A Combined Local Child Safeguarding Practice and Domestic Homicide Review concerning the deaths of Bethany and Darren in May 2021

Independent Chair and Author: Dr Russell Wate QPM
(January 2024**)**

Glossary of Terms

AAFDA – Advocacy after Fatal Domestic Abuse

ASD – autism spectrum disorder

BBR – Building Better Relationships

CBT – Cognitive Behaviour Therapy

CIN – Child in Need

CJL&DT – Criminal Justice Liaison and Diversion Team

CMHT – Community Mental Health Team

CPS – Crown Prosecution Service

CRC – Community Rehabilitation Company

CPN – Community Psychiatric Nurse

CSPR – Child Safeguarding Practice Review

CSPRP – Child Safeguarding Practice Review Panel

DA- Domestic Abuse

DASH – Domestic Abuse, Stalking and Honour Based Violence

DHR – Domestic Homicide Review

DLNR -Derbyshire, Leicestershire Nottingham and Rutland

DVDS – Domestic Violence Disclosure Scheme

DVPN – Domestic Violence Protection Notice

DVPO – Domestic Violence Protection Order

EDAN Lincolnshire – End Domestic Abuse Now

EHCP – Education Health Care Plan

HLNY CRC – Humberside, Lincolnshire, and North Yorkshire Community Rehabilitation Company

IDVA – Independent Domestic Violence Advisor

IMRs – Individual Management Reviews

LCC – Lincolnshire County Council

LCHS – Lincolnshire Community Health Service

LPFT – Lincolnshire Partnership Foundation Trust

LSCP – Lincolnshire Safeguarding Children Partnership

MAPPA – Multi -Agency Public Protection Arrangements

MARAC – Multi-Agency Risk Assessment Conference

MOSAIC – Children services IT system used to record the management of cases.

NCSPRP – National Child Safeguarding Practice Review Panel

ONS – Office of National Statistics

Operation Encompass – A police and education early information sharing protocol in cases of household domestic abuse.

PPN – Public Protection Notice

PSR – Pre-sentence Reports

RIO – an electronic patient records system for community mental and child health providers

SARA – Spousal Assault Risk Assessment

SLP - Safer Lincolnshire Partnership

SPA – Single Point of Access

VKPP - Vulnerability Knowledge and Practice Programme

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Section One - Introduction

1.0 Introduction

Bethany and Darren

1.1 For this report, the names Bethany (26 years old) and Darren (9 years old) (their real names) will be used. This is at the request of their family. They expressed their view to the review chair in the strongest terms, that no pseudonyms must be used for their loved ones, who were the victims of the murders. The family wish to ensure that both Bethany and Darren have a voice throughout this report and that this review is faithful to their legacy. The consequences of this decision have been discussed by the review chair with the family and they are sure this is what they want to happen. The review chair discussed this again with them when he re-visited them to go through the report in detail, for any further input that they wished, they were adamant that they wanted their loved one's real names used. This report starts with illuminating the lives of Bethany and Darren and the impact that their deaths have had on their family.

1.2 Darren's dad said the pain of losing his son was "*unbearable*" and that the moment a Police Officer told him his son had died would never leave him. *"I will never again hear him shout daddy. The pain and heartache kills me every day. Those are words no parent ever wants to hear. They will be in my mind forever."*

1.3 Bethany's parents and sister, having lost not just their daughter but also their grandson, sister and nephew, said their lives "*Will never be the same again*" and spoke of their *"Pain and emptiness".*

1.4 The review chair and the panel are keen that this report has at its very beginning a picture of who both Bethany and Darren were, and the fact that their lives were brutally taken by the perpetrator and the loss that these murders has brought to their family, friends and community. The murder of a loved one, and in this case the combined effect of the deaths, particularly under such circumstances as will be apparent within this report, has a profound effect on families that will endure for generations to come and continue to have an impact not confined to the family but also to friends, associates, and the wider community alike. An example of this, is that there is a charity set up because of them to give victims a voice. The following comments are from the family who wanted others to know who Bethany and Darren were, not just as individuals but also as a mother and son who were best friends to each other.

