gathered for a prosecution decision to be made. However, the investigating officer narrated to the supervisory officers, that the case continued to lack sufficient information in order to build a case for a further decision to be made by the CPS and consequently the case was not re-referred to the CPS as no further case was built and a decision was made by a police gatekeeper for a conditional caution.

08/11/21 – Call received from Leon stating that he was taking Sarah to the hospital emergency department as Anton had informed him that Sarah had taken an overdose of his blood thinning prescribed medication. Sarah was seen at hospital but discharged following an examination where it is inferred that no medical attention was necessary.

Leon refused to take her home without getting further medical attention causing her to walk away from the hospital emergency department stating she would *"rather die than be here with you*." Leon made further contact with the police expressing his concerns for her safety. He informed officers that Sarah had said that she wanted to die and that he should go to her house in order to look after the children. He had found her in a distressed state and took her direct to hospital earlier.

Officers left Sarah in care of healthcare professionals at the emergency department. The domestic abuse DASH identified a standard risk. An adult at risk referral was made concerning Sarah in view of the drug overdose and her mental health.

The Domestic abuse investigation was referred back to the submitting officer and the supervisor by the MASH for queries to be addressed of – *"Can you please give more information in the lived experience of the child as the DASH states both children live with [Sarah] Where were the children when all this was happening? Who was caring for them? We will need to share this with Children's Social Care due to mother's mental health, so we need to know if the children were/are at any risk and what safeguarding was/is in place for them."*

Comment: Unfortunately, the request for the additional information was not tasked to the officers and was sent via e mail and consequently does not appear to have been completed in response.

16/11/21 - A request was made to the MASH from social care for a strategy discussion due to concerns that Sarah had taken an overdose whilst caring for the children. The MASH research identified thirty-three incidents involving Sarah, predominantly as a victim of DA but also self-harm incidents, of which eight were recorded in the previous 12 months.

This identified that Sarah had indicated that the most recent incident was alcohol fuelled and triggered by her own mother's suicide four years ago. Daniel's vulnerabilities were noted due to his increasing seizures since 2014. Sarah had also spoken of her own experience of having suffered sexual abuse as a child.
From the police perspective circumstances of the incident leading to the strategy were provided appears to be a pattern of Sarah continuing to take overdoses but not being willing to accept help for her either her personal mental health or her alcohol abuse which meant that Sarah was failing to put the needs of her children first. The police perspective was however, that this should be single agency to social care as there was no ongoing role for police. The strategy outcome was single agency s47, Social Care.

04/12/21 - The OOCD team determined that Daniel would be referred for 'electronic anger management' and he was sent an email with the following narrative.

"Please note the conditions you have agreed to as part of your Conditional Caution. Should you fail to adhere to these conditions before the completion date, then you will be reported for summons to attend Court."

Daniel did not comply with the conditions or respond to the request. Communications on December 1st, 2021, appear to confirm that Daniel had not commenced the anger management. There is no indication that a personal visit was made to him in connection with the breach. The author's understanding is that the case should have been referred to the CPS for a charging decision based on the non-compliance to the conditional caution, however as by December 2021, six months had expired since the commission of the offence, and that any prosecution for a summary only offence would have been out of the statutory time limits.

The files reviewed do not indicate that in view of the failure by Daniel to comply with the conditional caution what action, if any, was taken in respect of the breach.

15/04/22 - At 04:50am on the 15th of April 2022, the police were contacted in an emergency telephone call made by Anton that Sarah was drunk, suicidal and had had some razor blades and broken glass taken away from her. Anton was upset but it was also established that Leon was at the premises. The police referred the call to the Ambulance Control as the incident was determined as having no immediate threat or risk to life and was identified as a medical incident. At 05:36 the police received a further emergency telephone call by a third party stating there was a domestic ongoing at the address and that they could hear screaming and shouting. A further call was received as an emergency call at 05:40 this time made by Leon who stated Sarah was drunk, and he demanded that the police should attend as she was going crazy, she had stabbed herself and cut her neck.

The child safeguarding referral identified that Sarah had the children for the day, but when she started drinking, Lucas contacted Leon to tell him what was happening. It was unclear of the extent that children witnessed the self-harming elements of the incident, however it is likely this was witnessed by both Lucas and Sophie at some point. Referrals were made to agencies accordingly and a case conference was requested by social care.

A strategy meeting was convened. It was established that both Anton and Daniel had been staying with Sarah, damaging her property. Anton was angry that he wasn't allowed to stay over, and he was also consistently drinking, and razor blades had also been found in his room. Sarah was reported as feeling that everything was getting on top of her, and felt Daniel was goading her. Sarah admitted to self-harming but also shown that she was black and blue from being hit by her partner [undisclosed] and that Lucas normalises the behaviour.

An agreement was made in the meeting for the following: Daniel not to have direct contact until further review. Sarah consented to a family safeguarding mental health referral and for CGL referral to be followed up and she would continue to talk to her GP. Lucas and Sophie remained subject to a CP plan for emotional abuse. These are the recorded details and there is no further information.

20/07/22 - On the 20th of July 2022, police were called from a third-party reporting concern for a female believed to be the partner of Michael, indicating that he was suspected of subjecting her to coercive control and that the alleged victim in question had bruising to her legs and had been noticeably upset at a planned social appointment. Officers attended and established that the reported circumstances were incorrect, and that Michael was not in fact an intimate partner of the alleged victim, although he was a friend but there was no suggestion of any abuse by him. Sarah appeared shocked that any such inference had been made and admitted she was tearful as her father had recently died and she was mourning and struggling with his death, which may have been why the third party had made a number of assumptions. She had no injury as was suggested. No further action was taken. Officers did not see Michael.

23/08/22 – On attending an incident at Sarah's home address regarding her self-harming, the children were seen by other officers at the neighbour's address and their voice was recorded on the incident, which was good practice, especially considering the confusion concerning actual events at that time. The children did not appear neglected or traumatised as might be anticipated arising from the original call information.

Lucas was spoken to and disclosed that his Mum often cries but that everything at home was fine and that he was happy. Sophie, by contrast, gave the impression that Lucas had seen and heard more than he was saying. She stated that her Mum does cry sometimes, and they both worry about her, but could not specifically say why. A child protection referral was made for Lucas and Sophie alongside an adult at risk referral for Sarah.

24/10/22 – At 01.04hrs, the police were called by the ambulance service disclosing that Sarah had been assaulted by her boyfriend that day as well as having been assaulted by him the previous day. She had bruises and a black eye consistent with an assault but had marks consistent with self-harming with a razor blade. Bleeding was under control. The incident was graded for response in order to establish the cause of the injuries alleged from a third party, but not as an immediate response and the ambulance control was advised accordingly.

At 01.13hrs, police received a further call by the ambulance service stating that the same female had since fled to another address having been assaulted by her boyfriend. Officers attended the location at 01:22 am and located Sarah on the pavement in the street close to Michael's address. She had no footwear and appeared intoxicated. She had visible swelling to her forehead, a black eye, and bandages on her wrists. Sarah was either unable to engage with the police or paramedics who had attended at the same time.

Paramedics deemed Sarah not to have capacity for treatment decisions and therefore, a best treatment decision was made under the Mental Health Capacity Act 2005. She was conveyed to the emergency department where officers attended and followed up the initial investigation.

2.3.8 Sarah provided an account to officers that on the 22nd of October, she had received texts from her son [Daniel] calling her a bad parent, a bitch, and other derogatory comments. This led her to cut her wrists whilst staying at Michael's address, who had then told her to leave. On 23rd October, Sarah had returned to Michael's along with Lucas and Michael told her to clear up the blood and mess that she had left the previous day. Sarah started to clean up as instructed by Michael but consumed alcohol whilst she was doing so. Michael then became annoyed with Lucas being present as he was making too much noise telling Sarah to chastise him. This led to a verbal argument which increased in intensity. Sarah went to headbutt Michael, but he placed her in a headlock, and she was unable to breathe, and she lost consciousness.

When Sarah came around, she tried to headbutt Michael again whereby he grabbed her by her hair, dragging her downstairs and then out of the house and that he was exerting so

much pressure on her that she felt she would lose consciousness again. Michael slammed her head onto the pavement, holding her face down stopping her from getting up. Michael shouted at Lucas to get out of the house and once he did so, Michael retreated inside leaving Sarah and Lucas outside, throwing her belongings out of a window for her to gather up. Sarah also alluded to the fact that Michael did not let her use social media or have contact with any friends and mentioned other incidents that had taken place during their three-month relationship but not on the scale of this incident.

An account was also taken from a friend who said that Sarah had fled to her address in the immediacy of the incident unexpectedly and had told her that she had been "*battered*" by her new partner and had been pulled down the stairs by her hair. Her friend could see that Sarah had a black eye and a large lump on her forehead. The friend returned Sarah to her home address, where she went to sleep but later when she returned to check in on Sarah, she was unconscious and unresponsive. It transpired that Sarah had consumed alcohol in the interim. Another neighbour came round to look after Lucas and when Sarah regained consciousness she ran out of the house, with her friend running after her and calling the emergency services. The same friend disclosed that two months prior to this incident, Sarah had told her that Michael had placed his hands around her throat, but she did not report this to the police, despite others encouraging her to do so both at the time and since.

2.3.9 Lucas was also spoken to by officers, and he gave a similar version of what had happened to his mother on the 24th of October from his perspective identifying Michael as the person responsible for attacking her and throwing them both out of the house.

A DASH risk assessment was completed with a medium risk by the attending officer and a child at risk referral made in respect of Lucas. Lucas was subject of Police Protection as Leon was not contactable and there was an immediate need to safeguard him from further harm. It was established that Sophie was safe and well as she was staying at another address at the time of the incident.

The Domestic assault was appropriately re-graded by a supervisory officer as a high risk with a request for a MARAC referral before referral to the MASH. This was to reflect the offence of non-fatal strangulation.

Michael was located, arrested, and interviewed, suggesting that Sarah was the aggressor, and he was acting in self-defence. The matter was referred to the Crown Prosecution Service (CPS) for a charging decision. Sarah, however, did not wish to cooperate with the investigation and without independent evidence the CPS declined to prosecute without the victim supporting action. Sarah was repeatedly engaged with during the investigation and maintained throughout that she was not supportive of a prosecution, making light of the fact that she was not scared of Michael but that the relationship was over. Michael was found to have injuries consistent with having been bitten. The case was referred back to the police, who are empowered to appeal a CPS decision, but this was not considered. The

matter was however, considered for a domestic violence protection notice (DVPN) as this was identified as a high-risk domestic abuse case.

2.3.10 The initial consideration was made by a supervisory officer, noting the evidential difficulties within the case which primarily were Michael had no previous domestic abuse history with Sarah, or other partners, no relevant previous convictions; Sarah, when spoken to concerning the DVPN, made it very clear she was against this and when asked about whether she feared Michael, she appeared to regard the prospect as amusing. Michael had injuries himself and provided a full account in which he alleged Sarah was the main aggressor, she had admitted to trying to headbutt him and had bitten him. They had both stated that they had separated and were living at different addresses.

The supervisors' initial views in respect of the DVPN were:

"In terms of the DVPN we would of course have to disclose everything [to the court hearing the application] including the reaction of the victim when asked about whether she feared the suspect. I think there are a multitude of reasons as to why a court would have rejected the application."

The matter was, under policy, referred to the on-call Superintendent who is responsible for independently assessing the application. The rationale in this case was, in writing from the Superintendent:

"On the basis that (i) the person to be protected, [Sarah], did not support the DVPN (ii) the perpetrator was not known to police prior to this incident, and, (iii) the relationship had ended meaning that neither party had to go to the other's home addresses, the decision was taken that a DVPN would not offer significant additional safeguards that could not be achieved by them not being in a relationship and not attending each other's home addresses. The DVPN was refused on this occasion.

Comment by IMR author: The reviewing officer has examined the casefile for the assault, and it is apparent that although the offences alleged were of a serious nature – which was re-assessed as non-fatal strangulation in accordance with statute (Domestic Abuse Act 2021), there were significant evidential inconsistencies, as Sarah did not support police action by making a statement, giving testimony or consent to the release of medical evidence. This unfortunately undermined the potential prosecution case.

2.3.11 Having reviewed the actual evidence, the supervisory review and the Superintendents rationale, the decision making in this case is proportionate taking the issues as raised.
The MASH made a referral to MARAC.
The Police Protection Order report and strategy meeting record for Lucas and Sophie states:

. "*There has been a history of coercion and control with both Sarah and Leon accusing each other of control and coercion and nasty behaviour. They have had a relationship where they have been together, split up, got back together, and split up again. Communication between them is tense. There is still regular shouting and aggression between the couple and between the adult children in the family: Daniel and Anton and their mother and boyfriends of their mother. Daniel and Anton no longer live in the family home. However, Sophie and Lucas have witnessed all of this. Sarah's sister [Hayley] said Sarah has significant childhood trauma and does not feel the children should be returned to Sarah. Sarah's sister said they feel the family have been let down."*

The matter was sent for legal advice by social care and there were no further actions for the police to pursue.

A further strategy meeting established that Sarah's most recent incident was alcohol fuelled and triggered by her own mother's suicide 4 years prior, her own experiences as child of sexual abuse and her struggles with Daniel's behaviour. The children were reported as nervous and frequently attending school hungry. Lucas was receiving pastoral support stating that arguments between mum and dad and his older brothers shouting made him sad. Sophie in comparison, was described as being mature and emotionally resilient although having witnessed distressing events. A single agency (social care) S47 was made with no ongoing role for police, with social worker to see the family within 24 hours. Sarah didn't engage with her GP and didn't wish for support from mental health or alcohol services.

16/11/22 – CGL had not been able to contact Sarah for a couple of days when she had been tearful and upset. A welfare visit from the police was requested. The information received from CGL was that Sarah was believed to be consuming two bottles of wine a day, and there were suspicions of drug taking and that she was understood to be back in an abusive relationship with Michael, who was had seriously assaulted her in October.

Officers attended for a welfare check and found Sarah at her home with Michael. Sarah stated her phone had recently broken hence her missing meetings and being uncontactable although she did not feel up to attending the meetings in any event. Although officers felt that she seemed upbeat, she became slightly tearful, stated she was not feeling suicidal and had not self-harmed. Officers signposted her to the NHS 111 service and the Samaritans and completed an adult at risk referral. The referral information was shared by the MASH with GP, IMHT and CGL.

January 2023 – At 08.28hrs, a call was received by Leon stating that Sarah was outside of his address and had been banging on the front door for forty minutes. Sarah had told Leon that she wanted to give Lucas '*one last cuddle'* and he was concerned she may have done something to harm herself. Leon made a further call a few minutes later stating that Sarah had left the location on foot. No unit was despatched.

The force control room supervisor reviewed the incident for closure and identified that there was a potential risk of harm to Sarah and that she should be located to ensure that she was safe. Consequently, officers attended Sarah's home address and spoke with her. Sarah answered the door and seemed confused as to why officers had attended. She allowed the officers into the living room, who then explained that they were coducting a welfare check and asked her what had happened earlier in the morning. Sarah appeared erratic in her behaviour and speech and was agitated by the officers' presence and did not want to tell the officers what had happened, only that she had burnt some toast and had gone to Leon's. She became tearful in parts of the conversation and explained that she hadn't seen Lucas over Christmas.

Officers visited Leon in response to the contact with Sarah and he indicated that he believed that Sarah's behaviour was triggered when there was a domestic incident between Sarah and her new partner, but he had cut all contact with her, other than concerning child contact. It was his belief that there was domestic abuse in her new relationship but gave no provenance to this suggestion. No domestic related incident was identified.

Later that day, the police received a call from Michael reporting he had discovered the sudden death of Sarah at her home address. He informed attending officers that they had argued the previous day after he returned home late from work, and Sarah had "*kicked him out*," believing that he'd been at the pub and not working as he had told her. As a consequence, he went to stay overnight at his parents' home.

2.3.12 He told officers that he last spoke to Sarah on facetime at 9:39am that day, where she was in a highly intoxicated state, making comments about not wishing to continue with her life. He stated that Sarah was an alcoholic and regularly consumed alcohol until she became stupefied. He did not respond to her further or report any concerns to other agencies as he did not believe that she had any intention of harming herself.

When Michael returned to Sarah's home at 3.30pm, he found that the front door was unlocked and entering the house, he immediately discovered Sarah hanging from the banister on the stairs leading to the first floor. She was slumped to the right side of the stairs in a seated position with a cord tied to the banister around her neck. He immediately called the emergency services and with his father, who had driven him to the location, they attempted resuscitation before the arrival of the paramedics. Sarah was declared deceased at 3.47pm.

Neighbours reported that hearing disturbances at Sarah's address was not unusual, and this was also borne out by the volume of attendances made by the police to reports made by Sarah and other members of her family over a period of a number of years. However, there was no suggestion of any third-party involvement in Sarah's tragic death, and it was concluded that she appeared to have taken her own life. The cause of death was asphyxiation.

Upon delivery of the tragic news of the death to Sarah's sister, Hayley, she expressed concerns to the reporting officers that Sarah had been more isolated from both family and friends, since a serious incident involving her partner Michael in October 2022.

The police investigation into the apparent suicide and circumstances preceding her tragic death indicated that domestic abuse featured as frequent occurrences within Sarah's background. A file was passed to the HM Coroner by the police and in view of the background of domestic abuse, the matter was referred to the Community Safety Partnership.

2.3.13 Initiatives, innovation, and practice:

Since the introduction of the Integrated Mental Health Team in the Force Control Room, there are other mental health initiatives that are available for the police to gain support when dealing with mental health issues. These are notably First Response Service (FRS) Mind Sanctuaries, reintroduction of the Liaison and Diversion Services (LaDS) in police custody. These initiatives have a history of working seamlessly together and which do not overlap. This is due to the specific nature of each project and the different areas of responsibility that they cover. The IMHT acts in a liaison role between all areas of front-line policing and mental health provision in Peterborough and Cambridgeshire as well as offering advice and support to officers at incidents.

In practice, this means that any incident that has or is suspected of having a mental health link, is flagged to the IMHT for an immediate review[10]. The IMHT can step in and take over the responsibility for supporting the officers in response to the incident or provide an immediate fall-back for advising officers during the progress of the incident.

The IMHT does not operate on a 24-hour basis but is operational at core times and consists of three Mental Health Nurse Practitioners, who work on a rotational shift basis and are located in the Cambridgeshire Constabulary force control room, with the core operating hours, Monday to Friday 10.00 – 22.00 and at weekends 13.00 – 21.00 hours. The duty practitioner provides advice and guidance to constabulary staff where there are potential mental health concerns for an individual of any age or nationality. They have access to medical records from the local healthcare trusts under information sharing protocols. This is a unique mental health provision that does not overlap or detract from any other mental health service provision across agencies and healthcare providers.

The IMHT will triage incidents with 'mental health' closure code 'tagging' that have taken place outside of their operational hours to gather relevant information. Constabulary call-handlers may also refer cases to the IMHT. This is completed on the basis that some of the

[10] When the team is on duty – Incidents outside of the duty timeframe are flagged for review by the IMHT.

cases may be open to mental health services and would involve calling the Care Co-ordinator, advising them, and updating their mental health records if relevant. The team also monitors the police STORM system for any incidents that may be relevant to mental health such as calls for concern, missing persons, and sudden deaths, and can share information in accordance with the agreed Information Sharing Protocols (ISP). As the team is co-located within the FCR environment, the lines of communication are immediate and capable of 'live time' professional discussion. The MASH will also refer incidents of relevance to the IMHT which include Adult at risk referrals with mental health concerns raised by officers.

2.3.14 In 2022 the constabulary introduced a 'mental health car' response function, across the south of the force area and in late 2022, this function has been broadened to two mental health cars. This deploys response (uniformed) police officers alongside a mental health trained nurse in a police vehicle, acting as a combined resource. This is a two-year pilot scheme. However, this service did not support Sarah or attend on the date of her death.

On average each of the mental health cars attends four incidents in a shift and operates between the hours of 1600 to 0200 daily, seven days a week. Attendance can be lengthy, depending on the nature of the response and the resource reduces the impact to operational deployment, freeing up resources. The mental health car compliments the IMHT but on an operational perspective can become the core response at an incident involving mental health. Although the two functions are not combined, the IMHT is able to provide a direct support to the mental health car, accessing medical records and other first response support. The two functions are able to operate on a dedicated communication channel reducing attrition to other services within the FCR although the IMHT will continue to respond to and support other flagged mental health incidents as required. The operational hours of both resources are aligned to the core requirements to incidents involving mental health. Mental health incidents outside of the core hours will be resourced accordingly.

In April and June 2021, two additional safeguarding functions were introduced in Cambridgeshire to support frontline decision making. The Early Intervention Domestic Abuse Desk (EIDAD) went live in June 2021. This function exists from the point that a domestically related call is received by the Force Control Room (FCR) When identified as a domestic abuse incident, the EIDAD will commence research which will involve identifying previous domestic related incidents, warning markers for parties at the address and any previous MARAC involvement. This information is then formulated into a research package which is then sent directly to the attending officer. Officers can also consult with the team directly from the scene.

2.3.15 The purpose of the EIDAD is to improve frontline decision making by providing staff with as much information as possible to make informed safeguarding decisions at the scene.

This also builds in an additional layer of safeguarding from a dedicated team in the ability to access information that the attending officers would not have time to research.

The Vulnerability Focus Desk (VFD) was introduced in April 2021 and is designed to support frontline decision making in the two critical areas of Missing Persons and Domestic Abuse. In respect of Domestic Abuse, the team function as tactical advisors for the initial safeguarding of the victim, investigative considerations and any onward steps which may be necessary, such as Domestic Violence Protection Orders (DVPO). The team advises frontline staff on which cases will be suitable for a DVPO and will support staff in preparing both the application and subsequent court processes. The Constabulary has also widened its own defined circumstances when a DVPO will be considered – medium and standard risk cases are now considered where there is an ongoing risk of harm identified and there have also been several cases where DVPO's have been successfully applied for alongside police bail conditions where the risk of harm is deemed to be exceptional.

2.3.16 Multi-Agency Safeguarding Hub

The MASH continues to dynamically evolve with initiatives to share information in an integrated safeguarding environment. A dedicated administrator within the MASH for transferring the adult at risk referrals to GP practices, has been recruited and although will be a Constabulary employee, the post-holder will have an honorary contract with the NHS and will be able to access health records. This should ensure that concerns that don't meet the threshold for Adult Social Care or CPFT (are not already cases that are receiving care through CPFT) will be shared with the individual's GP practice without delay.

2.3.17 Changes in process

In July 2019, the Constabulary reporting process for DASH referrals in family domestic scenarios (family related domestic abuse, not intimate partner abuse) was amended in that risk assessments were made on the incident report and were no longer subject to a separate DASH submission. The risk assessments made by the reporting officers were required to be supervised in order to ensure that all risks were adequately assessed, the categories of which remained as Standard, Medium, or High, in line with domestic abuse policy. This was designed not to minimise or subjugate the inter-familiar perspective, but to separate and identify the incident as either an intimate partner or familial occurrence.

From April 17th, 2023, officers will be able to record information and complete risk assessments at scenes with a new streamlined digital service which will reduce the need for duplication and ensure partnerships receive more timely referrals from the MASH.

2.3.18 Lived-in experience/voice of the child

Officers are encouraged to use the acronym VOICE in ensuring that wherever possible, any child/children present within a household in order to establish their lived-in experience. This

followed on from the National Child Protection Inspection in 2021. The changes took place from February 2022 and the acronym refers to:

- Vulnerability
- Observe
- Intelligence
- Curiosity and communication
- Environment

By ensuring each of the questions are answered, it allows officers to record the child's lived experience and assess against professional judgement to inform decision-making and risk assessments. In basic terms, it triggers officers to see the situation through the eyes of the child and record it in such a way. (analysis on effectiveness is made at 3.3.3 of this report)

2.3.19 Good practice/Reflective considerations:

A report narrative from 30/03/18 incident reflects the voice of the child, outlining:

"Upon speaking to the younger children at the address it would appear this kind of behaviour is a relatively common event, and they did not seem phased by what had happened on this occasion. Upon speaking to Sarah, she has got to a point where she no longer knows what she can do other than call the police. When Daniel was younger, they could intervene but due to his size and aggression they are no longer able to in fear of making the problem worse."

"There are indicators of serious harm. The suspect is showing escalating aggressive behaviour towards members of the family unit. It is clear that there is a negative effect being created on the mother and younger children who are withstanding the worsening behaviour of Daniel. Daniel himself is vulnerable due to his unique medical condition, which plays into the difficulties in the family unit. There is a question over Daniel's capacity to understand his actions which arguably makes him more unpredictable."

On the basis of the information ascertained, it would have been prudent for the attending officers to have submitted child at risk referrals in respect of the younger children as well as Daniel although the DASH and 101 reports narrative was comprehensive. The 101 in respect of Daniel contained information concerning the home environment: *'House is in a relatively messy condition with a lot of clutter on the floors, and kitchen in general poor repair with a lack of flooring'.*

There are a number of occasions when officers have ensured that the lived-in experience of the children was narrated within the safeguarding referrals which is good practice.

2.3.20 The current policy and practice for the constabulary is that a senior supervisory officer will attend the scene and direct the investigation and if there are no suspicious circumstances, a file will be presented to the coroner. This is good practice.

In the case of occurrences where there is a background of domestic abuse, the coroner will invariably open and adjourn the inquest process until the completion of enquiries in particular where there will be a domestic homicide review, or other statutory review process. In the interim, this will create a delay in the inquest process and in turn creates a hiatus in practice as there will be no dedicated officer appointed to function as the contact between the family, coroner, and the statutory domestic homicide review. This may continue for an extended time frame and could lead to the isolation of the next of kin from updates without an effective communication strategy in place which in turn could also have an enduring effect on the wider community.

2.3.21 Cambridgeshire Adult Social Care (ASC)

Adult social care became involved with the family due to the son having care and support needs. At the time, there was a separate physical disabilities team. The role of the adult social care was to work with a young adult to assess their needs and plan to address the identified needs. The team would also have the responsibility to support the carer by offering assessment and signposting to the relevant organisations if appropriate.

2019 – March – An Ambulance referral was received in regard to an overdose and alcohol issues with DA were noted. Sarah had taken Daniel's epilepsy medication along with other medication and was intoxicated having drunk two bottles of wine. Her mother had passed away in 2017 and she was having marital problems. Sarah lived with her husband and 4 children and was depressed and unable to cope. Sarah had a domestic incident on the previous Friday night in which she had to call the police on her husband and Sarah was taken to hospital. The referral states that it's a child social care referral and has been shared with Sarah's GP. No care and support needs were identified so it was not deemed to be an adult at risk and as she was conveyed to hospital, there was no role for adult safeguarding. The Son was under 18 so not seen as a carer due to his age.

2.3.22 June – A referral was received from the children's team for Daniel. It was recorded that Daniel had epilepsy and it was impacting his daily life a lot as he couldn't really go out on his own as he had regular seizures. He couldn't use a bike due to this as it would be too dangerous. It was dangerous for Daniel to be left alone for anything more than short periods in case he had a seizure.

He was living with Sarah and Leon who provided support. Daniel was looking for support to be able to go out and do things as he wanted to gain some independence and be able to go out without worrying. Sarah believed he had some learning difficulties but had not tried to get support for this before- as he was now getting to adulthood, Sarah was concerned that he would not be able to cope and these issues would make it difficult for him.

A children's social worker (SW) referred Daniel and it was assessed that the Physical disabilities team (PD) would be the most appropriate to support his needs.

A SW from PD contacted the children's SW who made the referral and confirmed that they would not have had sufficient time to assess Daniels needs within their team before his

birthday in October (4 months), so no assessment was completed but was informed that he was likely to be eligible due to his disability. He said Sarah was keen that he was supported to be as independent as possible.

August – PD team called Sarah to advise her they were unable to provide a timeframe but Daniel was now on a waiting list for a social care assessment. She was advised they would be in touch again once a worker is allocated.

2.3.23 September – (Daniel's file) It was noted that Daniel was approaching 18 years of age. They had a visit from a SW to start an assessment on Daniel. Sarah felt her son would benefit from getting out of the house and doing more "normal" things that an 18-year-old would do. She also felt she needed some time to herself, out of the house. Sarah talked about how sometimes when her son was about to have a bad spell of seizures, he would lose his temper and break things in the house. She had called the police at times when this happens, due to Daniel's age and size, and because her younger children aged 4, 9 and 16 also live there. Sarah said the Children in need team had been out to see them because of this, but they have ended contact.

Plan recorded: SW to speak with benefits team re Daniel's entitlement to benefits; TEC re alarm for seizures; Explore any help with employment opportunities. Consider further carer's conversation/assessment with Sarah. Consider advocacy – Sarah said her son "needs a voice".

October – A Police 102 was received stating Daniel had become increasingly angry after a meeting with a social worker regarding his disabilities. He had then proceeded during an argument with his mother to kick the outside wall, smash his mum's phone and smash a plate in the kitchen. He has then had a seizure which is common when he gets angry. Officers arrived just as Daniel was coming round from his seizure. He was very dazed and confused and could not remember what had happened. Sarah stressed although she was not happy at all with his behaviour, she didn't want to pursue any criminal charges. Sarah was mostly concerned that her son was not receiving help regarding his anger and general behaviour.

The anger seems to stem from his epilepsy, social situation regarding school life and feeling restricted by his disability. Although he's never physically assaulted Sarah, it was clear she is concerned that it could all get too much one day and he would do something that would result in serious consequences e.g., get a criminal record.

Daniel refused to meet the SW for a further appointment. The SW was to look into social opportunities locally that he could go to and requested information from the Community Nurse and START re any Education Healthcare Plan.

2.3.24 November – Daniel's file – A Phone call with Sarah was made who consented to a referral to Caring Together. Daniel was still refusing to make appointments. Sarah has tried to initiate a claim with Daniel for PIP but he did not want to speak to the DWP advisor and they said they could only speak to him. It was suggested Sarah call back and ask if Daniel can just consent over the phone to them speaking to Sarah. The SW Also emailed the Benefits Advisor to check any other way of doing this.

There was a further entry that the allocated worker for Daniel identified the need to maintain his confidentiality so advised that a different SW needed to have a carers conversation with Sarah in addition to the contact with caring together. An email was sent to Sarah to explain this. She was informed that someone would contact her soon.

Sarah consented to referral to Caring Together. Information given on services for son and contact details. Advice on benefits etc given.

2.3.25 Sarah's file – An email was received from Sarah – (outlined in full to show the context of how Sarah was feeling).

'I send this message with a heavy heart but I'm not able to cope with sons' abusive behaviour anymore. Unfortunately, last Thursday I had to call the police AGAIN as he tried to chuck a kettle bell at me but instead hesitated and decided to throw it at the television. This unfortunately is the 5th tv that son has smashed in a year not only that but he also put his fist though the glass of the front door cutting his arm. As I was calling the police son unfortunately continued to call me abusive names and leaned over me to intimidate me as he realised how scared I had become and I was screaming for someone to help me. Son also tried to snatch the phone off me to stop me for asking for help. The police arrived and took son to hospital for treatment but when he returned home that evening, he continued to call me abusive names and tried to continue to intimidate me no remorse for what happened earlier in the day. Since this day, I'm constantly being told to F off and called a t&wt which as you can imagine breaks my heart. No discipline can be put in place as he doesn't listen and he will become violent. Luckily on this occasion my other children were at school but this has happened a few times in their presence and for the safety of them, myself and even son himself I have to hold my hands up I just cannot cope with this negative behaviour anymore and I cannot live in fear of my own child.

Please can you advise me on my options regarding this situation?'

Sarah sent an email a few days later expressing her anguish that she had sent the first email and how it broke her heart that she was on the verge of making him leave. The email was responded to saying that they would speak to colleagues to identify options but there is no record as to whether this was completed.

December – Daniel's file – Sarah contacted ASC stating she can no longer support Daniel, citing violent behaviour as an issue. Sarah called asking for someone to come and get Daniel as he is out of control and she doesn't want to ring the police. He has hit her other son, smashed Christmas tree, knocked over TV and is currently outside the house. The call was passed through to Business Support where Sarah had to inform them of the history. She wanted the Disability Team to remove him that same day.

2.3.26 Sarah was advised that they do not have access to alternative housing and advised her to contact the police if the situation is continuing now, as they are the only agency with powers to deescalate and remove a person from a potentially dangerous situation. Sarah stated that she wouldn't want to press charges against her son which would mean that he would have to return home.

Daniel's SW and a Senior SW had a meeting in which they discussed how it had been agreed that Daniel's mum, Sarah would be allocated urgently to another worker, so that the SW can try to establish contact with Daniel. A letter was sent. The SW had not yet been allocated and it was agreed that the duty officer would be the most appropriate to liaise with Sarah.

A discussion was recorded on the case note 24 days later that the most recent incident involving Daniel becoming violent at home led to him being arrested. Younger children were present at the property and scared, and potentially at risk. A plan with the senior working from Adult Early Help was made involving contacting Centre 33 and Children's Services to make them aware of the situation at home and explore what support they could provide in relation to housing, activities and other support work. Independent living was to be explored.

2020 – January – Sarah's and Daniel's file – A phone call was made with Sarah in relation to referral to Children's services over the risk Daniel poses. Daniel's medication and schooling of children was discussed along with Daniel's unwillingness to speak with the SW.

Plan:

The SW was to email Daniel to ask if they could meet and needed to make it clear to him what support can be offered as he was not currently clear. The SW needed to ask about what he would like to happen - e.g., where he lives/might he benefit from TEC re his seizures and benefits. The SW was to link him in with other organisations who might be able to support him in the longer term.

2.3.27 Sarah was to be allocated back to SW as it no longer seemed appropriate for a different worker to speak with her. It was felt a more holistic approach would be more beneficial at the current time.

February – Daniel's file – A Phone call was received from Sarah who stated Daniel was not taking his medication and had been in hospital. Sarah described him as a bully and aggressive all the time. This is having a big impact on other family members. Daniel is living and sleeping in the living room. Sarah thinks he finds his room a bit claustrophobic. He is controlling everything through the family's fear of what he might do. They usually all go upstairs when sons home. The younger children (4 boy, 11 girl) are begging Sarah to let Daniel have his own way because they are so anxious about what he might do if she doesn't. Examples include eating their dinner, or the 4-year old's chocolate bar. Daniel's 16-year-old brother, Anton also lives there, and their dad. Sarah is feeling extremely anxious, and she thinks the children are too.

Sarah has experience of abusive relationships in the past and feels that whilst on the medication, son has similar traits - being threatening and verbally abusive to her. For example, he called her a 'fucking ugly c**t,' was apologetic when she cried, and then switched straight back to being abusive again.

Sarah was reminded about Centre 33 where Daniel could try going for support with housing and she said that she will try to get him to go and speak with them.

2.3.28 A formal carers conversation took place over the phone. Sarah became quite tearful when asked how she was and if she had anyone to talk to about how she's feeling. She said she didn't have anyone to talk to. She feels very anxious about Daniel's behaviour, worrying that he will be violent again. She did not want to go to the doctor about how she was feeling. She didn't want to become dependent on medication, but to feel like herself. She didn't really want to ask about talking therapies either. She felt she can manage the anxiety. It was agreed to be put in touch with caring together.

March – Daniel had moved out of home and was living with his Aunt. Leon has also moved out and neither will be returning. Leon will be the one dealing with Daniel going forward.

April – Referral received from police as Sarah had rung stating that she was not getting any help from NHS or Police. The Phone call was made on 18th March but the referral wasn't received until the 30th of April.

Daniel moved out of his Aunts and housing found a temporary accommodation address for him and Leon.

May – Daniel's file - PD end their involvement with Daniel. No services were provided.

June – Daniel's file – A referral was received and a risk assessment documented.

July – A missing person alert from A and E was received due to Sarah having previously overdosed in the past three weeks. The SW phoned Sarah who said she was absolutely fine. Sarah said things had been really overwhelming at times during Covid lockdown with Daniel staying on and off, but that things were better now.

August – A further referral was received as Daniel had injured Leon. This was the last entry made on Sarah's file.

September – Daniel's case was closed. Information and signposting were completed. Further concerns were raised re: Daniel so his case was re-opened.

November – A DASH was received. The main concern was for children following police attendance at Sarah's address due to Daniel's behaviour. It was noted that there had been multiple attendances and was an on-going issue.

2021 – May – Daniel's file - DASH received following a verbal argument between Sarah and Leon. There are numerous domestics involving all three parties (Leon, Sarah and Daniel) and are mainly evolved around son either going missing or causing damage to their property. Police have spoken to Leon as he has stated that himself and Sarah have had an argument earlier due to Sarah meeting up with another man whilst in the company of their child. Leon and Sarah have both confirmed that this has happened but it was done over the phone.

June – A follow up call was made with the parents. Mum said that on a few occasions Daniel has barricaded her from the house and locked himself up with their 6-year-old child and was threatening that 'mum will not come to save you' and the incident was horrifying for the 6-year-old child. He has also locked his mother in a room and has smashed the TV, windows, doors, and many things and the other children have witnessed this.

He has also thrown a kettle with boiling water to mum. (This was not reported to the police).

He has been referred by both parents to their respective GPs but there has not been any progress. He has been in hospital once a week due to uncontrollable seizures and the seizures occur more than 50 times a day.

Nov 21 – March 22 – 3 x Referrals were received stating son (which one not specified) has concerns over his Mums self-harming and drinking in front of younger siblings.

2022 – December – Leon reports concern over Sarah's contact with Daniel being detrimental to both of them. Concerns over safety of siblings now they are all living under together again under the care of Leon.

2.3.29 Terms of Reference reflections

There is clear information on the case file that the children were at risk from domestic abuse from son. There is evidence that the adult social worker contacted children's social care but no clear evidence of joint working, or the impact of the son's behaviour being explored, and this is a missed opportunity.

The voice of the child was not considered by adult social care.

Adult social care does not have a separate domestic abuse policy and use the SAB boards policies and procedures. We have separate factsheets on coercive control, MAPPA and MARAC. As Sarah was not recognised as a carer at higher risk of abuse the MARAC policy was not implemented. (Recommendation 8 refers to this)

2.3.30 In addition to the SAB policies adult social care has practice guidance around carers who are at higher risk of abuse due to their caring responsibilities. This is part of the care act. There is a lot of information on the case file indicating that Sarah was a carer at higher risk. Carers conversations took place as did signposting to caring together which Sarah agreed to. There is no evidence that completing a DASH was discussed which would have given clearer information around the level of risk. There is no evidence that the behaviour of the son towards his mother and siblings was recognised as familiar abuse which could have resulted in a referral to the IDVA team. This would have needed Sarah's consent but could have given her an opportunity to share her experiences of abuse. There are indicators of domestic violence between Sarah and her husband and if Sarah had agreed to a referral to the IDVA service this could have been addressed as well and promoted a more joined up approach.

Consulting her GP was discussed during a carer's conversation, but Sarah said that she didn't want to go to her doctor as she didn't want to become dependent on medication. Permission could have been sought by the Social worker to contact Sarah's GP which could have given more context around the impact of the behaviour of her son on her wellbeing. Her desire to return to work was discussed in a cares conversation as was the impact of having to be available should her son need her. (His epilepsy) The focus was on the son and what could be provided for him so not a holistic approach.

2.3.31 The disabilities team was responsible for assessing son's needs. There is evidence of a lot of advice and signposting being given and the parents being asked to support son with certain applications. The file indicates that these actions had not been conducted and the impact was that son remained in the care of his parents. What practical support the parents needed to support their son in competing these tasks was not explored. As explained above Sarah was not recognised as a carer at higher risk of harm due to her caring responsibilities. Sarah was a carer and not deemed an adult at risk under the care act so safeguarding would not apply to her in her own right. Her vulnerabilities as a carer of adult child and familiar abuse were not explored.

Sarah was spoken to by a different social worker within the team on one occasion as the conflict of interest was recognised but this was not an allocated worker who was able to build up a relationship with Sarah. Carers conversations happened but the main concern

Sarah expressed was the need for support for her son as well as the impact of his behaviour on her and his siblings. Sarah did share her deep sadness about having to make the decision that her son could no longer stay within the family home. There was a lack of exploring how family relationships could improve if Daniel was not living at home and no practical support to find alternative suitable accommodation.

The review of the case file does not indicate that any multi agency planning meetings took place. The case file indicates that there is a lack of communication and information sharing between adult social care and the children's team. Given the known risk son poses this was a missed opportunity.
There is nothing on either Sarah's or her son's file that during the time that Sarah was either living with or in contact with her son that suicide was a risk. In 2019 adult social care did receive an alert from the ambulance service, which was intended for children's services which detailed a suicide attempt made by Sarah and there is nothing after this that indicates that Sarah was at risk of further suicide attempts.

In relation to Sarah's son, Daniel, there are several references to the parents not supporting prosecution. There is reference to son being arrested on a couple of occasions and after one such incident Sarah reports a change in his behaviour. In May 21, a DASH form was received but clearly stated that the DASH was not informed by Sarah.

Where families are experiencing children causing harm to parents, what services are in place to support them? Is there additional support where this behaviour Were these services offered/provided in the case of Sarah and were her multi-complex needs and vulnerability taken into consideration.

Daniel was an adult. There is no evidence that Sarah was seen as a carer at higher risk of harm due to her caring responsibilities. No DASH was completed or referral to IDVA discussed. Signposting to organisations which could offer support to son is evidenced but little is recorded in relation to any other vulnerabilities Sarah may be experiencing.

There is nothing on record to indicate that Sarah was assessed as vulnerable in her own right.

2.3.32 Good Practice/Reflective considerations:

The reason for the initial referral was for an assessment to look at what support is required as son becomes an adult (OCT 19) The initial referral indicates that children's social care is involved under child protection but this is not explored and no indication is given by the referrer that son is the person who is potentially causing harm. This was disclosed by Sarah in September. The information she shared clearly indicated that the violent behaviour of the son was not an isolated incident she had called the police many times while he was under 18.

Although a relationship was not built, continuity of contact from the Same Social Worker was maintained throughout providing stability, point of contact and family knowledge prior to each contact.

2.3.33 Cambridgeshire Children's Social Care (CSC)

During the initial scope of this case, Cambridgeshire had a domestic abuse strategy developed for CSC and which was a development of the Safeguarding Board DA strategy. MARAC was a part of this strategy, and there was mention of child to parent abuse within it.

It is not clear that there is a current or recent authority-wide DA strategy iteration beyond the current Safeguarding Board strategy, apart from a draft policy which is not yet in circulation. In January 2020, the authority adopted the Family Safeguarding practice model, which has workers embedded into teams who specifically address DA, mental health or drugs and alcohol use with parents. The remit of these workers is to complete targeted, planned work with parents, which does not include working directly with child-to-parent violence, this would tend to be referred out to a specialist service if they are available. The DA worker should not be responsible for MARAC referrals alone, and MARAC should be considered by the team as a whole. However, if a DA worker is not involved, the team should still be aware of DA as a factor and manage it accordingly.

IDVAs are referred to regularly by the service, and a hypothesis is that workers assumed that the IDVA would link up to MARAC in this case. The only mention of MARAC was in the police referral of January 2021. There is no recording that CSC responded to this referral as the case had (just) been closed, although the system notes suggest the case was passed to the Assessment Team. There is no reference to MARAC being considered elsewhere in recording. This could be because of lack of recording or more likely because of how the service viewed the aggression shown by Daniel as part of his complex needs rather than considering it as DA until very late on, by which time he was not living in the family home. There is no record of MARAC being considered for Sarah after the incident on 24 October 2022, although the IDVA was attempting to work with her and it is entirely possible that the team thought this intervention would tackle the DA Sarah was experiencing as the children were safely removed from her home.

2.3.34 In terms of this case, it would appear that for the majority of the time, domestic abuse – in this case largely around child to parent violence was not considered as a primary factor. It was not considered in response to a direct suggestion that MARAC was required in January 2021. An IDVA was involved with Sarah but did not provide support due to Sarah disengaging from services. Domestic abuse was mentioned as a hypothesis around family functioning from time to time, but was usually discounted in favour of other factors, and by the time domestic abuse was a very real risk to Sarah and the children, the children were taken to live with their father.

Primarily, CSC necessarily has to focus on the needs of the children above all else, so they will be prioritised over parents, if necessary, from a safeguarding point of view. Practically, however, the family should be considered as a whole, and the focus of work is always to

support a family as a unit, which necessarily means assessing any needs that parents might have that is impinging on their parenting.

During the period of Early Help (EH) work, the planned work was focused on a collaborative approach to managing Daniel and reducing stress within family relationships. A number of goals were set to resolve practical issues such as applying for DLA, but also to address and support any factors that impacted on parenting, and for Sarah, this included how her mental health problems sustained from a difficult childhood acted as a trigger for her. Each of the family were considered in turn as well as together and the worker also sought advice from the service clinician to help think through strategies for the family once the worker had got to know them a little more, and some creative thought was put in to support Daniel with his specific set of needs. Changes in needs were also met – for example, signposting to a bereavement counsellor when Sarah's mother died by suicide. The work was all completed on a consent-based/voluntary basis and ended when the family felt they needed to stop the work after Sarah's mother's death, but the worker still offered a series of avenues of self-referrable support such as IAPT, Headway and Cruse.

2.3.35 This approach to the work continued when Early Help became involved again, with additional identified aims around support for Sarah's alcohol use and consideration of the added dimension of intense sibling rivalry between Daniel and Anton. Support for Daniel extended into seeking advice from the Epilepsy clinic and creating a family-agreed safety plan. Again, any self-identified issues were discussed, and possible solutions offered, with alternatives if needed – for example AA rather than CGL involvement for helping Sarah manage her drinking.

Daniel's needs as a nearly-adult were considered and as CSC began to become involved, a referral was made to Adult Social Care. Needs were re-addressed following referrals and as C+F assessments started to be completed on the family, there was a holistic approach to the family. However, the shorter periods of involvement meant that there tended to be a short-term pattern of involvement and closure which tended to offer the same solutions to what appear to be the same issues, so less opportunity for understanding the family in depth and in particular why Sarah continued on the cycle of drinking and self-harm and seemed unable to engage with the support identified with and for her.