1.5 Bethany was a quiet and private person who didn't go out very often. She separated from Darren's father before he was two years old. She was devoted to Darren who was affectionately known as DJ by her and the family. (Darren will be called DJ in the report as this is the name the family used for him. He will at times be called Darren when it is the name that agencies have used in their report, as a matter of accuracy.) Although she had friends and read books, Bethany spent a lot of time with, and was close to her immediate family. When it came to their relationship as mother and son; DJ and Bethany were said to be, *'two peas in a pod'* and *'best friends.'* DJ spent weekends

with his father who was still close to Bethany and a good friend of hers. Bethany had in the past various jobs in order to earn extra money.

1.6 DJ had a massive personality and he would say anything to anyone, not in a malicious way, he just said what he thought. He had special needs and went to a school which the family describe as amazing and they really *'got'* DJ and understood him. He was diagnosed with autism at a very young age. He struggled to deal with his emotions but not in an aggressive way. Due to communication difficulties, he often got upset with himself. He was mad keen on football and Chelsea was his favourite team. DJ also loved Mario games and everything to do with Mario. He would talk to everybody but didn't have any idea of keeping personal space. He was so loved.

1.7 On behalf of the Safer Lincolnshire Partnership and the Lincolnshire Safeguarding Children Partnership, both of whom have written to the families, the review chair has expressed their deepest sympathies to the family for their loss. The review chair and panel wish to acknowledge the essential and keenly supported involvement given to this review by family members, and others concerning the tragic deaths, and through their support and understanding, developed the lessons that need to be learned by all agencies.

1.8 The name of the perpetrator (29 years old) of the murders will not be used in this report. He will be called the perpetrator. The victim's family were adamant that this should be the case and asked the panel to honour this wish. This review is not about apportioning individual or agency blame. The perpetrator is the guilty person and received, following a trial, 40 years imprisonment for the murders of Bethany and DJ. The review does though look at where both individual and agency professional practice can be improved or enhanced and where changes to how agencies work together will provide further safeguards for the most vulnerable.

The Report

1.9 On the 7th of June 2021, Lincolnshire Police notified the Chair of the Safer Lincolnshire Partnership that the deaths of Bethany and Darren were being investigated as homicides. The Chair of the Strategic Board considered the case, in conjunction with other key agencies that had contact with the family and concluded that the case did meet the criteria and justification for a Domestic Homicide Review; the Home Office were notified accordingly.

1.10 The Safer Lincolnshire Partnership (SLP) is a statutory partnership which brings together agencies with the aim of promoting safeguarding across the statutory agencies, reducing crime, disorder and anti-social behaviour across the County area of Lincolnshire. These agencies work together to improve the safety of residents and visitors by information sharing and partnership activity. One of the key safeguarding roles of the partnership is that of examining and reducing domestic abuse and supporting victims of domestic abuse. Safeguarding policies are enshrined in each of the statutory agencies within the partnership and within the charitable and voluntary agencies who have participated in this review.

1.11 On the same day the 7th of June 2021, the Local Authority, under its duty as defined in Section 16c (1) of the Children's Act 2014 (as amended by the Children and Social Work Act 2017) notified

the Lincolnshire Safeguarding Children Partnership (LSCP) and the National Child Safeguarding Practice Review Panel (the National Panel) of a serious incident involving a child. A serious incident for the purposes of notification is defined when: abuse or neglect of a child is known or suspected and the child has died or been seriously harmed.

1.12 This notification triggered a statutory 'Rapid Review' which was completed by the safeguarding partners within 15 working days of the notification. The Rapid Review concluded with a recommendation for a Child Safeguarding Practice Review (CSPR). On the 1st of August 2021, the LSCP Assurance Executive agreed that this would be a joint CSPR review with the DHR.