Once the CP plan came into effect, the focus of intervention was more focused on reducing risk to the children. A wide range of interventions and actions were planned according to the presenting needs of the family as a whole and as individuals. However, due possibly to capacity and impacted by limited case recording, it would appear that whilst Sarah was offered various forms of support that she did not access, there was a sense that work with the CGL adult worker in the team would address most of the issues Sarah presented with. The children were offered support in school, and the plan was monitored through supervision and Core Groups and Conference but did not change substantially over time. Ultimately, the family were considered as a whole and a range of support was offered to try

and mitigate the identified needs; however, with drift and a lack of engagement during the latter stages of involvement due to worker turnover, there was little change to the perceived needs or meaningful exploration as to whether these changed over time.

2.3.36 Chronology

2017

A referral from the school was received following concerns for Anton (then 14yrs) who opened the door when school staff visited about school attendance and parents not using Education transport for Daniel to attend school and safeguard him. A MASH enquiry took place in which the family asked for support with parenting strategies and claiming DLA. A Family Worker was allocated and involvement ended in January 2018.

2018

Three Police referrals and a hospital referral were received relating to different incidents of Daniel causing damage and being violent. Daniel asked for anger management and a pattern relating to his violence and his seizures began to be noticed. A Family Worker was again allocated and further referrals were passed to EH. Sarah requested bereavement counselling as her mother had died recently.

2019

Following a further incident of violence by Daniel in the January, CSC received referrals from EH, Ambulance and the Police in the March as Sarah had overdosed. There were concerns around DA, neglect and the Parents not being able to manage Daniel's behaviour safely. It was allocated to CSC for a s17 Child in Need and the outcome was for a Disability Service Social Worker (SW) to support with an assessment of Daniel.

In the April, Daniel had a big fight with Anton which led to Daniel having to go to hospital. Sarah stated that she was at her wits end. Daniel refused ASC intervention which he had capacity to do and therefore in the May, EH and FW involvement ended. The case was transferred to the Children's team.

The first multi-disciplinary meeting was held in July 2019 and the case was closed to CSC the following month. Two further referrals were made that year in relation to Daniels violent behaviour in which both were closed to CSC as the children appeared happy and chatty and the school had no concerns even though they witnessed the incidents. Sarah informed them in the December that she was scared of Daniel, especially since Leon had left.

2020

There were two referrals in 2020. One at the beginning of the year from the police and school in which Daniel had been violent at Christmas and there were concerns Sophie and Lucas may get hurt and then one in the July, following an overdose by Sarah. Both referrals NFA'd by CSC.

2021

There were three referrals in three days at the beginning of the year in which the first related to Sarah self-harming with Leon trying to prevent this. The following day was due to Anton and Daniel fighting in which one of them pulled out a knife in front of Lucas and Sophie. Records show that the police said the younger children were ok and there was no role for CSC as it was seen as siblings fighting. The third was the MARAC referral.

In March, a hospital referral was received following Sarah self-harming. She informed them that all the children were with Leon as they had separated and she was struggling with Daniel. It is noted that Lucas is scared of Daniel. It is closed to CSC in the May as the parents stated they didn't need EH as wider family were supporting.

Sarah had two further referrals for self-harming and an overdose that year. The second following a fight between her boyfriend and Anton. It was noted that both Sarah and Leon describe each other as controlling and abusive. An Initial Child Protection Conference (ICPC) was convened and Lucas and Sophie were put on a Child protection plan (CP) for emotional harm. Sarah was to get support from the Mental Health team and CGL, however, she reported in late January 2022 that she had not heard from them and Anton was living with her.

2022

Sophie and Lucas remained on CP and in April, were spoken to following an incident witnessed by them where Leon had to restrain Sarah to stop her self-harming and had then taken the children to his. Sarah had still had no contact from CGL or MH and it was agreed these referrals would be chased up. It was agreed Anton would not stay with Sarah. Leon stated that she was drinking a lot and has new boyfriends that she was introducing to the children which he raised on more than one occasion. The Social worker felt Leon was overly interested in being in touch with the boyfriends.

A second meeting was held in the June in which split core groups were agreed and it was raised by Leon and Sarah that the case was drifting which was agreed by the Chair who felt this may be due to the lack of core groups as they were infrequent.

A change of Social Worker was noted in the August. SW attended Sarah's home to speak with Sarah, Leon and the children following an argument at a party in which she had been drinking. The Team manager had a discussion with Leon who implied that Sarah was emotionally abusive and silencing the children and that Sarah had a lot of boyfriends. CSC were sceptical of Leons position noting that there may be legal proceedings in the future. Sarah was not really engaging with CGL and Anton was living with her again.

In the September, there was a referral from the Police due to reports that Sarah had tried to jump out of the first-floor window. All was calm on their arrival with her and the younger children asleep upstairs. Anton stated that his mother had too much to drink and had a MH

episode. Due to this, there was an unannounced SW visit where it was noted that a male friend was in the house, events involving the Police were not discussed and the SW planned to visit Sarah to discuss but no follow-up visit is recorded.

2.3.37 The notes in October of an EDT summary are that the police took Lucas into Police protection following Sarah being a victim of DA and drunk. A strategy discussion was held and it was agreed Leon would exercise parental responsibility and keep Lucas and Sophie with him. During a monitoring discussion a few days later between the CP Chair and the SW it was noted that Sarah was not accessing MH support and CGL work was tokenistic. There were concerns for Lucas and Sophie being in the same house as Daniel given his aggression and outbursts.

In December at a further monitoring discussion, it was noted that the SW had been absent from work and it was not clear when the children were last seen. No professional contact had been made with Sarah since the incident in October and the MH referral was not made as Sarah was not engaging. The same concerns still remained for Sophie and Lucas and it was felt that the DA they witnessed on Sarah was injurious to them but it was not clear how she would be supported.

A referral was made to ASC in relation to Daniel in his own right. He is known to have eligible needs and still poses a risk to the younger children in the home. Leon had raised concerns that Sarah was manipulating Daniel which escalated his behaviour and that she was the guardian for his bank account with access.

An agreed split conference was arranged but Sarah could not attend her arranged meeting as she was with Daniel that day, informing the Chair the day before. A plan was made which included: Support for Lucas and Sophie – Contact to be supervised, not to witness any MH/drunk/DA incident. Sarah to complete CGL course, seek MH/GP support with a referral to the health practitioner and IDVA. A welfare check was requested late on a Friday as Sarah had not attended the conference the previous day and the CGL visit to her home had failed.

2.3.38 Police attended and reported that Sarah was spoken to outside her home and Michael was spoken to inside the home and an open bottle was seen. Sarah was a little tearful but stated she was not suicidal and had not self-harmed.

Two days later, the SW contacted Hayley who was very concerned about Sarah's alcohol and crack cocaine use. She was still self-harming and not getting on with various family members, not engaging with services and was completely dependent on Michael. A home visit to Leon's home took place the following day where Sophie was spoken to.

An entry in the notes on 29/12/22 stated – Management oversight – Agency SW has left, leaving significant gaps in case recording.

2.3.39 Terms of reference response

Until May 2019, the younger two children were not spoken to directly by a worker with a view to seeking their views, although they were seen during Early Help involvement during visits to the home. Feedback on how the children were presenting in school was sought by the family worker, and at each point of triage, although it appears that this took the form of asking whether there were any concerns about the children, rather than a professional directly seeking the views of the child with them. If the children were seen by the referrer, and spoken to, this was reflected in referrals made to CSC, although this could range from the children being upstairs/at a neighbour's house or spoken to and presenting as 'chatty' or 'happy.' However, even if there was little recorded discussion with the children about their views, there was enough information to give a sense of what the children's lived experience was like, given the numbers of referrals made about Daniel's outbursts and then the experience of Sarah's self-harming and what this would be like for the children. The full impact over time was not considered as fully as it could have been due to the parent's self-reporting that they were managing, along with CSC managing the case at Early Help level and periods of delay.

Once CSC began to complete C+F assessments, the children were seen at the minimum requirement to complete a short-term assessment, and until 2022 those visits were recorded. The children were spoken to, views sought from school, and information picked up from referrals about what the children had said. However, often the interactions were time limited that the children had little chance to develop a trusting relationship with the worker. Later in the case, there were reports from Leon in particular that the children had been warned not to speak to CSC, and the worker was also specifically tasked to speak to the children following an incident. More often than not, these sessions are not written up completely, and it was only really at the point of completing an assessment or at the start of the CP plan that the younger children's views were ascertained, or their lived experience considered. Even then, due to the patchy recording, the children were not always seen alone as per practice expectations and Sophie was not seen for long periods of time whilst subject to CP when she should have been seen every 10 days.

In terms of Anton and Daniel, they were older or adults during most of the scope of this DHR, so there is less recording regarding their sought views. Often their views were mentioned as part of referrals from the police, or they were seen in passing during visits to Sarah or Leon by Early Help when the focus was on supporting parents. Anton was not considered as part of the CP Conference process, potentially because he was older, and living mostly with Leon. However, it is possible to infer their lived experience from recording – partly if they were involved in discussions about solutions, their parents would express their concerns about the difficulties in their sibling rivalry, and information was gathered from schools about them both. Anton was very much seen as bearing the brunt of Daniel's behaviour for periods of time, and there were concerns for a time that his reaction to this

was to be absent from the home or on the edge of anti-social behaviour. However, the focus tended to be on the younger children so less focus was given on seeking Daniel and Anton's views. Alongside this, Daniel had moved out of the family home by March 2020, and Anton in November 2021, when the referral that precipitated the CP plan took place, so during the time CSC were more actively speaking to the younger children, they were not present.

2.3.40 Following the death of Sarah, the CSC explored a number of options available through schools for Sophie and Lucas to receive support on the day they were notified of Sarah's death. The team reached out to Leon to offer support and respected his request for a brief interlude before discussing support. A strategy discussion took place which considered support for the family. The clinical service was asked to get in touch with Leon to discuss the possibility of input from them, and a SW visited the family and discussed a number of options available to the family such as STARS (bereavement for children) but also practical arrangements to support the family around housing clearing of rental arrears, and proper furnishings in the house as these were adding an extra layer of stress on the family. Unfortunately, there were a few changes of social worker between January and March, which was a source of frustration for the family. Having to meet a new person and explore time after time what support you need and the situation you are in is frustrating at best for any family but would have been particularly unhelpful at this time – even if unavoidable. In short, support has ranged from practical tasks, social work support, signposting to charities and outside agencies who can offer specific support, counselling, and support in school for the children, and intervention from the CSC clinical service, although it is not clear if this offer has been taken up by the family. However, this is tailored to what the family are identifying as their needs currently rather than primarily addressing the impact of DA on Sarah.

2.3.41 For CSC, the majority of decision-making points are worked on a multi-agency basis. For this case, which would include MASH enquiries as a response to referrals; information-sharing as part of an assessment; strategy discussions and Child Protection Conferences and Core Groups. On the whole, where needed in this case, the appropriate partner agencies were involved in these processes, and there is evidence of a range of views given about the risks and needs of the children and family given in Conference minutes, for example. Alongside this, technically the case supervision in the social work team is multi-agency, as adult workers with their specific specialism contribute to the case discussion. This would have been much more effective for Sarah and the family had the adult mental health worker and domestic abuse worker also been involved – their involvement was discussed but never acted upon.

However, there were some interventions where other agencies were contacted but not involved in a multi-agency approach to the work – for example, Early Help intervention was planned to be supported with a CAF meeting and this did not happen. Also, virtually no Core Groups were recorded, and anecdotally, I was told some of these meetings were held between worker and parents and did not include partner agencies (usually schools). This is

not acceptable practice, nor is it usual, so the onus was on the Child Protection conferences to offer a more truly multi-agency arena.

2.3.42 More informal liaison with schools was a common feature throughout involvement – initially to try and settle Daniel in school and meet his complex needs; to offer an outlet and normalising activities for Daniel and Anton, and as monitoring and provision of support services for Sophie and Lucas. Schools were quick to become involved in any multi-agency discussion required of them and were able to raise concerns and referrals should any concerns about the children arise.

As noted elsewhere, the police did discuss utilising the MARAC process for the family, but there is no record that CSC did anything concrete with this referral or that there was escalation/challenge when CSC did not respond. As a result, it is hard to know what impact a MARAC process would have had for the family, but this is a missed opportunity for a multi-agency approach to a distinct issue.

On occasions where Sarah presented as having self-harmed or taken an overdose, mental health support was offered to her. However, it does not appear that capacity was considered as an issue for her as she was able to identify her triggers, usually ascribed alcohol as a factor and was able to show remorse, a sense of guilt and understanding about how events unfurled. Sarah was open and understanding (to a guarded extent) of the impact of abuse and trauma on her, was able to verbalise the complexity of her response to being bereaved when her mother died and would often begin to engage with services identified in partnership with her to give her support. Sarah was known to be an intelligent, warm, funny, insightful and kind woman who adored her children, and with all of these considerations, meant that she was not really considered as 'vulnerable' in her own right.

2.3.43 Reflective considerations/Good practice

There was an issue around resourcing which impacted on the service given to the children. During the episodes of Early Help intervention, there were periods of time where support for the family drifted as the worker had substantial periods of sick leave. Once the case became allocated to the social work teams, there was a change of social worker on more than one occasion, periods of worker sick leave and a high agency social work presence in the team, leading to at least one abrupt departure and a lack of case recording and case work. This included the recording of Core Groups and statutory visits. This issue around recording makes it hard to assess if a case is drifting and whether a plan is working if the information is not available, and we know that drift has been a factor on the support and intervention offered to this family.

The scope of this case covers a considerable length of time and a series of interventions at different statutory levels that addressed a number of factors impacting on the children. Domestic abuse in itself was hypothesised at a certain level in terms of Leon's possible controlling behaviour towards Sarah when they were apart, although by the time the CP

plan considered this factor, the picture showed parents were not able to communicate without conflict rather than evidencing domestic abuse from one partner to another. Episodes where Sarah or Leon or both had become hurt tended to be when Sarah was having a mental health episode or drinking, so whilst this was seen rightly to have an emotional impact on the children, this was not identified as DA per se, and services provided focused on supporting Sarah, ascertaining the voice of the children and implementing a safety plan at home should Sarah be drinking.

The police did request that a MARAC referral be considered in January 2021 and there were references to a DASH being completed in respect of Daniel's behaviour in a couple of other referrals. It is not clear why CSC did not identify Daniel's behaviours as child-to-parent abuse, or why specific services were not sought out to support the family with this, given the sheer number of referrals made about Daniel's aggression within the home. Parents were very keen to accept support and manage Daniel within the family, and a hypothesis is that because Daniel was a child/adult with complex needs who could respond to firmer boundaries, that CSC tended to choose a parenting approach to managing the situation at home rather than view it as DA from Daniel to his mother.

2.3.44 Whilst in the Child Protection arena, there was multiagency oversight and input into the family plan through the Conference process, with an added benefit of a consistent and active CP Chair. Challenge around drift was given through the monitoring process, and the Chair was able to raise the alarm about Sarah when she did not attend the Conference as discussed. However, the lack of recording around Core Groups makes it hard to know how effectively the multi-agency group were able to work on case progress or reflect on the lived experience of the children, which was the main focus during CSC involvement.

- Workers need to be more professionally curious and if necessary, challenging around self-reporting by parents around actions they have taken to address issues, especially if the support chosen is of a voluntary nature.
- If there are concerns about a parent's mental health being triggered by their children needing to be placed elsewhere for their safety, then urgent consideration needs to be given to how that parent can be supported should arrangements need to be made for the children to live somewhere else.
- Assessment should always make good use of chronologies and uptake of support over time. This helps to understand what interventions have or have not worked in the past, allows for patterns of engagement to be established and helps understanding around trigger points in family functioning. It also helps to understand if there has been an overoptimistic response to referrals either because parents have said things are better or because professionals have observed the children to be happy or asleep during an incident.
- Challenge of drift – managers need to be more responsive to a lack of recording, visits and progress of interventions, and challenge the progress against planned actions when they have not been carried out.

- The voice of the child needs to be sought directly and cross-referenced with views from other agencies and the worker's understanding of the child's lived experience over time.
- Families should be supported to manage their own problems wherever possible, in partnership with supporting services. This might need more robust intervention from workers to ensure children's needs are being met, rather than closing cases because of lack of uptake or parents saying things have got a bit better.
- Understanding and identification of child to parent violence needs to be carefully considered, even when a child has complex needs, and the available screening tool used to help create the right support package is put together.
- There was an absence of challenge around who was present in the family home when the children were subject to a CP plan – any adult staying overnight or taking part in caring activities should have been police-checked.
- Over time and when consulting records, it should have been clear that Sarah was struggling with the trauma of abuse throughout her life, and that a component of this was likely to be sexual. Once CSC understood more of her experience from her sister, there should have been a more tenacious social work response to ensure she was accessing support in her own right, although Sarah could not have been forced to accept help.
- The mental health worker in the Family Safeguarding team should have become involved with the family much earlier if they had been available.

2.3.45 Change Grow Live (CGL)

CGL have a Safeguarding Adults at Risk policy which does include domestic abuse and MARAC. The policy was abided by in this case. CGL Cambridgeshire has a MASH Lead Coordinator who attends all the MARAC meetings and feeds back to Recovery Coordinators. CGL routinely asks at comprehensive assessment and at full risk reviews (a minimum of six-monthly intervals) if a service user identifies themselves as being at risk of harm from others. All CGL staff undertake Safeguarding Adults training (classroom and e-learning) as well as training relating to specific aspects of domestic abuse (stalking, strangulation and working with perpetrators- all delivered by the Independent Domestic Violence Advisor service). Staff have access to the Cambridgeshire and Peterborough Safeguarding training portal and the service works with Women's Aid and make referrals as required. CGL Cambridgeshire have ten designated safeguarding leads across the three sites, as well as nine domestic abuse champions (individuals who have expressed an interest in supporting those who disclose domestic abuse and who have been upskilled in identifying and supporting with domestic abuse cases). Safeguarding meetings take place monthly where higher risk cases are discussed, and actions highlighted. In addition, safeguarding cases are highlighted and reviewed in daily Flash meetings to ensure actions are completed/followed up.

For service users accessing the service for support with their alcohol use, there are two pathways of treatment to follow, a dependent pathway and a non-dependent pathway.

Assessment tools such as the AUDIT and SAD-Q are used to determine the severity of the alcohol use and the degree of dependency, and an appropriate pathway is chosen based on these scores. Additionally, it depends on what the service user wants their goal to be in relation to their use, for example whether they wish to be abstinent or to be able to control their drinking.

Sarah was assessed and would have been suitable to follow the dependent pathway (including an alcohol detoxification), however followed the non-dependent pathway as she stated that her goal was not abstinence, but reduced and controlled drinking. Despite this Sarah was still offered a nurse alcohol assessment as part of the ongoing assessment and support for Sarah. As is not uncommon, Sarah revised her goals throughout her journey and asked to be considered for an alcohol detoxification. The Recovery Coordinator was responsive in organising the appropriate steps for this (requesting bloods, arranging a nurse assessment) and supported Sarah when she decided that she did not require a detoxification. CGL are a voluntary organisation and individuals cannot be compelled to engage nor follow a specific treatment plan which they do not consent to. Sarah was offered regular harm minimisation advice such as safe reduction of her alcohol use and she was signposted to mutual aid support to help build her recovery capital network.

The Family Safeguarding Team at CGL Cambridgeshire was introduced in 2020. Recovery Coordinators in this team have lower caseloads in order to work more intensively with service users and are able liaise and work more closely with Social Care. Sarah was allocated a Recovery Coordinator from this team due to the involvement of Social Care. CGL also have good links with other agencies and have specific roles which promote these links and share information such as Hospital Liaison Workers and a MASH Lead Coordinator. These links were utilised appropriately throughout Sarah's treatment journey.

2.3.46 Summarised chronology

2019

Sarah self-referred to CGL in March and a comprehensive assessment was completed where she underwent numerous tests and provided background information including that she liked yoga and cycling. The plan was for Sarah to engage with Alcoholics Anonymous (AA) and local mutual aid support. It was agreed that Sarah would start making reductions to her alcohol consumption and she was provided with advice and strategies for doing this safely.

In contacting the hospital liaison worker, they informed her that following the previous weekends stay in hospital due to self-harming following a period of heavy drinking, she had mentioned being unhappy in her marriage with her husband being away a lot while she managed things at home on her own and the main cause of her distress was her 17-year-old son who she had a volatile relationship with. This does not appear to have been recognised as domestic abuse or addressed as such.

Sarah continued to minimise her alcohol intake over the next few months and was offered differing support groups she could access. In the October, Sarah spoke to the Recovery Coordinator and said she was not having any struggles with alcohol use and no longer required support. It was mutually agreed to discharge her from CGL and a letter was sent to the GP.

2021

At the beginning of the year, Sarah attended CGL for a Conditional Caution assessment. She was attending AA meetings and declined support from CGL, stating the incident was due to her alcohol consumption and she had no desire to drink alcohol again as she was embarrassed by it. Feedback was provided to OOCD team. There were no actions from the MARAC the following day.

In May, Sarah entered treatment again with CGL following a referral from Social Services. A comprehensive assessment was completed and she was allocated to the Family Safeguarding Team due to being open to social care and a CP plan in place for the children.

Sarah said she self-harmed when she did not feel listened to. She advised she felt anxious in large crowds. Sarah reported that the relationship with her husband had broken down and they had separated. When asked if she was at risk from harm of others, she did not report any current issues however did report that she had felt controlled and manipulated in her previous relationship. A plan was outlined which included home visits at the request of Sarah. During a home visit in May, Sarah looked well and engaged and had reduced her intake to one bottle of wine every other evening. Her mental health was good other than some anxiety over lack of communication with her ex-husband over the children.

2.3.47 Sarah continued to miss various appointments at the welcome pod but text ahead with the reasons. She was receiving weekly home visits throughout May and alcohol detoxification was being considered. Sarah was booked on to the online Foundations of Change Group but did not join.

Home visits continued and Sarah's intake remained the same. Sarah missed a lot of phone calls but was engaging. In the August, contact was received from Sarah's social worker informing her of an incident where Sarah had self-harmed. Sarah reported she had abstained from alcohol apart from that one time. Contact continued and in September, Sarah said that she had spoken with her GP about her mental health but he didn't put a referral in so arrangements were made for Sarah to speak with the in-house Mental Health Practitioner.

Following a meeting with the Recovery Coordinator on 22/09/22, Sarah then provided several different reasons for not attending appointments over the next month and didn't answer calls made to her. Following an incident of DA where Sarah was injured, CGL were advised by the hospital liaison worker and attended the subsequent MARAC where they

were actioned to discuss alcohol detoxification with Sarah and promote and obtain consent for the IDVA service.

Following this, Sarah did not attend her appointments or answer phone calls. In mid-December, Sarah contacted her Recovery Coordinator presenting as tearful and said she would like to re-start her recovery journey. The Social Worker shared with CGL that Sarah was upset with the CP decision for the children to remain with their father and was concerned for her welfare. The Recovery Coordinator attended Sarah's address and got no reply with the blinds shut. The police were contacted with a request for a welfare check.

The Recovery Coordinator could not contact Sarah over the Christmas period as there was no reply to calls or texts. The day before Sarah died, she informed Social Services she would make an appointment with CGL.

2.3.48 Terms of reference

Sarah was allocated a Recovery Coordinator within the Family Safeguarding Team, where the staff have smaller caseloads to work more effectively with service users and Social Care. CGL also seek consent from service users to liaise with other professionals in order to promote and foster joined up working.

CGL staff regularly attend external meetings such as MAPPA, MARAC, dual diagnosis meetings, mortality review meetings, along with Childrens Core Group meetings and Child Protection Conferences. CGL have weekly internal multi-disciplinary team (MDT) meetings to discuss any service users of concern or where the worker may seek support or guidance in a particular area from within the MDT. Individual workers present cases and minutes are logged and revisited at the following MDT to ensure actions are completed and all notes are recorded in the service user's records. Daily Flash meetings are also held by CGL where there are discussions around patient concerns. Staff also have regular supervision sessions with their line manager for reflection, patient discussion, support and planning.

CGL strive to work well with other agencies and to improve this where concerns are highlighted, or communications may need improving. Staff have mobile smartphones for ease of communication with service users and others. Service user consent is sought to share information with other agencies, however in line with the Safeguarding Adults at Risk policy, safeguarding concerns or risks to selves or others can be shared without consent allowing the appropriate sharing of information when there is lawful basis.

CGL offer a comprehensive assessment that looks at all aspects of care including physical health and psychological health to identify other care or support needs and will look at signposting or referring on where necessary, CGL also have regular risk reviews with the service user which focuses on review of existing risks and any new risks, alongside a support plan and also identifying safeguarding needs which can then be discussed in safeguarding meetings if required. CGL seek consent from the service user to liaise with other professionals to ensure a good level of joined up working. CGL request a patient summary

from the GP surgery at assessment to help identify any risk or need, which can be incorporated into the risk review. CGL offered regular home visits with Sarah to make it easier for her to engage with the service due to childcare, school runs, Sarah was allocated a Recovery Coordinator within the Family Safeguarding Team, where the staff have smaller caseloads to work more effectively with service users and Social Care.

2.3.49 Rationale as to why Sarah's file had been closed on numerous times.

CGL are a non-statutory voluntary service and cannot enforce people to engage in treatment. If service users are in treatment and choose to exit treatment, there is a discharge pathway to follow which includes discussions with the service user to confirm they have met their goals, (not necessarily abstinence), and have gained everything they required from the treatment episode. A discharge form is completed and submitted to the Team Leader to agree the discharge. Sarah was discharged from her first treatment episode after advising she had reached her goals and controlled her alcohol use and no longer wanted support form CGL. She was signposted to mutual aid support such as AA and the Edge Recovery café for onward support and her GP was informed. The second episode was the conditional caution which Sarah attended and advised she had not consumed alcohol since the police incident and had been engaging with AA and finding their support helpful. Sarah was offered support from CGL, however declined this as she felt she was managing and knew how to contact CGL if she felt she needed additional support. This was fed back to the Out of Court Disposal/Diversion Team.

2.3.50 Reflective considerations/Good practice:

CGL were responsive to Sarah's needs around appointments and childcare to support her in fully engaging wherever possible, this included arranging home visits, both during term time and school holidays. In order to have confidential conversations during school holidays, appointments were offered to be held at local play parks where the children could be monitored safely and allow Sarah to have confidential discussions with her Recovery Coordinator. Sarah's engagement was, however, sporadic and during her most recent episode, she was offered twenty-one appointments with her Recovery Coordinator and attended eight. Attempts were always made to follow up these missed appointments by telephone or text and there was regular liaison between the Recovery Coordinator and Social Worker.

For each treatment episode that Sarah entered with CGL, a full assessment was completed. The assessment comprises of a detailed discussion about an individual's risks including details of substance use and reasons for referral, mental and physical health, children and family information, any risk of harm to themselves or others and risk of harm from others. The assessment also captures what the service user would like to achieve from working with CGL and based on this information the appropriate treatment pathway is chosen. From the assessment, the initial full risk review is generated, and this is a live document which is

updated throughout a service user's treatment journey as circumstances and risks change and at least every six months.

It is acknowledged that there was a gap in Sarah's first treatment episode between the Welcome Pod on 25/03/2019 and next contact on 21/06/2019, and this is not usual practice. There would be an expectation that an individual is followed up in a timely manner after attending a Welcome Pod to progress their treatment journey. However, at this time in the Cambridge team there were staffing issues with a high turnover of staff and multiple vacancies. The Family Safeguarding Team was also not implemented until 2020. There is a much higher level of staffing within the Cambridge team now. There are also weekly data reports now being shared with Team Leaders and their teams identifying those service users that have had no contact for 90 days or longer or those service users who, based on their risks, require more frequent contact.

2.3.51 Cambridge and Peterborough Foundation Trust (CPFT)

There are several Mental Health service provisions within Cambridgeshire including the following:

CPFT Liaison Psychiatry Service (LPS) - LPS are dedicated seconded psychiatry teams based in general hospitals, providing rapid access to assessment of acute mental health needs. They provide a plan which may include advice, signposting and/or referrals to community mental health teams and partner agencies and/or treatment of mental health problems, for example medication review. LPS covers the emergency department and medical wards in general hospitals.

CPFT First Response Team (FRS) - The First Response Service supports people of all ages experiencing a mental health crisis. FRS provides 24-hour, 7 days a week, 365 days a year access to mental health care, advice and support. By calling 111, and selecting the MH option, a person will be put through to a member of FRS who will speak to them and discuss their current mental health needs. Support may involve telephone support or a face-to-face assessment and if appropriate referrals onto other CPFT services.

The Sanctuary - This service can be accessed via FRS. It is a joint service partnered with Mind. This service supports people in mental health crisis. The team will see how best they can support individuals and decide if a safe space or a visit would be helpful.

CPFT Psychological Wellbeing Service (PWS) - This service provides help to people aged 17 and over (no upper age limit), who are experiencing common mental health problems such as depression and anxiety disorders, including: generalised anxiety disorder (GAD); social anxiety; post-traumatic stress disorder (PTSD); health anxiety; panic; phobias and obsessive-compulsive disorder (OCD). The main treatment offered is Cognitive Behaviour Therapy (CBT). This is now known as NHS Talking Therapies but would not have been at the time Sarah was accessing support.

Liaison and Diversion Services (LaDS) - The Liaison & Diversion Service (LaDS) identify people who have mental health, learning disability, substance misuse or other vulnerabilities when they enter the criminal justice system, predominately in police custody and courts. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required. LaDS work with children (over the age of 10 years) and adults, providing triage, assessments and sign posting, support with attending first appointments, time limited primary care treatments and court reports with the aim of improving overall health outcomes for people and supporting people in the reduction of re-offending or diversion where appropriate. The team consists of experienced mental health nurses, mental health social workers and support workers.

Chronologies

Sarah

2019

March – Sarah was assessed in the emergency department and a plan was put in place which included referrals to CGL to be seen while in the hospital, a referral for CSC for the family to be assessed for respite and an urgent referral to Cambs North community mental health team for ongoing psychological support. The case was closed the same day due to being discharged from the hospital.

Sarah did not attend her appointment with the Cambs North Assessment Team but a phone call was made as a follow up to discuss whether or not she needed to see them, in which she appeared bright and cheerful, stating the main issue was support for her son and that she was going to seek help for her alcohol intake and would never have done something so stupid if she hadn't been drinking. A routine assessment was offered but she did not attend that either.

April – Sarah was sent a letter notifying her that following the telephone call, she was being discharged back to her GP as per usual practice.

2020

July – Sarah was seen by LPS at hospital following an overdose and self-harm laceration to her arm. She stated that that her 'main problem' was her 18-year-old son. She and her other three children are 'all intimidated by him, she calls the police when he 'kicks off' and told the practitioner that she said in the moment "I'm done," had a bottle of wine and then took some tablets.
Records state Sarah attended ED whilst intoxicated and after taking small amount of son's medication which she says was an impulsive cry for help; denies low mood, depression. Sarah agreed she needs to address her alcohol and emotional issues in order to help her son. This was recorded as impression – stress reaction + alcohol.
Plan:

- Discharge home with husband
- Self-refer to PWS,

- Supplementary Information Form for CSC concern completed
- information given on CGL,

crisis plan which includes calling 111, GP, family, Samaritans.

Sarah had a further admission at the end of July following an overdose of tablets and three bottles of wine. There was a comprehensive assessment by PLS and an agreed plan put in place.

2021

January – Sarah was seen whilst in police custody by the local mental health Trust LaDS team and was referred to a Support Time Recovery Worker who is unregistered staff within LaDS that provide outreach work. LaDS uploaded the DASH completed by the Police to the health system so that it was accessible to relevant Trust staff across the range of services.

March – Sarah was seen by the hospital LPS following her cutting her wrists whilst intoxicated. She stated this was due to her husband not sorting anything out for Mother's day and she felt let down. The assessor spent time going through the difficulties with her eldest son, getting a mental health assessment, that it had been agreed twice but not yet happened. She is worried about his needs but this is impacting on her own wellbeing. It was explored if the son would talk to FRS but she did not think he would speak to someone over the phone.

Ex-husband now has his own flat and attending college. She described how they split up regularly and will probably get back together again. Sarah reports attending the emergency department a few times in the last seven days due to seizures. She denied any current suicidal thoughts, plans or intent…Risk appears to be whilst intoxicated, this can be reduced by cutting down/stopping alcohol intake.

Safeguarding: self-harmed whilst three children present in the house. Emergency department have agreed to complete SIF form. Previous Social Care input and safeguarding referrals. (SIF – Supplementary Information Form completing ensures information sharing with Childrens safeguarding, however staff are now requested to make a referral from CPFT to Childrens Social Care)

Plan: Discharge home when medically fit, Sarah will contact CQC/Healthwatch/MP to discuss difficulties in getting her son's mental health needs assessed, continue with AA [alcoholics anonymous], SIF [Supplementary Information Form], crisis management plan.

July – Sarah attended ED with Leon due to self-harm following an incident with a stanley knife and Anton at home. An argument had started due to Sarah planning to have a male friend stay overnight. Sarah disclosed that Leon is increasingly disruptive in her life when she starts to find a new relationship and will search for her when she is out of the house. Emotional and psychological abuse were identified and Sarah was referred to the hospital IDVA along with SIF form for concern for children's safeguarding and a crisis management plan was made.

October – Following an assault by Michael, Sarah was admitted to hospital due to her injuries. Sarah's sister phoned twice requesting a psychiatric assessment on the advice of the children's social worker because the children had been taken away from her. LPS questioned the assessment as Sarah's mood would undoubtedly be lower in these circumstances. However, Sarah was not expressing any intentions to self-harm so LPS advised the emergency department staff to complete a mental health triage to ascertain the level of risk and LPS would re-discuss the referral.

Although no triage was undertaken, there is a record in the emergency departments health notes which states 'Spoke to patient, she is sad but aware that the children have been taken away by her ex. She understands that it is safer for them.' The plan was to call FRS on discharge.

November – Sarah attended ED following an impulsive overdose due to a family argument taken in the context of alcohol. She had taken her son's prescribed blood thinning tablets. Later in the month with Sarah having self-referred to Psychological Wellbeing service (PWS) a letter was sent to her informing her that her needs were too complex for brief psychological interventions. Information was provided on CGL and an appointment with the GP recommended.

2022

September – An FRS phone call was made to Sarah following a referral from the GP as Leon and a friend had both contacted the surgery raising concern over Sarah that she may self-harm as she was behaving erratically, smells of alcohol and was angry and tearful with a 7-year-old in the house.

November – CPFT aware of DA against Sarah and her hospitalisation. A week later, a referral was received from the ambulance service as a friend had received a message from her stating she was suicidal. Sarah had self-harmed that evening but did not want help from the ambulance service or mental health teams.

Daniel

2018

There are seven entries in relation to Daniel during this year. Two are third party information informing them of DA incidents with no action taken by health. The remainder were in relation to communication with Leon as Daniel failed to attend appointments on multiple occasions. Good practice was shown as he was not immediately discharged but discussed at an MDT meeting with the parents present.

2019

Daniel was admitted to Addenbrookes due to his seizures. During the year, eleven third party referrals were received from differing agencies. Some of these referred to incidents of

damage caused by Daniel. A referral in March was due to Sarah overdosing and being taken to hospital with a concern for neglect of the children. This was not reflected in Anton's notes showing inconsistency of documentation across the family's individual notes. Later that week, a third DASH was received within a year. Information should have been taken to pass on to services involved with him to support his behaviour but this was not done.

There was no evidence of any services in health acting on any of the information they received.

Anton

2018

There are three records referring to a domestic abuse incident by Daniel and the communication with CSC whereby they were informed the family were not open to them. No consideration was made for a safeguarding referral due to this.

2019

A section 17 report was completed and CPFT informed. There were four records during the year from third parties of which there was no evidence of any health services acting on the information.

2020

One entry relating to Anton in which Daniel had punched him in the heads and a DASH had been completed.

Sophie

Records on the computer system only begin on 24/03/21 but there are letters entered prior to that date.

2018

Three incidents informed where DASH was completed making 3 DASH in a year. No action taken by health.

2021

Third party information and DASH received following Sarah taking an overdose and arguing with Leon. The school nurse was aware.

In September, a referral to Younited was accepted and a strategy discussion was held two months later by MASH Health. Following this there was a report prepared by the School Nurse for an Initial Child Protection Conference (ICPC) in which the School Nurse attended. The report was not uploaded on the computer system.

There was no request for Younited to attend the ICPC or submit a report.

2022

An invite was received for a Review Child Protection Conference (RCPC) and declined as it was policy at that time not to attend RCPCs. Younited were not invited to the Core Group or RCPC and did not provide a report for either. Sophie was closed to Younited in the December as she was receiving support from the Acorn project. There was no initial screening/assessment by Younited between Sept 21 – Feb 22.

In April, information was requested from MASH Health for a MASH strategy discussion after concerns were raised over Sarah's self-harm and poor mental health with the children present. The outcome was a s.47 but the notes reflect that no minutes were received, there is no evidence of information sharing requests from CSC to the Health and Care Partnership (HCP) Service and no evidence of the outcome of the s.47 in the notes.

2023

There is no evidence of an invite to an ICPC following the death of Sarah and no action for them to take.

Lucas

2018

A DASH was received and sent to the Health Visitor (HV) for review which is good practice. The HV contacted Sarah via phone and although she could not speak at the time a further call was made in which Sarah was tearful and disclosed the aggressive behaviour by Daniel. She was advised to see GP and discuss with school and the Social care number was provided. A home visit was offered and declined. There was no discussion within HCP in relation to the issues with Daniel for wider knowledge and a holistic approach.

Two further DASH reports were received and attempts to contact Sarah failed. HCP contacted Childrens services and were informed the family were not open to them. No consideration was made for a referral for safeguarding supervision by Safeguarding Team, with regards to whether any further action should be taken.

A home visit was later conducted by the HV and a CSC Support Worker arrived. HV documented that they feel that the Support Worker is offering all the support the family needs. Lucas was seen and no reported problems. Contact details were left with Sarah if she needs further support from HCP.

2020/21

Record shows that on the day that Lucas was absent from school, he missed his immunisation jabs.

Further DASH reports were received outlining incidents involving Sarah's self-harm and Daniels violent incidents within the home but no sharing across Health and HCP was recorded.

In July, a Safeguarding meeting at the surgery with the Health visitor present and Sarah's liaison psychiatry assessment said Sarah has had controlling behaviour from ex-husband and older son's and Sarah was responding by self-harm. It is not recorded what actions came from this.

In November, a strategy discussion was held. Sarah had taken an overdose after physical altercation with Daniel while the younger children were at home. Reported that Lucas was struggling at school and often reported to be hungry. Lucas has refused school meals and is scared of older brothers. Family worker currently involved. Outcome - Section 47 single agency School Nurse to consider a health assessment on Lucas and Sophie.

2022

May – Sarah spoke to School Nurse stating that 2 older siblings not at home and often out and not coming in until 8pm. Mum no longer cooks family meals and gives Lucas what he wants due to his fussy eating. Lucas eats mostly carbohydrates. School Nurse encouraged Sarah to cook meals and try to sit as a family.

ICPC notes reflect Sophie's.

October – MASH information shared - Strategy discussion held. Police and Ambulance service referred into CSC Reported that mother intoxicated alleged assault by her partner who strangled and punched mum. Lucas was present and witnessed the incident. Mum had also self- harmed Mum admitted to Addenbrookes hospital. Lucas is with his father whilst mum in hospital.

2023

MASH information shared. Strategy Discussion held following the death of Sarah who took her own life. Sophie and Lucas still supported on a CP Plan. Recorded support from School, CSC and Housing. No Unmet health needs identified.

2.3.52 Capacity

Mental Capacity Act 2005 - The Mental Capacity Act 2005 is a law that protects vulnerable people over the age of 16, around decision-making. It says that: Every adult, whatever their disability, has the right to make their own decisions wherever possible. The key principles of the Mental Capacity Act are Principle 1: Assume a person has capacity unless proved otherwise. Principle 2: Do not treat people as incapable of making a decision unless all practicable steps have been tried to help them. Principle 3: A person should not be treated as incapable of making a decision because their decision may seem unwise. This legislation

gives guidance on assessing capacity, who can take decisions in a person's best interest, in which situations, and how they should go about this. [11]

S136 Mental Health Act 1983 (amended in 2007) - The Mental Health Act section 136 is the legislation which lays down the power of a constable to remove a person with a mental disorder to a place of safety without a warrant. (1) If a person appears to a constable to be suffering from mental disorder and to be in immediate need of care or control the constable may if he thinks it necessary to do so in the interests of that person or for the protection of other persons; (a) remove the person to a place of safety (b) if the person is already in a place of safety, keep the person in that place or remove the person to another place of safety. (1A) The power may be exercised when the person is at any place other than: (a) Any house flat or room where that person is living (b) any yard garden garage or outhouse that it's used in connexion with the house flat or room (2) A person [removed to or kept at] at a place of safety under this section may be detained there for a permitted period not exceeding 24 hours for the purpose of enabling the patient to be examined by a registered medical practitioner [doctor] and interviewed by an approved mental health professional (AMHP) and making any necessary arrangements for treatment or care. This power is usually invoked where a person's abnormal behaviour is causing nuisance or offence or likely to put themselves or other at serious harm and they will not agree to an assessment of their needs on a voluntary basis. If the person is in a place in which a constable cannot invoke this power, and a Mental Health Act assessment is required, then a referral is required to the AMHP (Approved Mental Health Practitioner) service for the AMHP to consider the case. To enter a property to complete an assessment, without permission, a warrant subject to s135(1) MHA (83) would be required and the AMHP can only get this by making an application to the Magistrates court.[12]

2.3.53 Addressing Terms of Reference

It is clear from this review of the children's records that there is a history of poor emotional and psychological health and wellbeing with alcohol abuse and a recorded history of domestic abuse between both parents as well as the added pressure of a young person (Daniel) who has health difficulties that lead to him displaying aggressive behaviour in the family home. This has led to a high amount of Police attendances. Policy and practice around intervention and support for victims and perpetrators of domestic abuse is very different between 2017 and 2023. During the period of 2018 to 2021. Policy and procedures are clear now (there is a new updated Domestic Abuse Policy and two Standard Operating Procedures currently going through CPFT ratification processes), there is a clear pathway for reporting safeguarding concerns both internally and to Childrens Social Care. Domestic abuse training is offered to staff teams within CPFT and there is a Domestic Abuse Teaching Package planned for launch in 2023. CPFT have a whole time Domestic Abuse Advanced

[11] https://www.legislation.gov.uk/ukpga/2005/9/contents
[12] https://www.legislation.gov.uk/ukpga/1983/20/contents

Practitioner (2 part time posts) within the Safeguarding Team. A Datix is completed for all reports of Domestic abuse, this is reviewed by a member of the Safeguarding Team. 3 completed DASH within 6 months is a referral for discussion with MARAC on professional judgement and all MARAC referrals made by CPFT staff are asked to be sent to Safeguarding Team for review. Their policies and procedures also require staff to complete a DATIX report and all safeguarding DATIX reports are reviewed by experienced senior practitioners in the CPFT Think Family Safeguarding Team. Advice, guidance, and support is given to front line staff and managers. CPFT has a named nurse for Adults and Childrens Safeguarding and a Named Doctor, which further ensures tackling abuse of children is a high priority within the organisation.

The voice of the children in this case doesn't appear to be heard and there is limited evidence to show that services have been as supportive of the family as they could have been. However, there is evidence that the HCP Service having been supportive in seeking emotional support for Sophie and Lucas and support has been offered to Sarah with the younger children's health. The voice of the child is now embedded in policy, training, and practice within CPFT. CPFT recognises that further work is required to ensure it is more fully implemented and also documented.

The support for the child is led by Education. Where the child is under 5, support is led by the Health Visitor service. CPFT services fully engage in any support plan for the child.

Sarah had thorough face to face assessments of her risk of self-harm and suicide by LPS in the Emergency Department. The clinical record keeping meets good practice standards and also reflects the front-line staff's knowledge and skills in this area.

Where a family is referred to CPFT CAMH, there are services which provide assessment and interventions for the whole family. CPFT range of children's services are also able to give advice and signpost to specialist partner agencies for support.

2.3.54 Reflective considerations/Good practice:

Although good practice is shown on occasions when a holistic assessment is made, advice is given and information is gathered, the entry in July 2020 shows a lack any record of professional curiosity around Sarah being the victim of DA from her 18-year-old son and the needs of the younger children living in an abusive environment and their experiences of their mum's mental health. This was repeated in January 2021 when there was no consideration of other children in the house or a referral to CSC. On this occasion and others, there was no discussion or referral in reference to drugs.

It is now policy, and common practice for CPFT practitioners and managers to contact CPFT Think Family Safeguarding for case supervision but was not routine practice in 2021.

Sarah had a face-to-face comprehensive assessment and joint care plan by PLS in the Emergency Department.

Sarah was asked about suicide when presenting with self-harm behaviours.

FRS contacted Think Family Safeguarding for case supervision.

An IDVA was offered, and a referral was made and there was good follow up shown for missed appointments with CPFT.

The HCP Team supported Sarah with Sophie and Lucas with ongoing health concerns and support and had face to face contacts even though it was during covid.

Education had the younger children in school during covid due to their vulnerability.

CPFT policy now states that where there are 2 disclosures within 6 months or 3 disclosures within a year and there are children in the household a referral to MARAC must be made on professional judgement.

2.4 Summary reports

In addition to the IMRs, some members of the panel were asked to provide responses in relation to provisions in the area and responses to the Terms of reference.

2.4.1 – NHS Cambridgeshire and Peterborough Primary Care (ICB)

Report compiled on behalf of the GP for Sarah, her husband and their children and also Michael.

Michael

(To be redacted on publication as no consent provided, but the information is included due to its pertinence within this review).

2014 - GP produced some reports for a solicitor, unknown what they were.