1.13 In August 2021, the Chair of the SLP formally commissioned a Domestic Homicide Review to be conducted alongside the Child Safeguarding Practice Review. This review is cognisant of the NHS Mental Health Review that took place in parallel to it, and that a Serious Further Offence review has been conducted by the Probation Service. This report does not intend to repeat those reviews, but will comment contextually where necessary, although several recommendations and actions are mirrored across the respective reviews.

1.14 The purpose of this review is to:

- Establish what lessons are to be learned from the domestic homicide/serious incident regarding the way in which local professionals and organisations work individually, and together, to safeguard victims and improve outcomes for children.
- Identify clearly what those lessons are, both within, and between agencies, how, and within what timescales they will be acted on, and what is expected to change as a result.
- Apply these lessons to service responses including changes to policies and procedures as appropriate; and
- Prevent domestic homicide and improve service responses for all domestic abuse victims and their children through improved intra and inter-agency working.

1.15 This overview report has been compiled with specific reference to the comprehensive Individual Management Reviews (IMRs) prepared by experienced practitioners and authors from the key agencies, both statutory and non-statutory, who are involved in this case. Each of the IMR authors are independent of the victim and family and of management responsibility for practitioners and professionals involved in this case. Where IMRs have not been required, reports from agencies or professionals have been received as part of the review process and all those agencies has actively participated in this review process throughout.

1.16 The overview author has fulfilled a dual role and has chaired the panel meetings and professional events conducted in respect of this case. This is recognised as good practice and has ensured a continuity of guidance and context for the review process throughout. There have been several useful professional discussions arising and the six panel meetings have been narratively recorded and minutes prepared and approved for transparency. The professionalism of the panel members and the overall quality of the responses has been of a high standard with continued dialogue along with professional observation and critique throughout. The review chair is particularly grateful to the legal advisor to the panel for their hard work in providing quality assurance to the IMR process, with help and support to the authors and their agencies.

Terms of reference (Questions to be answered by the review)

1.17 The specific terms of reference for this review, which flow from the CSPR rapid review, including a Multi-Agency DHR policy focus, also include questions that are required to be addressed by the parallel NHS mental health review, have been agreed by the review chair and the panel with agencies and addressed within this report are:

Questions set by the panel for IMR authors
a) When, and in what way were practitioners sensitive to the needs of Bethany and Darren, knowledgeable about potential indicators of domestic abuse, and aware of what to do if they had concerns about a victim or perpetrator? What was known about Darren's lived experience of domestic abuse? Was it reasonable to expect practitioners, given their level of training and knowledge, to fulfil these expectations? b) What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way? Please consider how effective your agency's contribution was to multi-agency working in this case. c) Examine the referral arrangements, communication and discharge procedures of the different parts of the NHS that had contact with the service user. d) Review and assess compliance with local policies, national guidance and relevant statutory obligation. e) Examine the effectiveness of the perpetrator's care plan and risk assessment, including the involvement of the perpetrator and his family. f) Review the appropriateness of the treatment of the perpetrator in light of any identified health needs/treatment pathway. g) Did actions or risk management plans, in particular in relation to emotional and mental health issues for the perpetrator and Bethany, fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time? h) Exploration of how domestic abuse perpetrator history is transferred between areas and made accessible to those working to safeguarding children needs to be considered. i) Ensuring that relevant historic information and previous offending is researched and used to inform current assessments of risk needs to be addressed. j) Exploring how key indicators, which would suggest an increased risk of domestic abuse, are recognised and inform risk assessments and safety planning. k) Exploring how Lincolnshire's local profile of domestic abuse, including local learning from Domestic Homicide Reviews and MARAC, informs risk assessment and planning when working with domestic abuse perpetrators, victims and children. l) Were significant interventions/sentence requirements placed on hold pending assessments following self-reported conditions e.g., autism. m) Was appropriate professional curiosity exercised by those professionals and agencies working with the individuals in the case, this includes whether professionals analysed any relevant historical information and acted upon it? n) Did the agency have policies and procedures for Domestic Abuse and Safeguarding and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?

o) Were any issues of disability, diversity, culture, or identity relevant?
p) To consider whether there are training needs arising from this case.
q) To consider the management oversight and supervision provided to workers involved.
r) How has Covid-19 impacted on service delivery and interaction in this case?