2015 – Disclosure that he had difficulty controlling his anger, which was long standing. It was verbal abuse and he worries that he may lose his partner over this. He informed the GP that he had been verbally aggressive since the age of 11/12 and could be with family, work and new partner. No physical abuse was recorded.

2018 – August – Michael was heard at MARAC as an alleged perpetrator of DA towards his girlfriend who he had split from in the October.

2019 – January – Michael reported struggling with everything. He was panicky and stated that it was getting worse. He attended an anger management programme that he funded privately. He claimed there were two men in his head that caused problems and he was lonely, volatile, and irritable. He was referred for counselling.

2022 – December – Michael discussed fertility with his GP as his partner (Sarah) had four children and he had two children but they were unable to get pregnant.

Sarah and family

2018 - During the course of the year, there are three separate notes outlining the frequency of Daniel's fits and the affect it is having on the family. These were all sent from agencies who were dealing with incidents involving Daniel.

March – Safeguarding report sent to GP surgery. DA recorded in notes of Daniel, Sophie and Lucas.

April – Records of Police report from a domestic incident in March involving Daniel causing criminal damage and injuring himself.

May – At risk of violence noted on Anton's and Sarah's record with Daniel noted as the perpetrator. The following is recorded verbatim from the notes:

Sarah's mum suddenly passed away in December, coping mechanisms had been discussed with her as police had been called out again the previous night as Daniel had punched a TV and smashed the lounge up with a 3 and 14-year-old sibling present. Sarah stated she was unable to cope with his outbursts and he was also only like this with her (mum) she reported he's angry and cross but reasonable with his dad who they lived with (Leon). Sarah reported consuming wine to cope. They had previously had family counselling. Sarah reported she was going to self-refer to IAPT and CRUISE. Daniel and Sarah were both offered an appointment, but Sarah declined this as she felt it would make things worse with Daniel as they already had a difficult relationship. Agreed plan – also recorded in Daniel's notes, "does not want to talk to anyone at school, home or here, been to Family counselling in the past and the whole family found this difficult and intimidating. Mum will ref self to IAPT and call Cruise. I will speak to colleagues and call back - offered both appts, declined at this time as feels may make things worse for him and her. Difficult relationship, Mum feels that he also has multiple autistic traits that have never been addressed due to all his other problems, now as he comes in to being an adult this may be helpful to address, has community consultant for epilepsy only.

The MASH team when requested, could not forward any information as they did not have a case open and could not ascertain if the police had made any referrals to Social Services and therefore completed a safeguarding referral outlining concerns of Daniel's violent behaviours and physical aggression.

December – Leon reported experiencing a low mood as he was experiencing relationship problems.

2019 – May, June and July - Anton, Sophie & Lucas discussed in family MDT meeting due to Sarah overdosing twice that year and a section 17 being completed.

2020 – January - Mum felt Daniel was more violent and had more seizures on Topiramate.

March - Spoke to Leon, Dad. Daniel has smashed up house a couple of times recently. His younger brother was scared of him.
Taken to A+E for mental health assessment by police. Daniel's behaviour has changed since epilepsy meds were altered. Angry episodes, violent, smashing TVs, throwing things at family. He is now staying with his aunt due to the risk of harm to siblings.

July – Sarah took an overdose. Leon was spoken to in relation to Daniel. Social workers and police recommended Daniel be tested for autism. The difficulty is Daniel will always deny any problem which the Dad says couldn't be further from truth. There was an incident on Monday night where he smashed up glass windows and Dad sounds quite desperate. Concern - risk at home.
GP called Leon back the next day to discuss the situation. The police have referred him to the vulnerable adult's team. Number provided for IAPT & generic psychiatric referral done. Referral to IAPT completed.

July – September – Anton, Sophie and Lucas formed part of the family safeguarding MDT meetings.

August - Safeguarding received. The surgery received a call from the adult physical disability team as they had been contacted by the police as they were concerned about Sarah's wellbeing.

November – Long conversation with Sarah about Daniel. Sarah was desperate for help as she feels she can't keep calling the police when Daniels behaviour is out of control. He now lives with his father as it is not safe for him to be at home with his siblings.' *Mother feels the system has failed him*.' He visits her most days and is very socially isolated. Referral made to Mental Health Team.

2021 – Safeguarding referrals received within the first few months for the three youngest children. Comment in notes that Sarah needs a review of her Mental Health following the latest safeguarding referral.

March – DASH received following Sarah assaulting her husband as retaliation for Daniel's violence. Sarah reported she had been drinking wine to cope but had joined AA. She reported feeling positive about the future. And she can manage her anxiety. Ten days later, an ambulance report was received following intentional self-harm by Sarah. A s.17 was requested a few days prior to this.

July – Leon reports stress at home, requested counselling and was advised to self-refer to the IAPT service - a national talking therapy service for those experiencing anxiety and depression. Sophie is recorded as a risk of self-harm and hoping to get some psychological therapy as was refused by IAPT but the school have organised some after waiting two months. No safeguarding issues identified. The GP sent a text message to Sophie's phone providing details of a number of helplines.

August – Notes state: 'Child is cause for concern - Mum self-harmed, impacting on Sophie. Child at risk - MH support agencies info given to Dad in July, school also planning referral.

Family is cause for concern. Maternal alcohol abuse. 12th Mental health concerns - social services are now involved as she was not able to access C33. Has been instead advised to contacted Younited. Needs a professional referral to them - refer to Younited as per text.

November - Child is cause for concern (Lucas). Sarah takes an overdose and there is a referral into MASH, Sarah, Sophie and Lucas are identified included in Leon's records. This is followed by a strategy meeting as Sarah had been self-harming and there was concern about the effects on the children. It was reported Sarah had deliberately overdosed on more than one occasion, and there had been an altercation with the adult son and the children were present. Reported that Lucas was struggling at school and on occasions reported he was hungry although he refused school meals. Reported that he was scared of his older brother's behaviours. A family worker was allocated. The threshold for a section 47 was met as the children were reported as suffering significant harm, although identified as single agency with a possible view to holding an ICPC.

Relationship bad with ex-partner (presumed Leon), previous DA and he has moved out with eldest son. Middle son has now become controlling and abusive – preventing Sarah's friends from coming round. She felt that things were building up and she couldn't cope, so she took an overdose. Sarah asked this son to move out, but her ex didn't help. Social Care were involved and there was a CP plan.

Follow up call to Sarah made where she stated she was apprehensive about the safeguarding meeting. Told to self-refer to IAPT as advised previously.

2022 – April – Referral to MASH following an ambulance report. There was a child protection strategy meeting following Sarah's mental health breakdown after consuming alcohol, Sarah used the bottles to self-harm. Children on a CP plan and a s47 was commissioned. Child (Lucas) is cause for concern.

September - Sarah self-referred for cognitive behavioural therapy (CBT). She was going to liaise with CGL and will contact the surgery if her mood is dipping. She had been under lots of stress. Social care advised she found a coping strategy. The GP surgery sent Sarah an SMS containing links to counselling, CBT, and many links should she be experiencing any deterioration of her mental health. A friend rang the surgery concerned about her mental health, suggesting she was consuming alcohol with a seven-year-old in the house and her ex-husband was also ringing the surgery.

2.4.2 Good Practice/Reflective considerations:

Reports were shared in all individuals notes across the family where relevant and not just in the referees which allows effective cross referencing. SMS texts to numerous members of the family with support information was sent on more than one occasion.

2.4.3 Peterborough and Cambridgeshire (Cambs) MARAC

MARAC thresholds for Peterborough and Cambs MARAC are:

1. On Dash threshold of 17+ and or on professional judgement.

2. Repeat Incident- as defined by Safe Lives.
3. On escalation- 3 or more incidents over a 12-month period. Cambs Police specify that the Police incidents are of medium or high risk, not standard risk. They are referred on their own professional judgement.

The basic purpose of a MARAC meeting is to work safely in partnership with designated DA partner services to reduce risks to DA victims and their families who are believed to be a very high risk of significant harm and or a potential DHR. No one DA partner owns or dictates a MARAC Forum. The Cambs and Peterborough MARAC is administrated by MARAC co-ordinators, that sit within the IDVA team and are employed by Cambridgeshire/ Peterborough County/City Council. The meetings are convened three days per week and chaired by Cambridgeshire Police and Cambridgeshire and Peterborough IDVA Service.

The primary reason for MARAC Co-ordinators to be based alongside the IDVA Team, is the process journey of a MARAC referral, the MARAC case is allocated to an IDVA in the early stage of receipt, this is with a view to facilitate a prompt and timely engagement with the victim, explaining the MARAC process and to offer safeguarding support and intervention, whilst they may still be in crisis.

2.4.4 The core objectives of a MARAC are to:

- Share all risk led information concerning the named victim, perpetrator, and children in a confidential setting.
- To identify, collate and agree all risks to the above-named parties, based on information shared.
- The MARAC chair collates the risks and invites assistance and expertise from MARAC partners to add or amend to the list of risks after all information is shared.
- Using the agreed collated list of risks, each MARAC partner present then recommends specific timed actions from within their organisation, that will assist in reducing or eliminating further specified agreed risks to the victim and children. In addition, to identify actions that would reduce the risks of named parties perpetrating behaviour within that family setting.
- All actions should be defined and clear, each partner ensuring that the actions can be completed in an appropriate time frame.
- Completed actions are monitored by the MARAC Co-ordinators. MARAC partners are responsible for updating MARAC case management system with the outcome of actions allocated to their service.
- Active listening to information shared is essential for the collation of risks and a clear understanding of the sources of the existing risks.

Two MARAC meetings took place in regard to Sarah.

2.4.5 The first meeting was held on 15th January 2021 having been referred by the Police with Leon named as the victim and Sarah as the perpetrator following an incident in which Leon was trying to stop Sarah from self-harming. Observations are summarised as follows:

- Information and reports made available to the MARAC meeting were not clearly reflected in the agreed list of risks recorded. The Police report reveals the source of

the abusive and offending behaviour was with their 19-year-old son, Daniel, who suffered with epilepsy and did not take prescribed medication.

- Sarah's behaviour on arrival by the Police at her home address on 4th January 2021, was not about her being the primary perpetrator of abuse to others, but of harming herself; her husband was trying to prevent her from cutting herself.
- Sarah's 11-year-old daughter, attempted to manage the situation on the date of the incident, she called the Police and at the same time placated her distressed younger brother. The impact on the children during this incident and the numerous reported incidents over the last 12 months, were clearly prevalent. The education report supports this concern for the potential risks of harm to the children and witnessing abuse between their parents and older brother Daniel. This was not detailed adequately in the risks. It is not clear whether the report was available to be read during the meeting?
- The MARAC notes did not give any details of what Children's Social Care's response was to the Police incident on 4th January 2021, as they would have received the DASH, along with all other core services following Police triage. There is no record of this being challenged during the meeting, In addition, there were no actions to ensure the future safety of the children.
- The incident that brought the case to MARAC on 4th January 2021 included information of separate incidents over the recent Christmas period where 2 siblings had argued and fought, and a large kitchen knife was used during that incident; also, an incident where Daniel assaulted his father. Escalation and severity of abuse does not appear in the risks. The Education report states weapons were used in DA incidents, but this does not appear in the risks.
- Police information provided by the DA force lead stated that Police had attended the address on 21 occasions over the previous 12 months. A significant percentage of those incidents included abusive behaviours perpetrated by Daniel. It is not clear how the 21 DA Police incidents were triaged, or why there were no MARAC meetings prior to January 2021, if not purely on escalation and or professional judgement.
- Daniel's name does not appear on the risks as a person in that household regularly perpetrating abuse towards both his parents and his siblings.
- There were few risks identified and recorded in the case notes and the notes were not clear in clarifying the dynamics that existed within the family and identifying family members who were known to perpetrate abuse and those who were also victims of abuse.

2.4.6 The second MARAC concerning Sarah took place on Friday 28th October 2022 where she was the named victim. The named perpetrator of the abuse was Michael, her current partner.

This case was referred to MARAC by Cambridgeshire Police on professional judgement, as Sarah had scored 9 in the Safe Lives Dash risk indicator checklist (RIC).

A very serious violent assault took place towards Sarah by Michael on 24th October 2022 in the presence of Sarah's son Lucas. Sarah sustained significant injuries including non-fatal strangulation, where she lost consciousness on at least two occasions during the said

incident. She was treated at Addenbrookes Hospital and at the time of the admission, was believed to have mental capacity. Sarah did provide a detailed account of the lengthy violent assault to a response Police officer but declined to support any prosecution of said incident. The questions answered in the Dash RIC did not clearly reflect the severity and complexity of their very short 3-month abusive relationship or the seriousness of the DA incident that brought the case to MARAC.

Observations of this meeting are as follows:

- There was no link to the MARAC in January 2021 with Leon as the victim and Sarah as the alleged perpetrator. The link should have been made at the point of triage by Cambs Police and the MARAC co-ordinator.
- There was no contribution made to the MARAC by CPFT, when Sarah's mental health was of significant concern, and she had been open to CPFT at the MARAC in 2021.
- The collated risks in this second MARAC were more reflective of the current escalating violence, however, a concern is that non-fatal strangulation and the short period of time that the speed of which the violence escalated within this short 3-month relationship do not appear on the list of risks.
- The notes recording the grounds for refusing the DVPO by the Police Superintendent, differentiating the bruising on Sarah's neck caused by a 'headlock' and not 'direct strangulation' was incorrect. The outcome was that sufficient pressure was administered to cause her to lose consciousness on two occasions during the incident. In addition, that Sarah and Michael live in separate properties, the chronology by the officer states that there had been a number of unreported assaults and both parties frequented each other's properties all the time. It was noted that this was the most serious. No challenge was made to this.
- No risks were recognised that Michael posed to Lucas during the incident that sparked the said assault.
- No mention of the grounds for a DVPO being refused by a Police Superintendent.
- No specific actions suggested by CSC as to how the children would be safeguarded by similar further incidents.
- No actions around Michael's offending violent behaviour and looking at other criminality and relevant Police intelligence around his drug misuse.
- There were no actions regarding safeguarding children at school and home, especially in light of Sarah's reconciliation with Michael. There is no Education report included. Education rarely attend or contribute to Cambs MARAC cases during school holidays.
- The contents of the information presented at the meeting suggested that the reconciliation with Michael and Sarah had in all likelihood already taken place. Sarah was actively avoiding all professionals following the assault by Michael which was not risk assessed.
- The investigation had been NFA'd by Police prior to the MARAC meeting- just four days after the assault, with no known Police safeguarding measures for Sarah considered or implemented that show in the notes other than the DVPO being declined.

2.4.7 Reflective considerations/good practice:

The partnership creativity appears lacking, identifying a gap for development across the MARAC partnership.

It is of note that routinely only Detective Constables and Detective Sergeants chair and present at Cambs and Peterborough MARAC meetings. MARAC meetings are also chaired by IDVA managers, there is separate representation by an operational IDVA member and additionally by the allocated IDVA if deemed necessary. All IDVA chairs have completed Safe Lives training but the police chairs haven't. The last training was in 2019 but police chairs have mostly changed since then and none of the new chairs have completed the training.

Following the first MARAC meeting, the lack of risks will have impacted on the lack of specific actions that may have contributed to a reduction in risk. The two actions that were agreed, were neither creative nor robust around reducing risk to a family where the risks were escalating.

For several years, Cambs Police had not routinely completed DA Dash risk indicator checklists for DA incidents, where the victim and perpetrator are not intimate partners or ex-partners. This may or may not have had an impact on MASH staff collating escalating violence and patterns of abuse between members of the same family, as in this case.

The attendance of Children's Services at MARAC is intermittent, with capacity stated as the reason although the CSC MASH in the main do attend but recently, this has been infrequent as well. Where the case is open to a social worker, they are expected to call into MARAC but this isn't always followed and is raised with the Seniors of CSC when it occurs.

2.4.8 IDVA Service

Sarah was referred to the IDVA service by the Clinical nurse at Addenbrookes Liaison Psychiatry Team in July 2022 following a history of previous admissions due to self-harm, attempts to take her life and depression.

Sarah disclosed emotional and psychological abuse by her ex-husband, Leon but doesn't feel threatened by him. She described her relationship with him as toxic and that he broke into her home at 01.30hrs in the morning. Sarah felt he was manipulative and not accepting the relationship was over, trying to maintain control following their separation when she was seeking other intimate relationships and attempting to move on. She spoke of a new partner and abuse by her son Daniel but felt that his aggression was due to his epilepsy medication. She described her drinking as 'can take it or leave it.'

She did not feel she required further IDVA support as she did not feel she needed it. IDVA support is consent based. The IDVA service continued to try and contact her on several occasions thereafter and finally closed the case in September.

A high-risk MARAC referral was received in October following a violent assault by her then partner, Michael. Sexual violence was disclosed in the DASH. Several attempts were made to

contact Sarah with no response and the case was closed in the November having not successfully made safe contact with her.

The OOCD IDVA role is funded by the Cambs and Peterborough OPCC to The Cambs and Peterborough IDVA Service.
In the cases of Police DA conditional cautions, the IDVA will offer the victims support, having consented to a contact.
The IDVA Service will make initial contact explaining and offering the service and if the client consents to support then this will be provided throughout the caution process and beyond if necessary.
The IDVA will work in partnership with the OOCD team and the Officer in the Case (OIC's), advocating for clients, as necessary.

2.4.9 Primary school of Lucas

The Head Teacher of the school was spoken to at length over the phone by the author to ascertain the below information.

The school are part of a system in Cambridgeshire which is the notification of a domestic abuse incident involving children. This is an alert that is sent to them by the MASH team in relation to any child they have in their school. This will then be shared with the pastoral team within the school for them to ensure they provide any appropriate support for the child and can keep a close eye on their well-being at that particular time.

The Head had a good relationship with Sarah as Sarah would go to see her and tell her of the struggles that she was having with Children's Services and ask her to be her voice to make things happen, which she obligingly did. Sarah felt frustrated with the constant changes in Children's Services and felt people often listened to Leon over what she had to say.

Sarah worked hard and closely with the school to try and support Lucas and would confide of situations with Daniel which she admitted were not because of his medical condition that would frighten the younger children and worried she would lose them because of his behaviour. She also disclosed of times when Anton was difficult to cope with including a time when him and his girlfriend were living with her and were drinking and staying in bed all the time and when she asked them to leave, he caused a scene. Sarah felt a lot of blame was put on Daniel and Anton's behaviour was overlooked because of it and said he treated her badly.

Sarah never disclosed any domestic abuse from any partners and the school never received any alerts in relation to partners apart from when Sarah self-harmed and Leon had to restrain her. Sarah spoke well of Leon and said that they had been really in love for a long time but after 21 years, it had faded but they still got on and worked together for the children. The Head is aware of Sarah's mental health and alcohol issues and recalls her being really poorly at times but this never stopped her coming to school if she was needed. Sarah was insistent she was not an alcoholic and the Head states that having seen her on drop off and pick up from school, she would never have suspected it either.

Lucas is described as easy-going and enjoys life at school. He is a private, quiet boy but became more reserved prior to his mum's passing. Following Sarah's death, the school spoke with Leon and he was enrolled into 'Blue smile' which is a form of counselling and support. Lucas uses this time to play as an escape from everything and doesn't sit and talk to the counsellor which isn't an issue. As time has passed, Lucas looks healthier and happier and is more engaged at school which the Head feels is due to a settled home life.

2.4.10 Academy school of Sophie

The Family Liaison officer who is the Head of Safeguarding (HoF) at the school was spoken to at length on the phone by the Author to ascertain the below information.

This school is also part of the DA alert system as outlined in Lucas' school summary. If the school receive an alert, then they will speak to the relevant child it refers to and the parents where necessary. They recall that both Sarah and Leon were always open and honest with them about the situation at home as was Sophie.

Sophie is described as open, articulate and mature. She is a model student who shines and excels. She likes to keep her school and home life separate and so she wouldn't offer normally approach to disclose anything but would if she was asked. She didn't really mention the issues with her brothers much but Sarah had informed the school that stress caused by Daniel and Anton caused her huge stress and led to her drinking.

Sophie would mostly tell the school what she witnessed in relation to when her mum self-harmed. Out of everything that went on, this was her main cause of concern and she would say she wasn't worried about anything else as her Dad was a safe person to be around. When she was first offered counselling by the school, she declined as school was her safe place but eventually, when Sophie and her Dad asked again, the school initially referred her to Younited and Centre 33 which are local counselling provisions for youths but due to their waiting list being so long and Sophie's age, they referred her into The Acorn project who accepted her immediately. They attend her school every Wednesday and their support is not time restricted and remains open ended.

The biggest issue the school were told by all members of the family who spoke to them were the constant changes in Social workers of which the school counted 6 on their records in one calendar year. This led to them losing their trust in the service as they didn't feel valued.

The school were consulted in relation to the Child Protection plan but not to an extent that they could have been as they had spoken with Sarah, Leon and Sophie frequently so would have been in a good position to provide information.

Following Sarah's death, the school offered Sophie bereavement counselling by Stars but it was too soon at the time. They have now made the referral with the blessing of Sophie and Leon and support is being provided.

2.4.11 Domestic Abuse & Sexual Violence Partnership - DASV

To address the issue of child to parent domestic abuse, Cambridgeshire Police and the DASV collaborated by working together and currently have a Family Respect project.

Adolescent to Parent Violence (APV) is a pattern of physical, psychological, and emotional behaviour seen in children and adolescents who cannot regulate their feelings in other ways and/or have a great need to gain control over their parent/s or carers. In families who experience CPV, violence as well as destructive behaviour by the child are often the most pressing concern; it has the potential to destroy families.

- Constabulary data: Locally, whilst Cambridgeshire Constabulary warn of significant under-reporting:
- 6% of all recorded domestic abuse incidents were 'Child on Adult' abuse and were part of a pattern of overall domestic abuse incidents that were most prevalent in Peterborough, Fenland and Trumpington in Cambridge City. (Snapshot data April 2019 and April 2020)
- There were 658 Child/Adolescent to Parent Violence crimes in 12 months ending March 2020 where the offence was Violence Against the Person and the suspect/ victim relationship was son, stepson, daughter, or stepdaughter (aged between 10 – 24 years) (Cambs scoping report, 2022).
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The Office of the Police & Crime Commissioner and partners have secured funding to fund the Respect young people programme facilitated by the YMCA and supported by RESPECT. The programme is a voluntary programme and is not to be mandated through either a CR or a CC. The Family Respect project works with the child or young person in a face-to-face environment (where this is possible) over several weeks, working with them as part of the solution, rather than viewing them as the problem.

The intention is to rebuild family relationships and create long lasting change in for everyone in the family, by providing healthy and sustainable approaches to manage conflict.

In 2022/23, 89 families were offered support for abuse suffered from their child. Twenty-three families completed the programme and calls to police from these families reduced by over 90% following completion of the programme.

To be eligible for the programme:
Both the parent/carer and the young person must voluntarily submit for participation and give consent; The young person must be of secondary school age 11-17; The young person

must have been abusing the parent/carer for at least the last 6 months.; The young person must be prepared to address their behaviour; and the parent/carer must be ready to commit to this work with the service.

Daniel would have been 20 years old at the time and out of the scope for the project.

Carers

In a caring relationship, the carer may be subjected to domestic abuse from the person they are caring for. The abuse may be long-standing and occurred prior to the care needs but the shift to a caring relationship could have been a trigger that increased or changed the nature of the abuse. In some cases, changes in behaviour are attributable to mental ill health, including dementia, use of drugs or alcohol and side effects of medication. Some physical illnesses such as urinary tract infections can also cause changes in behaviour. It should be remembered that the role of a carer involves a significant emotional input, as well as physical, and that the role is often taken up unexpectedly with no formal training or support.

Carers who are experiencing abuse from the person they care for may be unwilling or unable to seek support for several reasons, including not wanting to appear that they can't cope with their caring role, being worried about opinions of other family members, feeling guilty if the abuse is linked to change in behaviour due to illness and concerns about what will happen to their loved one if they report the abuse. They will often prefer not to involve the police and there may also be limited criminal justice interventions available anyway, for example when the abuser has dementia.

Specific risks include the opportunity for physical and sexual abuse when the carer is carrying out personal care, coercive control if the abuser refuses to allow other carers into the home or for their carer to have any support, and financial abuse which could include refusing access to money the carer needs. It should never be assumed that someone is unable to be abusive because of ill health or disability – abuse takes many forms.

Most carers will not meet the definition of an Adult at Risk so will not be eligible for support under Safeguarding Adults sections of the Care Act 2014. However, the Care Act does enable local authorities to carry out discretionary safeguarding enquiries where there are significant risks around an adult.

All carers are entitled to a carers assessment under the Care Act 2014 but data from Carers UK shows only around 25% of carers have a carers assessment. This could be because many carers don't identify as such and instead see themselves as wife, mother, husband etc and view the care they provide as simply part of that role. Additionally, accessing Carers Allowance has a number of restrictions around eligibility which may result in carers feeling they are not really a carer unless they qualify for Carers Allowance.

Currently, there are no national datasets around carers experiencing domestic abuse and little research into the topic. What is known is that, in a lot of cases, the carer does not want to give up their caring role. This can be for a number of reasons but these often include

concerns about the cost of alternative care and anxieties around a lack of social care support which is regularly reported in the media as the 'crisis in social care.'

Professional awareness is key to supporting carers who are subjected to domestic abuse. Professionals should understand the complexities of a caring relationship and make appropriate enquiries into the nature and history of the abuse. A multi-agency approach is recommended, including Health professionals to review any medication, social care to review options for providing care and the opportunity for carer breaks and all agencies should ensure they speak separately to the carer and cared for person.

Where Child/Adolescent to Parent Abuse and Violence (CAPVA) is occurring and the abuser is under 18, it is important to involve specialist services and be aware that police involvement may be unavoidable if the child is using violence outside of the home as well.

A multi-agency Unpaid Carers and Domestic Abuse Project is in place in Cambridgeshire and Peterborough to address some of the issues detailed above. Outcomes achieved so far include a successful request to add support to carers as victims of domestic abuse to the revised countywide Carer's Strategy and the addition of specific actions around domestic abuse awareness being added to the contracts for Home Care. It is also planned to include domestic abuse support to carers in the re-tender for Carer Support Services for Cambridgeshire and Peterborough to start from July 2024.

The project is running an anonymous survey to try to gather data on local prevalence and is also consulting with carer user groups to determine the type of support that carers would find useful to feed into development of public facing resources/services. Professional awareness is also being increased via three, one hour awareness sessions delivered to a range of professionals in July 2023 as part of the Domestic Abuse and Sexual Violence Champions Network and development of professional guidance for working with domestic abuse where there is a caring relationship.

2.4.12 Clare's Law

The Domestic Violence Disclosure Scheme (DVDS), also known as Clare's law, enables the Police to disclose information to a victim or potential victim of domestic abuse about their partner's or ex-partner's previous abusive or violent offending. This was implemented across all police forces in England and Wales in March 2014.

It is to provide a victim or potential victim with enough information to make an informed decision on their relationship and highlight any potential risk they may be facing if they continue in that relationship. The scheme has two elements: "Right to Ask" and "Right to Know." This allows an individual or relevant third party to ask the police to check if their partner of ex-partner has a violent or abusive past. The police will consider whether to disclose any information due to its relevancy. It also allows the police to make disclosure on their own initiative if they feel a person's violent or abusive behaviour may impact on the safety of their current partner.

Section 3 - Analysis

3.1 Family and friends' perspective

3.1.1 Family and friends of Sarah have been very open and honest throughout this review and with the permission of Leon, have enabled this review to reflect the Voice of the Child, a vital part of information that learning can be taken from.

Both Hayley and Leon have been upset and frustrated at the lack of support their family have received since Sarah's death including help for the children and updates from the police as they took Sarah's phone. This was accentuated when Leon attended the second panel meeting and saw the number of representatives taking part and said that it just struck him of 'where were they all before when we needed the help and Sarah was still alive.'

Leon would like to make it clear that during the incident in 2021 when the police attended, Sarah did not strike him. She was unhappy about going to hospital in the police car as an ambulance was hours away. She was frustrated and had consumed alcohol and as he walked back into the house, she raised her arm towards him but made no contact.

Both Hayley and Leon are upset at the use of language by the IOPC in their rationale of decision making seen at 1.6.2 of this report. They disagree that there wasn't enough evidence that Sarah was suicidal due to the comments that she made to the police on the morning of her death and find the tone dismissive.

Leon also disagrees with notes made during a strategy meeting in April 2022 when bruises to Sarah are recorded as being from a boyfriend (unknown name). Leon states that these were caused by himself whilst restraining her from self-harming. He does however accept that this may be recorded as such as that was the explanation Sarah gave to them.

3.1.2 Leon

'Sarah was the love of my life. Leon spoke to the author at length when they met at his workplace and was in tears at numerous times throughout. Tears through grief, tears through frustration and tears of concern for his children. Leon feels that Sarah was failed throughout her life and never got the hep she deserved and what may have helped her recover from the trauma she experienced. Sarah was the definition of proud and throughout her life she did her best to convince the outside world that she had no demons. However, behind closed doors her family would sometimes see a different picture.

Leon feels that the authorities have failed himself, Sarah and his children time and again when they have been crying out for help and have not received it. Leon's opinion of Children's Social Care has changed. He believes that he has never met anyone from Children's services that was not keen, but that they are overworked with a high turnover of staff and it is the system that is broken. Following Sarah's death Leon has realised that CCS did not have any understanding of the case. That the high turnover over staff (Social Workers) was due to many agency workers and that vital information was not recorded, emails and phone calls were ignored and concerns that were raised from himself and other

family members were looked at by CCS that we had ulterior motives and concerns for Sarah or the other children were ignored.

He feels great frustration in the fact he feels he has had to fight to get his children the help they need and has had to find this for himself even though he had asked for help.

He remembers Sarah as always emotional and loving. She wouldn't disclose anything that troubled her or about her past until she had been drinking and would then not want to discuss it further once she was sober.

Leon finally left the family unit and moved out in June 2021 as he felt it was doing more harm than good for him and Sarah to be together. He started attending a support group and recognised some behaviours that were reminiscent of his relationship with Sarah. He was aware that she had affairs and states that he never cheated or laid a finger on her in anger, yet these were things that Sarah did and immediately accused him of which he feels was her gaslighting him.

Even after he had left, they still maintained a co-parenting relationship and Sarah or the children would always contact him to come and sort things out if either Daniel was being violent or if Sarah was self-harming. He appreciated that at times, he would appear aggressive when the Police attended but this was out of pure frustration that he wanted them, mental health or Social services to help them as a family. He would inform them of the issues but they would speak to Sarah who was capable of being totally coherent to authorities, even if she had just been erratic prior to their arrival and they would say she was capable of making her own decisions and had 'capacity'. This was a word that caused total frustration to Leon as he felt he was not listened to as he tried to portray what both he and his children had witnessed on occasions. His arrest for assault when it was clear that he was trying to stop Sarah from self-harming as also outlined by Anton on one occasion yet the Police acted on the allegations of Sarah rather than standing back and looking at the whole picture provided the narrative that he was abusing her when he was trying to look after her on behalf of the children and because although they had separated, he still loved her.

During the time Sarah and Michael started a relationship Leon had no contact with Sarah. After the incident in the October when the children went to stay with Leon, mutual friends of Leon and Sarah's expressed their concerns with the relationship. Domestic Abuse was witnessed on several occasions by neighbours and the children. Then after the children had left, Sarah had not been seen or heard apart from when arguments or abuse had spilled out onto the street.

Michael took advantage of Sarah at possibly the most vulnerable time in her life. He got her hooked-on drugs, he physically assaulted her in front of the children and emotionally abused her. He doesn't think they will ever know the whole truth of what happened in the lead up to Sarah's death.

3.1.3 Hayley

Hayley has given her thoughts and opinions to this DHR to provide a siblings view of what she has seen, witnessed and heard throughout her sister's life and to provide an insight into what Sarah was feeling from an early stage in her life.

Hayley accepts that Sarah, herself and Leon must have some accountability but feels that throughout her life, Sarah was crying out for help and was never provided with what she was needed or listened to properly and that she was failed by numerous agencies over a long period of time. The processes were not suitable for Sarah's needs, nobody helped her with how to manage Daniel or realised the pressure that this put on her. Children's services did not follow processes on numerous occasions, particularly when the children were on a Child Protection Plan and the Mental Health service did not listen or take action to safeguard Sarah, even when Hayley herself was telling them the real risk that Sarah may take her own life.

Hayley has helped this review understand some of the difficulties that Sarah had to cope with in her life and how this may have influenced her thought process and behaviour as mechanisms to cope.

Reflecting on the relationship Sarah had when she was 17 years old and beaten up by her boyfriend, Hayley said that what they had seen and been through in their younger years made Sarah grow up to be needy and desperate to feel wanted rather than being strong. The beating by her then boyfriend was accepted behaviour. Her body didn't mean anything with Sarah being promiscuous as she thought that sex would mean she was loved. Hayley remembers frequently giving each other advice of not having to put up with it but neither taking that advice. The sisters understood each other.

Hayley spent some good times with Sarah as they used to attend Botox together but this stopped once Sarah had met Michael. Hayley found out from the lady providing the treatment that Sarah had been attending with Michael and he would not allow her to go into the treatment room on her own but on the last appointment, the lady noticed Sarah had a black eye and asked Michael to wait outside the room which he was not happy about, but he did stay out on that occasion. The closeness they had always felt became fractured almost immediately after Michael 'came on the scene' and Hayley felt that he controlled when Sarah was allowed to contact and visit due to Sarah's demeanour when she did so. This contact always found Sarah upset in the last few months, leaving either tearful messages on voicemail or those in anger which caused Hayley additional concern for her mental state and the effect Michael was having on her.

Within the last few months, Hayley met with a social worker face to face and spoke with her for an hour outlining her concerns for Sarah and the fear she would eventually lose her life and not one word was written down. Lucas was available to be spoken to but wasn't.

Hayley is frustrated that the police attended on the morning of Sarah's death and did not do anything to help her. She accepts that the day would have probably come but feels that it being that day may have been prevented. Hayley feels that Michael's abuse of Sarah was

'the final nail in the coffin.' Sarah always had the gun but Michael provided the bullets through his gaslighting as the emotional abuse was more harm to Sarah than the physical abuse.

Hayley attended the second panel meeting, spoke openly and ended by saying 'please just do better.' The panel commented on how impactive those heartfelt words were.

3.1.4 Debbie

Debbie has been a good friend of Sarah's for 12 years since she moved to Cambridge. Her child is best friends with Anton as they started school together and they lived close by. Debbie is a qualified IDVA. The words used below are Debbie's words of description. Debbie describes Sarah as funny, clever and a person with true humility. She was so proud of her children and had admiration for them. Daniel with his art, Anton who she would say was super intelligent, Sophie who she would say was her twin and soulmate and so grown up with her beauty and kindness and then Lucas who she always said she loved so much and was too clever for his own good and was growing up into a lovely child.

Sarah would turn to Debbie for emotional advice and vice versa and Debbie states that what happened does not define Sarah. Sarah struggled with her mental health and alcohol whilst she was splitting up and reconciling with Leon time and again. She would disclose that her main causes of stress and finding it hard to cope were from the things that happened to her when she was young, then losing her mum and then the Daniel and his epilepsy. His aggression was difficult to manage and the support was hit and miss.

Sarah always wanted to be loved and said that she couldn't be on her own. Splitting up with Leon hit her hard. She felt controlled by him but not on an abusive level. Leon would not know how to cope and the mood in the house was better after they had split up. They both tried their best. Sarah knew she had to prioritise the younger children's safety over Daniel which caused her anguish. However, through all of Sarah's struggles, Debbie believes that Michael was more than a minimal contribution to her taking her own life.

3.1.5 Shortly after Sarah started 'seeing' Michael, Sarah started to isolate herself and would not answer phone calls when they normally talked every day and would put Debbie off going round for a visit which was out of character. She said that if she met him, she wouldn't like him.
After Michael's violent attack on Sarah in October 2022, Sarah and Debbie met. Debbie has prepared the following for what happened the following day.

25/10/22 - Account of information Sarah shared and my observations:

Late Evening - Sarah and myself were chatting on Facebook messenger and she facetimed me. I could see she had a black eye and bump on her forehead. She started laughing. I asked her directly if Michael had done that to her and she said yes and started to cry. I offered to go round but she insisted she would come to mine, and that Leon had the kids. Sarah came round pretty much straight away, and I was so concerned that I made notes on my phone as soon as she left so that it would be fresh in my memory.

Injuries that were clearly visible included black eye (R underneath going towards cheek), large tom and jerry type bump on forehead (R side with two scabs that looked like friction burns), bruises on both forearms including round ones, right leg and pelvis. Clump of hair pulled out at the scalp. Fingerprints and scratches on neck. Self-inflicted wound (deep cut) to right forearm which I bathed and dressed.

What Sarah said:

She had been to hospital; Lucas had been taken by police (I assumed PPO) as no one could get hold of Leon and Sophie was at a friend's house. Michael had "picked Lucas up and threw him out of the door, called him a little c*nt and shouted at him." That was why he was now with Leon.

Sarah said, "He hit me on many occasions."

"Paraded me up the road "(to show the injuries) – Michael "so everyone can see what a whore you are." "Like he was proud of what he'd done"

Called her the following "chav," "slut," "look like a crack head ", "scum"

Asked about the neck marks –

"Strangled me until I passed out. I pissed myself, no knickers on, hurt down there think he had jiggy jiggy. "She remembered asking at the hospital where were her knickers / what had happened to them? Her jeans were wet from wee. She said she "felt ashamed"

"He humiliated me about the self-harm ". On the night the police were called he "shouted at me, I went upstairs to the bathroom cut myself it was deep and lots of blood "He was swearing at me "don't bother cutting yourself again this time do us all a fucking favour hang yourself do it properly." "kill yourself no one will miss you no one gives a fuck about you" – kept saying this

Asked if he'd said anything like this before? "Yes, but not this bad"

3.1.6 How many times? "Loads of times." "It's like he wants me to do it. He made me go back when I got out of hospital and clean the blood up at his mums. he pushed my face down into it"

I looked her in the eyes and said if she went back with him, he would kill her. I repeated this. She looked shocked "do you really think so "? I told her "yes," I did, "he will kill you." I said it was non-fatal strangulation and she was lucky he didn't cause her serious injury like stroke or death this time.

"Sometimes I think I'll let him kill me, saves me from doing it, but I couldn't leave my kids after my mum, I don't want to die, I just want to stop feeling so shit "

She had spoken to police but had lied. She hadn't told them everything and a nice female officer had said to her "we've been here before haven't we Sarah?" I asked her to speak with my colleague and explained that because of what happened our team will get contacted by the police. She said she would.

Sarah told me he got her into coke – "He does it so I feel I have to do it just to get on the same level." "I should've realised what he was like when he first gave it to me." "He uses it for jiggy jiggy, you know sex acts. I don't really like it makes me feel like I'm dirty "

Asked about the strangling – it wasn't the first time, indicated she had consented once previously "this time I kept saying no I don't want you to". I told her that it is rape.

Subsequently Sarah asked me if she had "any chance of getting the kids back" – I told her things had to change but this wasn't the end and to take all the support offered. Michael had told her that "Leon has won," she wouldn't get them back, so I reminded her that I actually knew more about that than he did.

Debbie went and visited Sarah a couple of days later and noticed how much the house and garden had deteriorated and the physical and emotional deterioration in Sarah was apparent. Debbie had never seen her this bad. Sarah felt that the Child Protection Plan was all about what she had to do and didn't feel respected or listened to. She believed what Michael was saying over Debbie and he had told her she would never get the children back and it was as though she had given up.

Debbie believes that an option for repeat victims would be for an IDVA to attend with the Police so that they could have immediate engagement and build a rapport from the outset.

3.2 Voice of the Child

Sophie

3.2.1 Sophie has been receiving help and support from the Acorn project at school. Leon initially tried to get assistance from Centre 33 but due to her age at the time, she was too young. Leon learnt from Sophie after some time of being on the project that she was still not opening up about her personal life and what she had witnessed but only spoke about her schooling. She is now opening up to her family a bit more as time goes on and remains on the Acorn project which was arranged by Leon after asking numerous times for assistance through Children's social services.

Sophie has provided her thoughts by writing them down over time, having talked them through with her Auntie Hayley and her AAFDA advocate. This has then been forwarded to the Author. It was agreed that this would be the most appropriate way rather than the Author speak directly with her, although the Author did meet and have a short general conversation with her to provide her with some confidence of who was receiving her thoughts.

The words have not been altered by the author apart from pseudonyms so that the sentiment is not diluted in any way and the true **'voice of the child'** can be heard.

When my mum was little, she went through what I went through. Like what I have but a lot worse, her mum was an alcoholic and died when I was 8. She went through a lot, her babysitters were bad to her, she was traumatised when she was very little. She told me she

had no help, she dealt with all of her demons and problems on her own. I think she started self-harming and drinking after my nan passed.

When I was younger something had happened to mum, she had hurt herself, and the police and ambulance came. The ambulance took her off, but the police were still there. It had happened before, the police never seemed to want to help my mum and the ambulance would just come and sometimes take mum to hospital but then she'd be let go when she said she was "fine". They never listened to my dad about how bad my mum was.
They, the police, spoke to me and Lucas in my bedroom and asked me if there 'was anything they could do to help me?,' I asked them for help and someone to talk to, and they said yes that will be no problem, but they never did anything. I was 10 or 11 then and nothing happened they didn't help me. It took a lot of courage for me to speak up as I had started to realise how bad things were getting. This has affected me even now as I don't want to speak to anyone. A lot of people are focused on getting me someone to talk to but it's too late, it happened. I dealt with it on my own, no one got me the support when I needed the help.

I think that not all kids will ask for help as they are scared and even if parents say the kid is fine, kids should have someone to talk to. The police should offer a chance for kids to talk to someone without kids having to ask. I understand that it is tricky when the police and ambulance come into a house, and you have a male and female telling you different stories, but they always steer towards the female if she's distraught. The kids are not going to speak the truth at that time as they do not want to take sides, but I feel the police should investigate more before they make any decisions and just leave.

3.2.2 Experience:
I think Michael should be arrested as he hit my mum - he hit my mum in front of Lucas and that alone is child endangerment. I think that a 7-year-old boy at the time shouldn't have seen that and for my brother to then see Michael back after all the things he saw him do is almost like it's normal for a man to beat a woman. My brother has been traumatised by Michael and has panic attacks when he sees people in hi vis work clothes and he also has nightmares.

I had to defend my mum to Michael, I was 13 years old and no one would listen. I had to tell him to get out of our house and he kept saying 'Sophie, let me in, your mums crazy.' He tried to make out that my mum had lost it. He's a bad man, he's just a bad man. He shouted at mum a lot. I don't want him to be near me or my family again. I don't want to see him ever again. He does drugs and he did it in my house.

Michael would go through my mum's phone all the time but never let mum go through his phone. If mum ever said no, Michael would start an argument with mum and call her names or say she is hiding something. He wasn't helpful, he played with her mind a lot knew she was vulnerable depressed and suicidal. Michael would say 'no one is here for you, your family are here for you only me,' so mum would rely on him.
Michael would tell my mum he didn't like mums' friend, so this stopped mum seeing them. Michael made mum believe my auntie didn't like her, this impacted on mums' relationship with everyone and attending my little cousins party, which she wouldn't have missed before! They were very close, she used to do everything with her but then just stopped. I have pictures

of my mum and cousin together, so when she grows up, I can tell her all about my mum and all the memories of them together!

Michael used to do things to make mum believe she was going crazy like hide the house keys in shoes so that we couldn't go out, but mum knew she hadn't put them there, but he made mum believe she had. One time mums phone went missing and me, my mum and Lucas looked everywhere for it but it definitely was not in the house. Then when we came home the next day it was in mum's bedroom on the side, like it had always been there, but it hadn't!

One time mum and Michael were arguing, and mum asked him to leave but he refused to so mum throw his wallet outside in the bush. Michael got really mad and made mum go and look for it but she couldn't find it. I was sat on the stairs while they were outside with the door open, and I could hear Michael shouting at mum and mum was crying. Then she came running in the house screaming that Michael had just grabbed her neck to push her.

3.2.3 Michael used to not like mum drinking red wine as she would defend herself against him and he would tell her he was going to leave. If he ever disrespected her and she had drunk red wine, she was able to stick up for herself and had more confidence to kick him out. She would turn on a lot of people when she had red wine, including me and my aunty, but he mostly didn't like it when she turned on him and stood up to him, so he made mum stop drinking red wine as she wouldn't defend herself when he was horrible to her and made her drink white wine because then she wouldn't stick up for herself. White wine wouldn't make her drunk. If she didn't drink, she said her head would be too loud and drinking stops this but then if she did, she would get too drunk and self-harm. I don't think he wanted to help her, if he wanted to, he would have helped her stop drinking in general and not give her some other wine.

Mum said if we were taken away, she would have fought everything in her power to have us back, to have me back. I know full well that she would. But Michael, he would say 'no one else likes you' and I think he would have said to her I didn't want to be there and told her things like 'why do you think they were taken away from you in the first place'. Because she was very protective of me, I think she sided with Michael because I feel Michael would question her if she didn't. Mum used to text me saying 'you are in a better place at dads,' and when I went to see her near Christmas, she said 'no one else is ever here for me, everyone else has left me.' When I asked her about my aunt, she said she was angry at her. A lot of the things she said you could tell came from him.

3.2.4 Experiences with Agencies:
Mum told me once said she was going to go into a detox (I thought she meant Botox!), but that she had to be tested to see if she needed one, to see if her liver was bad. I was happy with this as I thought she was going to finally get better and stop drinking. I kept asking her everyday had the tests come back and when they did, they said her liver was fine – but I had seen her drinking 2 or 3 bottles a night. I was gutted as I really thought she was going to get help to stop drinking and everything was going to be alright, more normal, and mum wouldn't be drinking every night. They didn't offer anything else; I was frustrated as my mum needed the help. I don't know who it was through, but she did it and asked for help and mum never liked asking for help!