1.18 The family were asked their thoughts on the terms of reference and whether they wished to add anything. They were very clear that they would in addition like the review to explore *'Why the perpetrator was not sent to prison, when he appeared at court (17/2/2021) for a further offence against Bethany and her mother.'* The family when seen together again to go through the report in detail feel that this is still in their view the crucial time of intervention and that the perpetrator should have gone to prison on this occasion. DJ's father when also seen to have the final report shared with him agreed that this was for him a key time to intervene.

1.19 In view of the fact that this overview is a combined Child Safeguarding and Domestic Homicide Review, the safeguarding partners must ensure that:

- Practitioners are fully involved in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- Families, including surviving children, are invited to contribute to the reviews. This is important for ensuring that the child is at the centre of the process. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

1.20 The scope for this review focussed on the **period 9th of November 2018 to the date of the murders**. The 9th of November 2018 was chosen to align with a significant domestic abuse incident by the perpetrator on a previous partner, and then includes Bethany's pregnancy, and pre-dates any knowledge of any worries in her relationship with the perpetrator. This timeframe would also allow for an understanding of Darren's life, pre-Covid-19, and therefore allow the panel to consider any potential impact of the lockdown on him and his family. The scope runs to the date of Bethany and Darren's deaths.

Panel members

1.21 The following individuals forming the panel and representing the agencies involved in this review are:

Agency	Advisor	Job Title	Panel Role
United Lincolnshire Hospitals NHS Trust	Elaine Todd	Named Nurse for Safeguarding Children and Young People	Representing Local Hospitals
United Lincolnshire Hospitals NHS Trust	Rebecca Ross	Named Midwife for Safeguarding vulnerable women and children	Representing Midwifery

Lincolnshire County Council (LCC), Adult Social Care	Linda MacDonnell	Head of Adult Safeguarding	Representing Local Adult Services
South Holland District Council	Emily Holmes	Communities Manager	Representing East Lindsey District Council
Lincolnshire Partnership NHS Foundation Trust	Tony Mansfield	Head of Safeguarding Public Protection & Mental Capacity	Representing Local Mental Health services
Lincolnshire Community Health Services	Gemma Cross	Head of Safeguarding / Named Nurse for Safeguarding	Representing Local Community Health
LCC, Education	John O'Connor	Head of Education Support	Representing Local Education
Lincolnshire Integrated Care Board	Nicola Wilkinson	Head of Safeguarding Children	Representing Local GP Commissioning Services
Lincolnshire Police	Richard Myszczyszyn	Detective Superintendent – Head of Protecting Vulnerable Persons (PVP)	Representing Local Police Service
Lincolnshire Police	Sarah Norburn	DA Coordinator	Representing Local Police Service
Probation Service	Becky Bailey	Head of E and W Lincolnshire	Representing Probation Service
East Midlands Ambulance Service	Liz Cudmore	Children and Young Person Safeguarding Lead	Representing Local Ambulance Service
Niche Consulting	Carol Rooney	Associate Director	Representing Independent NHS Mental Health Review

Panel Chair and Report Author

1.22 Dr Russell Wate, QPM is a retired senior Police detective. He has significant experience in partnership working within numerous safeguarding environments, authoring Serious Case Reviews and conducting Child Safeguarding Practice Reviews. He also has extensive experience in conducting

Domestic Homicide Reviews; having chaired and authored several such reviews across the country, as well as internationally. He has completed the Home Office DHR training, the Sequeli and NSPCC training and the Standing Together and Advocacy after Fatal Domestic Abuse (AAFDA) DHR training. He presents training to agencies, both nationally and internationally, on the conduct of and carrying out of Statutory Safeguarding Reviews.