- To the Social services, police and ambulance: I didn't want to get taken away from my mum obviously but there were so many signs that my mum needed help. Like my mum got taken to the hospital like 15-16 times and I don't think anyone did anything about it.

- To the Hospital: If someone is getting brought to the hospital for the same reasons time and time again someone should have done something. I wouldn't want my mum to get taken away and locked in the hospital but if it would have made her better than she maybe would have been happy now and not where she is. There were so many signs and no one listened or took it seriously like they should have.
- To Everyone involved: I just want them to know there were a lot of things they could do better. I know I keep repeating it but they could have done more to help my mum. I don't want them to feel bad because obviously there was other problems in the house. But if someone is going to hospital that many times they should investigate more and see there is problems and help. No child should have to see scars on their mum like it's normal or their house covered in blood and no one help us!

- To Social services:
We had social services involved and every time something would happen and my mum would go to hospital they would come a few days after ask us a few questions involving "how are you" "how's school" and "what do you think about mums drinking" which are all questions obviously I'm not gonna be able to answer and you're asking me after my mums just nearly ended her life 'how am I' and I have to answer "oh yeah I'm fine" I'm a little girl who's scared confused and just wants her mum to get better and they didn't help me or my mum at all, they also looked for the wrong things with my mum one day Lucas had a bruise on his knee and one social worker asked "have you been a naughty boy and mummy have to discipline you" inferring that my mum abuses Lucas when she's never laid a hand on us. They knew why they were there because my mum was poorly and needed help, and so did we, and they didn't help my mum, and if you're not helping my mum, you're not helping me. They ignored all the signs they needed to listen to and when it came to something that wasn't even do to with the case such as a bruise on Lucas's knee when they should have been focusing on why my mum is going into hospital so much what's causing this and how can we help this family.

We had lots of different social workers. It always felt like they couldn't be bothered, I sometimes didn't speak to the social worker's whenever they came because they were useless and asked pointless questions like, 'am I ok?', of course I am going to say 'yes', what else could I say? and I knew they would just go away and do nothing as usual anyway. They never really knew what was happening. They were meant to know why they were there, but they never did anything. It felt like they didn't know anything about us. At the end of each visit with the social worker they would say 'don't worry we are going to help your mum' but I never saw that. I wanted to see physical change, if I don't see anything done then I'm not going to believe it.

When I did speak with one social worker, I can't remember their name I told them things that were not really bad things, and they went and told mum straight away and then mum got mad at me and told me not to say things but what I had said was not bad, so the social worker didn't need to tell my mum. (*The social never advised Sophie that it would need to be discussed if the social worker thought it was important/relevant).* I think social workers, before they say

anything, they should explain what confidential things can be, no one said to me that it was going to be spread, I didn't know that I could tell them why I wanted to keep it between us.

A few times they said they would come (*to visit*) and never did, they said they would come and see me in school, which I have wanted them to do, they never did and they never explained why not. They sometimes came at bad times; we would be busy and I remember mum asking for them to change the time but they didn't say why not.
I hated having to come home to speak with them. Like if I had had a bad day, if I knew they were coming after school and I remembered they were coming, I dreaded it and it felt like a chore, as nothing would change. It was something I didn't want to do but I had to. It got to the point where I ended up 'just putting up with them' but I was always polite but felt bored with the visits and gave blank sort responses so they would leave. I feel mum felt the same she said 'I don't enjoy it either' but we had to. I never knew what they said to mum, but sometimes we would have to find the light of the visits and make jokes, I remember telling her about a visit with one social worker and how he took everything out of context and that they ended up just being necessary. They never explained why they changed so much; some would say 'this was my last time seeing you' while others just left. Then you would start again.

Now I don't like social services, due to everything, since I was little, since they betrayed my trust. I've thought that 'they were bad people' in my head and always felt that way. Always felt they weren't helping my mum and focusing on taking me away. What annoyed me the most was having the same visit over and over again. They would take me up to my room and say, 'how are you feeling, what do you think about mums drinking and how was school.'

Recently, I got on more with F most because she came off more as friendly than as just a social worker. Instead of asking those questions she asked more personal questions about me and Lucas before asking about mum.

3.2.5 Views:
Mum was always protective of me when it came to men and stuff like that and she always told me that no matter what she would always believe me, if I ever was in a situation where someone (a man/boy) had hurt me or you know?
I don't want a man to do what he did to my mum and it to happen to another woman like it did my mum because of him. I know physically Michael didn't kill my mum but mentally he killed my mum. She's dead because of him.

Michael got very aggressive to mum and they all failed my mum. They failed her. I do believe my mum would be alive if people like the police and ambulance took the signs seriously and did something about it. Thats why people should be given support at a young age before it gets too bad that they start refusing help because of the trauma they went through as a kid.

I struggle to go out now, I used to be outgoing and always out and outgoing, but now I'm struggling with depression and anxiety. It just gets mentally exhausting. When my mum passed it was kinda like wanting to stay away from everyone and lock yourself away from reality. Then when you hear that your asked to speak to this person or that person, I want to do something for mum to help but sometimes, It doesn't feel real to hear back what I've

shared, hearing it back its hard to hear as it feels it happened to someone else and you feel bad for that person, then it hits me that this is me and what I've been though.

3.2.6 Lucas
Lucas has opened up and talked a little to the AAFDA children's specialist advocate. He wanted to be able to be included in this report. The words have not been altered by the author apart from pseudonyms so that the sentiment is not diluted in any way and the true **'voice of the child'** can be heard.

Experience:
I saw it, Sophie didn't. I think it was school holidays as I had to spend a long time away from school. I saw Michael punch mummy in the face, we were at his house, and I was upstairs in Michael's room. I heard swearing from Michael, mummy was just shouting, like screams. Then Michael called my name, I went downstairs to see what was happening, Mummy was outside then, kicking his door to get in. Then I remember we went to mummy's friend's house as she put a plaster on mummy before we were going back home to mummy's house, then we went to mummy other friends house where the police came. I spoke to the police there and they asked me what happened. We went back to mummy house to get a coat, then they (police officer) took me to the police office, I got to sit upfront and press the siren! I slept there for the whole night before dad picked me up.

I would hear Michael swears at mummy a lot. Heard arguments about Mummy getting some money from Michael, he would shout at her a lot and swear at her saying 'give me my f-ing money.' I was scared to talk about this before as I didn't want mummy to get in trouble for having the money and because I didn't understand what they were taking about.

There was other stuff, but I don't remember it all. Sophie does, I know she saw lots too.

3.2.7 Experience with Agencies:
To Social Services - The social workers would come to see us at mummy's house. When we were younger, I think we had a little time with them but when we were older, we had a few weeks with them. The one I remember before was call G and my recent one F. F was amazing. She would take us out to McDonalds and KFC, she took us places instead of just meeting us at the house, she actually played with Rosie (our dog), she would ask me questions about me, but I was ok to answer them.

The other ones just asked 'what do you think about that' it was always at home in the living room, it always took a long time and they never had anything to play with or do, it was very boring. I still don't know why they had to visit and I had to talk to them. They always said they were going to come to see me at school, but they never did, I told the chairperson when I met her once *(from the CP conference*) but they still didn't come.

It was normally dad who told me we had a new social worker; F was the only one who told me she was leaving. I was the last person to know what was happening which annoys me at times.

To School –
I have teachers at school and the room (*pastoral team*) to go to, they don't make me talk which I really like. I can do what I want and talk if I want and they have things to keep me busy! I talk better when I am busier. I feel safe there and have told them things before which made me sad or worried and they made sure I was ok. Mummy used to come into school too and talk to someone too.
I feel they were middle with helpful. I've had Bluesmile since year two. I didn't get told right away, mummy just said that 'there was a really nice lady coming to see you today'. R was really nice; I was happy to go and I still go now. I say she is my favourite teacher but I know now she is a therapist. I don't use her as a therapist but as a playtime friend, she has loads of cool stuff.

To Police –
The police boss was very nice, they brought my Nintendo switch with me when I had to go with them for me to play with. I waited there for hours and hours until dad came. I was ok though, I felt comfortable.

I asked what happened after once, no one told me what was happening, because I was little, so I didn't know after what happened. I wanted to know, for the police to come again and talk to me …… I don't know if I know what to ask them but I didn't see them again.

3.2.8 Views:
I remember how things were with my family, being happy and playing games with mummy. She was the best at winning games after me! We play games now about what mummy did and did not like and I joke to Sophie about me being her favourite. I have mums' funeral heart in my bedroom so its close. I have people I talk to but don't always remember, but I like knowing why they want to talk now, I can tell my dad things.

3.3 Terms of reference areas

3.3.1 - Has domestic abuse in any form been the causation or a contributory factor to Sarah taking her own life?

Sarah suffered emotional abuse in her childhood from various male partners that her mother had relationships with. At 17 years old, she had a relationship with a male who physically abused her, causing frequent bruises and marks and threw her into the street naked on one occasion. Her sister states that this was accepted behaviour by Sarah although deep down, she knew she shouldn't 'put up with it'. Sarah was always susceptible to alcohol abuse and self-harming from a young age due to these experiences and had shown a protecting side towards her siblings.

This was then reflected in her motherhood. Friends and family comment on how she thrived during her first pregnancy and early childhood of Daniel, not drinking alcohol and the care she took over his medical care for Cerebral Palsy. Her sister Hayley remembers how she looked on her as having the perfect life and marriage at the time.

Daniel's behaviour due to his medical condition became a stress and as his seizures became more frequent, his behaviour became more violent. His abusive behaviour was never medically linked to his illness and although there was a slight pattern between them, his father and Sarah at times admitted that his behaviour was not solely down to his medication and seizures. Children's Services became involved with the family in 2017 and the following year, the police were called to the family home due to Daniel either damaging something or being violent on numerous occasions. Sarah would call them or Leon to help her as she admitted to professionals that she was afraid of him. Sarah would not make a complaint against Daniel as she wanted to protect him and did not want him criminalised. It is not known whether or not she recognised his behaviour as domestic abuse but it had an adverse effect on her, causing emotional and psychological harm as records show that as the Police attendances increased and had been on-going for some while, there was a direct correlation with her mental health records and self-harming beginning.

Sarah would openly admit to professionals from all agencies that she could not cope and needed help with Daniels behaviour and would cite this as her main cause of stress when she self-harmed and was spoken to in hospital. Sarah would also disclose controlling behaviour from Leon and the affect her relationship with him had on her, both while she was with him and after they had separated. Some of this behaviour may have stemmed from Leon's mistrust when he discovered Sarah's affairs and some of the disclosures can be equated to times when he has been contacted to help her after self-harming. However, the most important and frequently overlooked issue was that Sarah felt that his behaviour was controlling and restrictive.

When Sarah began a relationship with Michael, she behaved and reacted differently to how she had previously. She became isolated from her family and friends, started taking drugs and there was a noticeable deterioration in both her physical and emotional state and also that of the house which was unkempt in total contrast to her pride in her home when she was with Leon. She would later confide in a friend that all of these things were the influence and control of Michael. Hayley witnessed the control in the relationship's early stages whilst out with Sarah in the constant phone calls and questioning which at the time in a new relationship and considering Sarah's need for love as outlined by her sister, Sarah may have not realised the gravity of his behaviour at that time.

Sarah endured being humiliated with sexual abuse from Michael which included making her take drugs which she did not disclose to a friend until after he violently attacked her causing head injuries. On that night, she was strangled to the point of unconsciousness twice and disclosed to her friend that this had also happened previously. He also caused extreme emotional abuse with crude name calling in public and ridiculing Sarah's self-harm, gas lighting her to make her feel worthless. Sarah disclosed to her friend that he encouraged her to hang herself which is a method of self-harm and attempts to take her life that she had not carried out or even spoken about with anyone previously. Sophie provides an insight into Michael's behaviour that, although through the voice of a child, reflects her maturity and insight into the understanding of the mind games that Michael 'played' on Sarah which would have affected her mental health even further.

Sarah's sister's words are telling when she said, 'Sarah always had the gun but Michael provided the bullets through his gaslighting as the emotional abuse was more harm to Sarah than the physical abuse.' Her friend Debbie said similar and that Michael was more than a minimal contribution to her taking her own life.

3.3.2 The effectiveness and response of agencies in a collaborative approach to supporting those with multi-complex needs that include DA.

There were a number of agencies, both statutory and non-statutory/voluntary that were involved with the members of Sarah's family over a number of years in response to differing needs. All agencies in response to children and adults are now working towards achieving collaborative working to address safeguarding needs but do they actually work together or do they work in isolation and share some information and refer on to another agency whilst closing their own file, only to re-open it months later, when the same issues re-occur?

Sarah had issues with her alcohol intake and self-harming from an early age but managed this during the pregnancy and early childhood of Daniel. These only manifested themselves as there became problems within her marriage and Daniels behaviour became progressively worse and difficult to manage. On each occasion that Sarah called the Police, she stressed to them that she could not cope and the reasons why yet no referrals were made in relation to substance abuse support at any time. Although consent is required, it does not appear that the question was asked in relation to mental health or alcohol referrals.

Daniel is the named suspect/offender in respect of 48 criminal allegations made against him by either Sarah or Leon and although a DASH was completed on the majority of incidents, none were graded high and a MARAC referral was only made after a supervisor reviewed the fact that there were 21 incidents over a short space of time and the incident that triggered the referral was one of self-harm. No referrals were made from any of these 21 incidents for domestic abuse support and there is no record of signposting. This impacted on the MARAC meeting where they did not consider the child to parent abuse. Also, awaiting 21 incidents is not compliant with the Safelives guidance of referrals as outlined at 2.4.3 of this report.

Out of these 48 criminal allegations, Daniel was only arrested on four occasions as Sarah would always state that she did not want him criminalised and blamed his behaviour on his illness and medication. The Police did not investigate whether this was the case and did not take positive action against Daniel as per their policy. On the one occasion they did take the case to the CPS and it was returned for further evidence to be gathered, which was not completed, losing the opportunity to hold Daniel accountable for his actions. Good practice in relation to policies and processes is outlined within the Police IMR however, it does not appear that these were followed on numerous occasions including those outlined above.

There is record of 'advice' being provided to Sarah but not practical support to help with Daniel's behaviour despite her constantly asking for this and she was then seen as an alcoholic with mental health problems rather than addressing the issues that were compounding these.

The MARAC meeting, which was the first multi-agency meeting in relation to the family and the records are not reflective of any considerations that took place. The risk assessment was brief and did not include Daniel as a risk although it had been heard that the majority of incidents were due to his violent behaviour. (Recommendation refers)

CPFT have a Think Family team which incorporates a DA Lead. Their representation at MARAC ceased at the beginning of 2022 due to resourcing issues. They do support MARAC through representation at the MARAC Steering Group but do not have enough capacity to research cases and attend MARAC meetings which can leave gaps and potentially pertinent information omitted when risk assessing. Although they requested to be removed from the MARAC distribution list as they stated they did not have the capacity to read it, MARAC have maintained CPFT on the list to ensure they have been made aware of the cases and can manage their own risk surrounding this.

On the occasions that Sarah self-harmed and spoke with the Mental Health team, she again informed them of what the causation of her stress was and although she was referred to CGL in relation to the alcohol abuse, she was deemed to have capacity and would be articulate with blaming it on the alcohol. The family and in particular, Leon were the main witnesses to Sarah's behaviour at the height of an episode but felt frustration with all professionals that they were not listened to and a holistic approach was not made rather than believing Sarah once the episode was over and she convinced them everything was alright. There was no consideration or referrals for support of the domestic abuse she disclosed to CPFT in relation to Daniel. (Recommendation refers)

CPFT, ASC and CSC were all intrinsically involved with Sarah and knew of the demands she faced looking after Daniel but only ASC recognised and identified her as a carer but still did not provide practical support and provided advice of caring together. This is an example of when they could have completed the referral process for her to alleviate this stress. This would have provided additional support in its own right including financial support and respite. This was not progressed and not re-addressed.

There is a lot of information on the case file for ASC indicating that Sarah was a carer at higher risk. Carers conversations took place as did signposting to caring together which Sarah agreed to. There is no evidence that completing a DASH was discussed which would have given clearer information around the level of risk. There is no evidence that the behaviour of the son towards his mother and siblings was recognised as familiar abuse which could have resulted in a referral to the IDVA team. This would have needed Sarah's consent but could have given her an opportunity to share her experiences of abuse.

CGL showed good practice in sharing information with others and follow up contact with Sarah when they could not get hold of her or she missed an appointment. Information was also shared across CPFT during combined meetings. Agencies could have utilised the relationship built with Sarah as a means of introduction which may have eased any concerns she may have had.

In terms of the abuse shown to Sarah by Michael, the first recorded incident of this with the police or CSC was when the children were removed under police protection and Leon exercised his PR to care for them. However, Sarah had been experiencing DA in historical relationships, CSC had concerns over the relationship between Leon and Sarah over time, and as it should have been clear that an escalation in Sarah's self-harming or drinking was usually a reaction to a trigger which had occurred previous to this assault. This is something that Leon pointed out to professionals on more than one occasion. The visits, both announced and unannounced should have led workers to discuss whether Sarah was in a relationship, that person police checked as the children were subject to a CP plan, and the voice of the children elicited to see how safe they felt around a new partner, but none of these actions were carried out.

CSC's response to all the information being received from the police was not robust enough to effect change earlier or more effectively. CSC did not appear to fully investigate who was living in the home with the children when it started to become clear that a partner (Michael) was living there, and a police check (which should be routine for adults living in a home with children on a CP plan) may have revealed a better indication of the potential risk Michael posed.

Neither Sarah nor any member of the family were advised of Clare's Law by any Professional from voluntary or statutory sector, even though it would appear he had previously been heard at MARAC.

Following the violent assault on Sarah whereby she returned to him almost immediately after being discharged from hospital, the police had the opportunity to apply for a DVPO when the CPS made the decision not to prosecute without victim support. The officer in the case showed good practice in identifying this option as a means of safeguarding but the rationale provided by the Superintendent who declined the DVPN was inaccurate and misled. The decision not to pursue a DVPN based on the fact that Sarah and Michael lived separately and Michael had received injuries consistent with biting shows a lack of understanding of the criteria for authorisation. A DVPN is an opportunity to safeguard those who sometimes are unable to safeguard themselves and would have provided Sarah with a safe space not to be immediately influenced by him. (Recommendation refers)

3.3.3 The effectiveness of agencies responses to support children who are victims of domestic abuse with multi-complex needs within the family home

Previous research and reports have found that children living in households involving domestic violence are sometimes not considered to be victims due to indirect experiences of violence and abuse. The Domestic Abuse Act (2021) requires for children who see, hear, or experience the effects of domestic abuse (i.e., live in a home where it takes place) to be regarded as a victim of domestic abuse. (Ref. College of Policing Vulnerability, Knowledge and Practice programme). This is referred to in guidance as Voice of the Child.

Since Sarah's death, Leon and Hayley have stated how one of the main frustrations and barriers to obtaining appropriate support and understanding was the constant change of Social worker assigned to the family. This was also voiced by Sarah to the schools of Sophie and Lucas. CSC have explained that this was due to the high turnover of staff and the requisite to have agency workers assisting with the high volume of cases but that is not a consolation to the family. It prevents relationship building, rapport and trust and does not provide consistency and in-depth knowledge of the whole situation.

There are large gaps in the recording, which prevents an informed risk assessment and comparison and raises a question into the adequacy/process of supervision and oversight. (Recommendations refer)

Resolving the situation took longer than CSC would have wished to see – family take-up of support was uneven and there were gaps in the support offered over time due to sick leave, and long periods of overoptimistic triaging of referrals which led to too many incidents taking place at home in front of the children who said they got scared when Daniel 'kicked off.'

Sarah asked for help and support with Daniel on numerous occasions and made it clear to CSC and CPFT that this caused her stress and she then resorted to alcohol abuse and self-harming as a coping mechanism. Daniel was a victim of being of the age where he was about to become an adult in relation to his age and records show that he fell within the gap of Children's services not progressing a long-term plan because of this and Adult Services would not begin a plan as he was not of age. Focus was on Sarah and Daniel's response, not the actual cause.

The fact that when Daniel was referred to Adult Social Care, he did not want to accept support, which is his right not to accept, did impact on overall support for him and his family. In the end the family managed the issue themselves by sourcing accommodation for Daniel away from the main family home, causing additional stress for them and also not having any professionals assist with safeguarding or have oversight of the family. It is recognised that Daniel's views were not established and alternative ways of engaging with him not explored. Respite could have been considered which may have been beneficial to both him and the family. His physical disability is not covered by the young adult's team. (Recommendation refers)

Incidents involving Anton were either involving Daniel in which his family state that he was protective of his parents and his behaviour towards them or was in protection of Sarah in the event of her self-harming or having men around the house. Anton rarely appears on any documentation of CSC or ASC. He is not incorporated on any child in need or child protection plan and appears to be the forgotten member of the family in any risk assessment or referral. No records produced for this review show that he has ever been spoken to. This is prevalent on the occasion that he rang Leon to help him as he could not stop Sarah self-harming, yet the police dealt with it as a domestic abuse incident between Leon and Sarah.

Police officers experienced the household and environment which was, on occasions referenced in the reporting. In examining all of the incidents attended by officers, although a number of safeguarding concerns were raised by officers, there was only one occasion in October 2022, when immediate police protection was considered necessary for Lucas, although the child safeguarding reports made do suggest that there was a deterioration in the home environment as time progressed, but none that triggered any immediate risk of harm for intervention by the police.

Officers did speak to Sophie and Lucas on a few occasions showing good practice but this was sporadic and not always completed and the effectiveness of the times that they did could be questioned due to Sophie's comments of how she felt when spoken to. Child referrals after incidents were inconsistent and there were times when the children had been at home during both domestic violence and when Sarah had self-harmed and no referrals were made.

It has been discussed earlier as to whether agencies and professionals recognised Sarah as a victim of domestic abuse. If this is found to be not the case, then the children were also not recognised as victims.

Sarah and Leon were frequently frustrated in asking for help for their children and not feeling they received it with the schools being the only professionals that obtained support and counselling and that they felt listened to. This was proven in Sarah asking them to be their voice to other agencies including Children's Services. The schools have shown great support and understanding whilst ensuring the school lives of Lucas and Sophie remain a safe and thriving place for them.

CPFT notes in November 2021 show a s47 single agency for the school nurse to consider a health assessment for Sophie and Lucas. Ten months on there was no evidence of a health assessment within Lucas or Sophies notes. There is inconsistency in recording across the four children's notes within health which means that information could be missed if only one record was checked on behalf of them all.

Lucas and Sophie were placed on a child protection plan in December 2021 for emotional harm and this was continued throughout the year 2022 with provisions and processes in place to safeguard them. The focus of attention was to be on reducing the risk to the children. However, these processes were not followed and an opportunity to risk assess Michael during an unannounced visit was missed due them not being followed and lack of supervisory oversight led to poor recording and no follow-up.

The drift of the Core Group and a lack of engagement during the latter stages of involvement due to worker turnover meant that there was little change to the perceived needs or meaningful exploration as to whether these changed over time. (Recommendation refers)

Following their mum's death, CSC report offering support to Leon and the family but it was too soon. When they were ready, Leon then struggled to get any support and again, felt like he was having to find help for his children all on his own. He has been assisted by the schools to get bereavement counselling from Stars for them.