1.23 Dr Wate is entirely independent of all agencies in this process having no connection with the Safer Lincolnshire Partnership or the Lincolnshire Safeguarding Children Partnership, other than previously providing professional and independent services in respect of unrelated Domestic Homicide Reviews and one historical Serious Case Review.

Contributors to review.

1.24 The following agencies have contributed to this review by the involvement in a very thorough CSPR Rapid Review and also the preparation of an IMR or report for their agency and the panel:

Agency	IMR	Report
Lincolnshire Police	➢	
Lincolnshire Safeguarding Children Partnership		➢ (Rapid Review)
Lincolnshire County Council Adult Social Care		➢
Lincolnshire County Council Children's Services	➢ (x2)[1]	
Lincolnshire Community Health Services		➢
EDAN Lincs [Ending Domestic Abuse Now]	➢	
East Midlands Ambulance Service		➢
Lincolnshire Integrated Care Board on behalf of GP Practice	➢ (X2)[2]	

[1] This IMR consists of children health (0-19) and children social care.
[2] Separate IMRs Bethany and Perpetrator

Lincolnshire Partnership NHS Foundation Trust	➢ (x3)[3]	
Probation Service	➢	
Salvation Army	➢	
United Lincolnshire Hospitals NHS Trust	➢	
Darren's School	➢	
Northern Lincolnshire and Goole NHS Trust	➢	
Derbyshire MARAC services		➢

Timescales

1.25 To ensure the review into the circumstances that led to the deaths of Bethany and DJ was dealt with in a timely manner, the panel have maintained momentum of the review whilst recognising the need for professionals to observe their agencies requirements in respect of the Covid-19 pandemic but has expedited the review to accord with best practice where possible to minimise delays to the process. However, the review acknowledges that inevitable delays have taken place and that health professionals have had to prioritise services both locally and nationally during the pandemic and the consequential effects thereafter. Also the delays that took place during the criminal justice process.

1.26 The review commenced in August 2021, and involved the completion of an extensive combined chronology, IMRs, a well-attended and extremely well received practitioner event. A practitioner event is widely used in CSPRs and adds a richness and depth to the review process, which it did in this case. This event was followed by a multi-agency IMR challenge day. This multi-agency IMR challenge day, which was also attended by the panel, provided an opportunity for all agencies present to challenge individual IMR findings. This helped the panel to resolve any discrepancies in what various agencies were reporting in their IMRs. After various versions, that the family were kept up to date and involved in, the final report was agreed by the panel in January 2023 and shared in detail for further comment by the family in March 2023. The family expressed to the review chair that they were moved by the extensive detail of the report, the findings and recommendations. They expressed their heartfelt thanks to the panel for all of their extremely hard work.

[3] This encompasses the services provided by the NHS Trust of; Perinatal teams, Steps2Change, Mental Health Teams, Criminal Justice Liaison and Diversion Teams.

Confidentiality

1.27 The findings of this review are confidential pending publication. Information is available only to participating professionals and their line managers from the participating agencies, the Home Office and the National CSPR panel. This matter has not been discussed other than in closed and minuted confidential meetings with appropriate representatives present or informed of progress in their absence. Other than the victims, pseudonyms are used in the report to protect the identity of other individuals involved.

Involvement of family and friends

1.28 Homicides are tragic not just for the family but also for friends, the school and work colleagues, and this review process has worked hard to include their respective thoughts and views throughout. In support of the information received from agencies, the author has engaged by meeting with the whole family on two occasions, and corresponding with the family of Bethany and DJ, in particular Bethany's mother and father, enabling them to feel integral to any learning that emerges.

1.29 The review author has maintained open communication channels for all contributions that both family, friends, and other relevant parties wished to make, and has kept them updated and involved them about the progress of the review process and individual drafts and findings of the report in full.

1.30 The Home Office DHR leaflet was sent to the family members in August 2021, and the letter that accompanied it also emphasises the opportunity to access an advocate (including the assistance of AAFDA) to support them in the DHR/CSPR process in voicing their views and feelings. The family has been supported throughout by advocates from the Victim Support homicide section, who also provided support for them throughout the criminal trial process. The family have also been supported by further advocacy provided by 'Be Their Voice.' This is the charity that was set up following the deaths of Bethany and DJ as a tribute to them to raise local awareness of domestic abuse.

1.31 Some of the views of the family has already been included at the very start of this report and it is not necessary to duplicate here. Other views are also included as appropriate throughout the report and not needed to be duplicated in this section.

1.32 The family spoke at length to the panel chair of Bethany's life growing up and how she became a teenage mother of DJ, and how she absolutely loved and was devoted to him. As were all the family. They also remained very close to DJs father.

1.33 Although Bethany moved around a little bit, she always remained roughly in the same area. DJ stayed at the same school and was taken firstly by a minibus and then when he moved to a Lincolnshire market town by a provided taxi to school. Bethany sometimes worked as a cleaner locally to where she grew up and where her mother and father lived.

1.34 The family also spoke at length about the perpetrator and how he not only treated Bethany and DJ in an abusive way, but how he was also extremely verbally and physically threatening to Bethany's mother, father and DJ's father. They felt that the quality of their lives in having the perpetrator involved in it, even against their wishes, was severely blighted by his presence.

1.35 The love and affection that the family had for DJ was palpable and the review panel chair had the overwhelming impression that DJ had a personality and charisma that people could only be subsumed with. The family said that the one person that DJ would never talk about was the perpetrator.

1.36 The family showed the panel chair a number of photographs of Bethany and DJ, but one in particular which they selected of the two of them together that they felt captured their relationship with each other.

Perpetrator and his family

1.37 The panel chair has also contacted the perpetrator's family to request their participation in the review but didn't receive a response. The perpetrator has been contacted in prison asking him if he wishes to engage with the review. The panel have received no reply.

Parallel reviews

1.38 The criminal investigation and subsequent trial at the beginning of 2022 caused some aspects of the review to be paused as is normal practice within the local DHR and CSPR processes. As mentioned earlier in this report, the perpetrator was convicted of the murders of both Bethany and Darren. The trial judge, Mr Justice Pepperall said, *"I take the starting point of 30 years but move significantly upwards in view of the many aggravating features. In my judgement, the appropriate minimum term after considering all of the aggravating and mitigating features of your case is 40 years."*

1.39 An inquest into the deaths of Bethany and DJ was opened by the Lincolnshire Coroner for identification following the referral by the Police of the deaths. HM Coroner has confirmed to the review panel that the cases have been suspended and closed following the prosecution and there will not be an Inquest in this matter.

1.40 The Probation Service have completed a Serious Further Offence Review and their findings have been included in the Probation Service IMR for consideration and inclusion in this review. The family have had the opportunity to consider the Probation Serious Further Offence findings.

1.41 NHS England have commissioned an independent investigation via the mental health homicide review process and have been working in parallel with the DHR and CSPR to prevent duplication for the agencies and the family.

Equality and diversity

1.42 The panel has scrutinised the IMR's and discussed the nine protected characteristics in accordance with the Equality Act 2010. Specific comment is made accordingly within the report narrative where appropriate in respect of those characteristics which are recognised as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

1.43 In this case, each of the subjects identify as being white and British by either self-defined identification, or, as has been determined by this review process. Any disabilities referenced herein are reflected within information provided by health practitioners and other professionals. The family of DJ wish to emphasise that although it must be recognised that he had definitive special educational needs, his physical health was good, his Autism Spectrum Disorder (ASD) which did not affect the family's care for him, as they adapted to make sure DJ knew he was cared for and he was always included and fully involved in family life.