3.3.4 Services and agencies provisions to suicide and those contemplating taking their own life within the Cambridgeshire area

CPFT have five umbrellas to their Mental Health provisions. When Sarah self-referred to the Psychological Well-being service in November 2022, she received a letter from them informing her that her needs were too complex for brief psychological interventions and was provided information on CGL and advised to see the GP. Sarah inconsistently accessed support from many agencies and so to self-refer would have been a big step. Consideration was not given to how Sarah would feel being declined by letter and provided information on another service to then have to get the courage to contact another service. It may have been more appropriate for PWS to refer to CGL and make the introduction on her behalf. (Recommendation refers)

The Police were called to Sarah's home address on nine separate occasions in relation to Sarah's mental health. The ambulance service attended a number of these following self-harm and a big frustration for Leon was that when Sarah spoke to professionals, she was lucid and articulate, blaming her behaviour on alcohol when Leon had seen an 'out of control' person minutes earlier. Leon would be told that Sarah had capacity and as an adult, could choose whether to attend hospital, but the word capacity and the limitations of police powers within this area were not explained sufficiently and led to stress and the feeling that no-one was prepared to help.

Sarah had on-going mental health problems that were exacerbated by alcohol abuse. This area was focussed on with referrals to CGL and there does not appear to have been consideration by any agency as to whether the self-harming and alcohol abuse were due to the core of the issue being domestic abuse and addressing assistance and support in this

area to reduce the subsequent repercussions. Mental Health issues and alcohol abuse have historically overshadowed the identification or addressing of domestic abuse in multi complex cases. With over ten contacts with one of the CPFT provisions for mental health in a three-year period, Sarah was always discharged when medically fit with little follow-up and no long-term plan made. Guidance points to alcohol moderation before talking therapies can be undertaken is advised but both at times overshadow the domestic abuse which could be the cause of either and this was not explored.

Good practice was completed when a referral was made to the hospital IDVA on one occasion but this was following a disclosure from Sarah that Leon had physically harmed her when he had restrained her during self-harming and not from any of the disclosures of domestic abuse that caused her emotional and psychological harm.

3.4 Other areas for analysis

Out of Court Disposals (OOCD) – Police

There were two separate cases where a conditional caution was administered to Daniel by the Police which were inconclusive and of no effect. This was a process that was allowed to drift and a poor exercise of a diversionary judicial remedy without a formalised conclusion. This did not support Daniel, nor the family in addressing his behaviour.

On the 12th of May 2021, Daniel was conditionally cautioned for criminal damage, The record identifies 'conditions outstanding' with a finalisation date of 14th July 2021 for completion.

It was noted by the OOCD that Daniel already had a previous referral to Outside Links for a session with them so it was not proportionate to make a second referral and the condition determined was that Daniel would be referred for an assessment with LaDS. The crime log identifies that Daniel was referred but had not engaged with LaDS for a voluntary assessment which was the only condition he was to abide by. It is apparent that the LaDS team made innumerable efforts to contact Daniel, as did the OOCD team, without success. Effectively this was a breach of the conditional caution however, in view of the length of time it took to resolve the contact, the case was closed, and no prosecution took place. It appears that in this particular instance, Daniel chose not to engage, and the case was closed rather than escalated for a file to be submitted for a prosecution decision. Summarily, the conditional caution is valueless.

This outcome raises the wider questions of whether the reprimands and cautions on Daniels PNC record are factually accurate as the administration of the conditional cautions dated 19/05/2021 and 04/11/2021, appear to be incomplete. (This matter has been dealt with internally and rectified)

Where individuals fail to comply with conditional cautions, there is a clear pathway for decision making. The Crown Prosecution Guidance suggests.

Consideration can then be given to whether the alleged offender should be prosecuted. This approach is consistent with paragraph 10.1 of the Code for Crown Prosecutor, which states that, although normally when a suspect or defendant is told that there will not be a prosecution this will be the end of the matter, occasionally there may be special reasons where this may not be so. These reasons include those cases where a new look at the original decision shows that it was wrong and, in order to maintain confidence in the criminal justice system, a prosecution should be brought despite the earlier decision.

If imposed, this could have led to a change in attitude/behaviour of Daniel which could have minimised further incidents within the home and lessened the risk to Sarah and the remainder of the family. (Recommendation refers)

Good practice has now been implemented in this area to assist with DA as an OOCD IDVA is now integrated in the Police team. The OOCD IDVA role is funded by the Cambs and Peterborough OPCC to the Cambs and Peterborough IDVA Service.

In the cases of Police DA conditional cautions, the IDVA will offer the victims support, having consented to our contact.

They will make initial contact explaining and offering the service, if the client consents to support then this will provided throughout the caution process and beyond if necessary.

The IDVA will work in partnership with the OOCD team and the OIC's, advocating for the client, as necessary.

Section 4 – Conclusions and Recommendations

4.1 Conclusions

4.1.1 - Sarah grew up as a child witnessing violence and emotional abuse towards her mum from various partners through the years. She saw her mum turn to alcohol as a way to cope. Sarah was subjected to sexual abuse both in her early teens and shortly after her marriage. These adverse child experiences went on to affect Sarah's response to stress throughout her life when she felt unable to cope. Her sister, Hayley, tells how her body meant nothing to her and thought that sex would mean she was loved and their upbringing led to Sarah being needy and not strong.

Friends and family speak of her as funny, loving and a person who has great humility. She showed protectiveness of others throughout her life, over her sibling when she was younger and then over her children, constantly trying to prevent Daniel from a criminal conviction even though this would be to her detriment with continued abuse.

As Daniel grew older and his behaviour became more demanding, Sarah turned to alcohol as a coping mechanism as she had done in her early years before he was born. Sarah asked for help from Children's Services, CPFT, The Police and CGL with them having full knowledge of incidents in the home involving Daniel and although a DASH was completed by the Police on

most occasions, no agency specifically recognised this as abuse from a child turning adult to their parent and the only MARAC referral by any agency was made by the Police after 21 incidents had occurred. No Dash, despite the accumulation of incidents was graded as a high and Safelives guidance in relation to referring to MARAC for repeat incidents was disregarded. Daniel's behaviour was violent in that he would cause damage around the house, cause fear in those present, including his younger siblings and there was an occasion that Sarah discloses where he had thrown hot water towards her.

Although no physical abuse occurred, the emotional abuse had a detrimental effect on Sarah. There is a direct correlation between the incidents attended by the Police increasing and then the re-occurrence of self-harming and hospital attendances by Sarah who admitted her actions were due to the stress she was under from Daniel's abuse and that she couldn't cope. However, the domestic abuse was not addressed. This was not seen by any agency as the core issue that caused Sarah to have to utilise coping mechanisms. Had domestic abuse been addressed, supported and adequately safeguarded, then this could have reduced her stress and potentially minimised her mental health issues and alcohol abuse.

Communication between agencies was poor at times with Daniel falling into a gap between CSC and ASC due to his age, which meant that neither he, nor his parents received the support that they should have. Records were made in his name with no separate file to identify the needs of Sarah or Leon. They were not recognised as carers and therefore did not have additional support for this area and would not then have had the additional risks identified that carers have in relation to caring for someone, whether that be their child or not.

CGL showed good communication with other agencies and good follow up welfare checks when an appointment was not made and were the only agency to build any kind of rapport with Sarah, even though help was rejected frequently as with other agencies. Other agencies did not utilise the rapport with the CGL to foster their own relationship. An example of this was when Sarah eventually built-up the courage to self-refer to PWS, a CPFT primary care provision and received a letter in response informing her they were not appropriate to assist her as her needs were too complex and to refer herself to CGL when this could have been done on her behalf, as there was a risk that she may not have had the strength to do this herself.

Agencies had short periods of involvement with Sarah before closing their files, meaning that there tended to be a short-term pattern of involvement and closure which tended to offer the same solutions to what appear to be the same issues, so less opportunity for understanding the family in depth and in particular why Sarah continued on the cycle of drinking and self-harm and seemed unable to engage with the support identified with and for her.

Sophie and Lucas were placed on a Child Protection Plan for emotional harm to reduce this risk, however, the family's needs as a whole were not considered and there was no holistic approach by multiple agencies towards this. Anton is not mentioned on any records as

having been considered, the MARAC meeting that took place was ineffective with only two actions and the core group for the child protection plan lacked pace and progression.

The schools of both Sophie and Lucas provided good support and assistance for both the children and gained the trust of the parents so that they had a good insight into the situation at home and made appropriate referrals and shared information when necessary.

Following an incident where Sarah had self-harmed and then disclosed that she had been assaulted by Leon, who had been restraining her at the request of Anton, CPFT correctly referred her based on her disclosure to the hospital IDVA. However, this was only completed on one occasion following a reported physical assault.

CSC's response to all the information being received from the police was not robust enough to effect change earlier or more effectively. CSC did not fully investigate who was living in the home with the children when it started to become clear that a partner (Michael) was living there, and a police check (which should be routine for adults living in a home with children on a CP plan) may have revealed a better indication of the potential risk Michael posed.

It is known that Sophie and Lucas witnessed a number of incidents of domestic abuse by their elder brother, self-harm by their mother and both saw and received abuse from Michael with Sophie ringing the Police in the middle of the night whilst her mum was self-harming. Lucas has hid in the wardrobe and also been thrown out of the house by Michael with no shoes on. Anton argued with Sarah's male friends who attended the house and even rang the Police to ask for advise which is an example of how this affected him.

Michael immediately started isolating Sarah from her family and friends from the beginning of their relationship. He was controlling and coercive over her, tracking her movements, making her take drugs for the purpose of sexually abusing her and gas-lighting her, calling her names, putting her down and behaviour witnessed and recognised by Sophie as gaslighting by hiding her keys and making her question herself. Sarah's self-confidence was fragile throughout her life and Michael exploited that as a means of control, telling her that her family did not love her and she wouldn't get her children back.

Following the violent assault on Sarah from Michael, she was referred to the MARAC even though the DASH was still not graded as high. Although this is good practice, again, this is an example of the identification and action following violence and physical abuse but causes concern over the identification, recognition and response to emotional and psychological abuse.

It is accepted that Sarah self-harmed at different stages of her life but her family state that these were cries for help and not attempts to take her own life as you could tell by her response on one occasion when she knew she had gone too far and hurt herself severely. Sarah also re-iterated throughout those last years that she would never leave her children the way her own mum did.

Hayley makes a poignant remark that the emotional abuse was far more damaging to Sarah than the physical abuse and the isolation from her family and friends that Michael caused and initiated, the children moving to Leon's and Michael's constant torment of Sarah that she would never get her children back and that her family did not love her, knowing that to be loved and have her children were the most important things to her, will have caused irreparable psychological damage and shows a sinister exploitation of her vulnerability.

It is accepted that when Sarah had been drinking alcohol, she could be a different person and records show that Sarah withdrew from CGL support over the Christmas of 2022 which would have been an emotional time for her and Michael utilised both the alcohol and drugs to maintain that control and isolation with friends not asking anything poignant about her relationship over text or phone in order to minimise her risk as they were aware he monitored her phone, iPad and social media, which eradicated an avenue of support that Sarah had leaned on previously.

Hayley, Debbie and Sophie all state that they believe the abuse by Michael on Sarah was the cause of her finally taking her own life. Hayley summed this up by saying that "Sarah always had the gun but Michael provided the bullets" and feels that Michael's abuse of Sarah was 'the final nail in the coffin.'

The panel concur with this sentiment and conclude that domestic abuse was a contributory factor in Sarah sadly taking her own life.

4.2 Lessons to be learnt

4.2.1 Lack of continuity in assigned Social Worker causes additional stress and frustration

The Head of Safeguarding from Sophie's school commented on the fact that they had recorded six different social workers in a calendar year assigned to Sarah's family and the fact that this led them to losing their trust in the service as they didn't feel valued. It prevents relationship building, rapport and trust and doesn't provide consistency and in-depth knowledge of the whole situation.

CSC have acknowledged that due to the lack of permanent staff, they have to utilise agency staff and have a high turnover of personnel which has caused issues in a lack of knowledge of the history when they visit the family. Poor recording of information has been identified in this review which prevents an informed risk assessment and comparison and raises a question into the adequacy/process of supervision and oversight.

The comments by Sophie in relation to Voice of the child also evidence a lack of trust in speaking open and honestly with a social worker when they have only just met them and know there will be a different one on the next occasion.

4.2.2 The identification of child to parent abuse and the collaborative working that is required

This review outlines the number of incidents attended at the home address of Sarah where Daniel had either damaged property or was being aggressive and the number of times that Sarah asked for help and told professionals that she was afraid of him. There were a number of times when positive action was not taken and no specific MARAC referrals relating to this particular abuse. When mentioned at the MARAC, it was not discussed. A Dash risk assessment was completed for the majority of incidents but the mash did not identify this as an issue on secondary review.

When Sarah asked Children's Services for help with Daniel as she couldn't cope, she was informed that there was no time for an assessment as he was four months away from becoming an adult yet wouldn't be able to be assessed as an adult until he reached that age. Sarah was initially provided with a different Social worker but was still not assessed as an adult needing help in her own right. Communication between Children's Services and Adult Services was poor and improved working together could have assisted the transition of the ages to obtain the support that was required.

Also, the domestic abuse was not recognised by Children's Services as it was overshadowed by Daniel's medical condition on which they focussed their response.

4.2.3 The recognition of the Voice of the child in domestic abuse cases

The Voice of the child is known by all agencies but it is not clear whether all practitioners understand the extent of the considerations that they should take into account.

The Police response was inconsistent when attending incidents in both speaking with the children present and the subsequent referrals thereafter. When they were omitted, these were not identified by the MASH which is the secondary review of the DASH forms which were completed and would have identified children in the home.

Although it is recorded by Children's Services that there was a risk to Sophie and Lucas with Daniel in the home, it was not recognised as domestic abuse and any specific support they may require in direct relation to this, nor was this considered at the MARAC.

CPFT received notifications of the incidents and also Sarah directly informed them of the fact that her stress levels and mental health difficulties were due to the abuse she received from Daniel, but this was not always responded to and the children within the home were not taken into account, even though at least two complex factors had been identified.

There is currently an ongoing programme of work by Cambridgeshire Public Health regarding support for Children and Young Persons who have been bereaved by suicide with one strand being a booklet containing information and pathways for support. Consideration is being made to disseminating this widely with all schools. This is good practice and has been encouraged by the DHR panel.

4.3 Recommendations

National

There were no National recommendations from this review.

Local

1. **CSC to implement a staffing strategy to ensure those with multi-complex needs are allocated a permanent member of staff.**
   This will provide consistency for families and a historical footprint of knowledge to provide a holistic understanding of their needs, building trust in the relationship to be more effective in support.

2. **DASV within Cambridgeshire to commission Safelives to complete an independent review of MARAC processes, policies and working practices in line with their guidance.**
   This will identify good practice and also areas that may need change or gaps that require addressing to ensure it provides representation from all relevant agencies, decision making and actions are applicable and accountable and it ensures that sufficient safeguarding measures have been met for the victim.

3. **In all cases of suicide reported to Cambridgeshire Constabulary, a Detective Inspector (DI) will be responsible for updating families and being their Single Point of Contact (SPOC), this will ordinarily be the DI who is the Sudden Death SPOC for North or South of the county, respectively.**
   This will ensure that families are kept up to date following the death of a loved one in the case of DHRs including suicides when an FLO may have not been assigned. This is in direct response to observations from not just Sarah's family, but also found in previous DHRs.

4. **Cambridgeshire Police to conduct a review of the processes within the Out of Court Disposal Team to ensure effectiveness and accuracy including:**
   - **Recording processes.**
   - **Additional scrutiny prior to closure**
   - **Communication with Liaison and Diversionary Service (LADs)**
   - **Obtaining specialist advice when dealing with Domestic Abuse**

   This will ensure improved recording and a review process on occasions when the conditions are not complied with and eradicate omissions. It will provide accuracy to PNC records.

5. **The refreshed DA strategy for CSC to be signed off and circulated to all staff, with a communication package with a focus on the role of MARAC, IDVAs and the agreed practice around child to parent violence.**
   This will provide renewed guidance and training input on the areas identified within this report that provided learning and reflective points from this review.

6. **CSC to ensure that policies for supervision and management oversight for both individual cases and members of staff are adhered to.**
   This will ensure timely recognition of any omissions within recording, regular reviews of cases and safeguarding measures to ensure they are appropriate and current and identify any good practice or learning in staff performance.

7. **Adult Social Care and Children's Social Care to promote collaborated working in cases of child to parent abuse when the person who is alleged to be causing harm also has care and support needs.**
   This will provide a holistic approach and ensure all individuals within the family's needs are met and supported, particularly in those cases where the child is approaching adult age.

8. **CSC to give consideration on open cases as to what support parents might need in the event of a child being removed (either through court proceedings or by a parent with care exercising their PR) and for families when a parent takes their life.**
   This will ensure the whole family's needs are met, supported, and prevent solitary focus on the initial core reason for referral, providing a holistic approach.
9. **CSC to refresh practice guidance around assessments, ensuring workers gather evidence and exercise professional curiosity around parental self-reporting.**
   This will ensure that an accurate picture of the family's needs can be gained and the right levels of support be put in place.

10. **DASV Strategic board to review funding streams and a possible trial of an IDVA attending repeat domestic Abuse locations alongside the Police and the feasibility.**
    This would provide advocacy and an opportunity to build a rapport from the outset of Police attendance when it is identified that there is a repeat victim and they may not respond to authorities in the same relationship trust manner.

11. **ASC to undertake a s42 enquiry with discretionary powers when it is identified that there is significant ongoing risk to either a carer or someone being cared for and they are not engaging with services.**
    This is to increase the identification of carers within a family unit and ensure that the risk assessment considers all facets of the family's stresses and risks. This will also provide additional support where needed which may not have been available otherwise.

12. **Cambridgeshire Police to implement the process that all officers delivering a sympathetic message are aware of the Lifecraft service and are able to refer onward with consent. Material is to be left with the family on all occasions outlining the service and support.**
    This will assist families who may not be in the right frame of mind to either take in information at that time or are not in the right place to receive

13. **Ensure frontline professionals responding to incidents involving vulnerable people are aware of the continuing risk of suicide in those who have previously attempted suicide, self-harmed, or spoken of suicide.**
    There were several comments in the IMRs that although Sarah had previously attempted suicide or was currently speaking of suicide, she was deemed to not be at immediate risk. However, research shows that a previous suicide attempt is a significant risk factor for future suicide attempts, even after several years. In addition, there can sometimes be a mistaken belief that those who talk about wanting to end their life are doing so to seek help or attention and won't go on to take their life – this is not the case and every mention of suicidal behaviour should be taken seriously.

14. **All professionals are able to access training and to be aware of resources available to support those subjected to Child to Parent Abuse, regardless of the age of their "child," with any local agency domestic abuse policies to include the issue of child to parent abuse.**
    This has been identified as an area in which Adult Social Care need to be more informed in order to respond and support appropriately.

15. **Signposting Support: Where a person is seen by a CPFT service and they are then signposted to self-refer to another service within or external to CPFT, support should be offered to assist in making that new self-referral to ensure the person has the support and encouragement they need.**

    This will improve the likelihood of the person self-referring for appropriate treatment and support and improve overall outcomes for the person.

16. **Assessment documentation: Where a person is assessed or triaged by CPFT, the assessment documentation should include sufficient prompts and plans for safeguarding adults, children and young people and domestic abuse.**
    This will ensure improved identification of domestic abuse and safeguarding and ensure referrals to safeguarding and/or domestic abuse services feature more explicitly within health plans

17. **Referrals to MARAC for numerous incidents of DA: CPFT will include in their DA Policy and Standard Operating Procedures that where a DASH has been completed by CPFT staff but scores below the MARAC threshold of 17 and above, but there have been 3 incidents of DA in 12 months or less, and there is imminent and significant risk, an automatic referral to MARAC should be made on professional judgement.**

    This will ensure that cases such as Sarah's are heard at MARAC sooner, information is appropriately shared and safety planning and support is discussed.

18. **CPFT staff working in general hospitals: CPFT will amend the Standard Operating Procedures (SOP) for CPFT staff on Honorary Contracts and staff working on an 'on-call' basis working within general hospitals to ensure greater clarity of responsibilities, recording systems and referrals in relation to safeguarding adults, safeguarding children and young people, and domestic abuse.**

    This will ensure greater consistency and best practice in response to safeguarding and domestic abuse.

Appendices

Appendix A

Terms of reference

- The date parameters under consideration are from January 2017 up to the date of death of Sarah.
- This is to be reviewed as a suicide based on the investigation by appropriate authorities. The purpose is to establish if DA was a factor in the death of Sarah.
- Ensure the review seeks to involve the family in the process and takes account of who the family may wish to have involved as lead members. Identify any other people the family think may assist or be relevant in the review process, including voice of the child.
- Where we know children are victims of domestic abuse, what protections and support are provided to those children?
- How effectively do agencies listen to the voice of the child?
- What are the provisions and support in the event of a parental suicide due to DA?
- Do agencies have a domestic abuse policy which includes MARAC? Were agency policies abided by in this case?
- How effective was MARAC in increasing safety for Sarah and her children?
- Do services consider people holistically rather than just address what that agency provides? Did agencies consider Sarah's other needs whilst working with her?
- How effective are agencies within Cambridgeshire on a collaborative approach to supporting those who are vulnerable and require safeguarding, particularly with multi-complex needs including:
    - Fostering relationships
    - Utilising existing multi-agency meetings for planning
    - Improving communication between agencies
- Establish accessibility of services for those contemplating suicide and whether training for professionals has been received in relation to the effects DA may have towards this.
- How effective was the Criminal Justice system in responding to domestic abuse for this family?
- Where families are experiencing children causing harm to parents, what services are in place to support them? Are there additional support carers where this behaviour occurs? Were these services offered/provided in the case of Sarah and were her multi-complex needs and vulnerability taken into consideration.
- Did agency intervention identify or consider Sarah's protected characteristics. Were any of the other protected characteristics relevant in this case?
- Was Sarah assessed as vulnerable in her own right?
- Identify and highlight good practice for wider sharing
- Panel to have a parallel action plan for expedited implementation where practicable during the review

Appendix B

Glossary

AAFDA: Advocacy After Fatal Domestic Abuse

CSC: Children Social Care

CSP: Community Safety Partnership

CPFT: Cambridge and Peterborough NHS Foundation Trust

DA: Domestic Abuse

DASV: Domestic Abuse and Sexual Violence partnership

DHR: Domestic Homicide Review

EH: Early Help

GP: General Practitioner

HCP: Health and Care Partnership

ICB: Integrated Care Board

ICPC: Initial Child Protection Conference

IDVA: Independent Domestic Violence Advisor

IMHT: Integrated Mental Health Team (Police)

IMR: Individual Management Review

MARAC: Multi Agency Risk Assessment Conference

MASH: Multi Agency Safeguarding Hub

MCU: Major Crime Unit

NFA: No Further Action

OOCD: Out of Court Disposal

RCPC: Review Child Protection Conference