1.44 DJ's ASD did, though affect how the perpetrator treated him, who showed a total lack of understanding and discrimination to DJ of the impact of his ASD. This will be highlighted later within the report. The review has however found that there was no recognition by any agency that any advice or awareness raising was given to the perpetrator on how to communicate with DJ or cope better in his relationship with him, even though he did describe to the family and professionals how challenging he found the experience of living with DJ.

1.45 Evidence has shown that domestic abuse is a gendered crime so applies to Bethany, and research supports the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. The Crime Survey for England and Wales in the year ending March 2020,[4] estimates that 5.5% of adults aged 16 to 74 years (2.3 million) experienced domestic abuse in the last year. This equates to a prevalence rate of approximately 5 in 100 adults. The latest prevalence estimates for all types of domestic abuse experienced in the year ending 2021, suggests no statistically significant change compared with the previous year of which 1.6 million were women and 786,000 were men, although it showed that

4 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/crimeinenglandandwales/yearendingmarch2020

women were more likely to be repeat victims of abuse and men are more likely to be repeat perpetrators.

1.46 The national homicide statistics (which are for all homicides and not specifically domestic homicides,) for the period ending March 2021[5], identified that the figures for homicide decreased by 12% from the previous year and masked different trends between males and females; the number of male victims decreased by 16% (495 to 416) whereas the number of female victims was the same as last year (177 victims). There were 114 domestic homicides in the year ending March 2021, a similar number to the average over the last five years.

1.47 Section 120 Adoption and Children Act (2002) extended the definition of 'harm', as stated in the Children Act (1989), to include 'impairment suffered from seeing or hearing the ill treatment of another'. Prolonged or regular exposure to domestic violence can have a serious impact on a child's development and emotional well-being, despite the best efforts of the victim parent to protect the child. The harm is caused by the person who causes the child to see or hear the ill treatment, which. is the perpetrator of the violence or abuse.

1.48 Domestic abuse is the most commonly cited factor when children are assessed by children's social care services to determine whether they need support. In 2015-16, there were around 222,000 episodes where domestic violence was cited as a factor. This translates into around 28 new episodes every week in every local authority in the country.[6]

Dissemination

1.49 This report and an executive summary have been prepared following the completion of the review process by the author and panel for consideration of publication in accordance with the policy of the Safer Lincolnshire Partnership and Lincolnshire Safeguarding Children Partnership. The report will be shared with the Police and Crime Commissioner for Lincolnshire, Lincolnshire Adult Social Care, Probation, Lincolnshire Partnership Foundation NHS Trust, Niche Consultants, EDAN Lincs, Lincolnshire Police, United Lincolnshire Hospitals NHS Trust, The Salvation Army, LCC Education, David Ross Education Trust, 'We Are With You,' LCC Children's Health, LCC Children's Services, NHS England, Lincolnshire Integrated Care Board, East Lindsey District Council, Lincolnshire Community Health Service and East Midlands Ambulance Service.

1.50 The author wishes to assure all parties that the decision to publish was made with due regard to the potential ongoing sensitivities specifically concerning those surrounding the development of Child A, as a survivor, and those others affected by this tragic event. The author also recognises the impact on the front-line professionals who attended the incident of May 31st, 2021, and those professionals who worked with the family including the Social Worker and DJ's school. The decision

5 https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2021

6 https://www.gov.uk/government/statistics/characteristics-of-children-in-need-2015-to-2016

made to publish this report was made by the Chair of the SLP and the Assurance Executive of the LSCP.

Section Two – The facts

2.0 Circumstances

2.1 At 20:29 hrs at the end of May 2021, the East Midlands Ambulance Service informed the Lincolnshire Police that they had received a call to report someone had been stabbed at an address in Lincolnshire and a male had run from the address shouting, *"Call an ambulance, call an ambulance. Someone's been stabbed."* A witness had gone to the address before the emergency services attended and noted the front door was ajar, they could hear a baby crying and saw the infant crawling along the entrance hallway. They entered the house and removed the infant to safety.

2.2 Police Officers attended and spoke with the witnesses who had flagged them down and shortly thereafter, the Police entered the premises where they discovered Bethany lying in the lounge area. Significant wounds were apparent and Officers commenced CPR. Other Officers discovered DJ in his bedroom, also with significant injuries, and despite best efforts of those first responders, both Bethany and DJ were pronounced deceased at the scene. The infant was unharmed and identified as being Bethany's youngest child, Child A.

2.3 It was apparent that both Bethany and DJ had been stabbed in what was a horrific attack. The Police commenced a murder investigation and a suspect was immediately put forward as being Bethany's former boyfriend (the perpetrator), and enquiries were commenced to locate and arrest him. He was detained the following day after attacking and injuring an off-duty Police officer who had attempted to arrest him.

2.4 The perpetrator was interviewed and denied the homicides but was charged with the murders of Bethany and DJ, subsequently pleading not guilty. He pleaded guilty to manslaughter part way through his trial process, citing his mental health and diminished responsibility, this plea was not accepted by the prosecution. He was convicted of the murders of both Bethany and DJ and other related offences. In February 2022, he was sentenced to life imprisonment. He was also made the subject of a further restraining order to prevent him contacting the family members of Bethany and DJ, either directly or indirectly by any means, including letter, phone, text and social media.

2.5 In passing sentence, Mr Justice Pepperall said the Perpetrator had subjected Bethany and her son to "*Abhorrent physical and psychological abuse*" and described him as a "*very dangerous man*" who took pleasure in inflicting violence. As he delivered the sentence of a minimum of 40 years'

imprisonment, the Judge said he had "*given anxious consideration*" to imposing a whole-life order due to the seriousness of the case.

Chronology-Key Practice Periods

The victims

The following section is provided as evidence of the lived experience of Bethany, DJ and the perpetrator.

2.6 Bethany was 26 years old and DJ, just 9 years old when they were murdered in such tragic circumstances. DJ was the child of Bethany who had been in a relationship with his father from 2010, and she had become pregnant with DJ aged 16 in 2011. They had mutually separated during 2014. There was no domestic abuse within their relationship or following their separation and they remained friends. Bethany had continued to live in the area and as a single parent, devoted her time and efforts to DJ.

2.7 DJ was diagnosed with Autism Spectrum Disorder (ASD) in 2014 and consequently was assessed as having special educational needs. He had difficulties in his social interactions and use of language. He attended a special school and had an Education Health Care Plan, with which he was reported to be doing well and was very settled. His school described him to the review chair as being keen to please, curious and he had a good relationship with his teachers and staff. Despite his needs he was a happy child and enjoyed being with his family. DJ saw his father as regularly as was possible which was of great value to DJ's development and his life. Other than his ASD diagnosis, DJ had no clinical needs as he was otherwise a fit and healthy child.

The perpetrator

2.8 The Perpetrator at one year old after living with his mother moved so that his father took over his care with his father's then partner who is known in this review as the perpetrator's stepmother (this is the title that Bethany knew her as and is called step-mum in statements). She has been the one constant in his life and when she split up with the perpetrator's father, the perpetrator remained with her. The perpetrator initially grew up in the Lincolnshire area before moving into the East Midlands area. He is reported as having had a particularly troubled childhood, having been frequently excluded from schooling due to his behavioural issues. His offending history identifies convictions for shop theft and handling stolen goods, but, from 2009 onwards, his offending became much more violent in nature, including two convictions for assault occasioning actual bodily harm and robbery, for which he received a substantial prison sentence. He has further convictions which include public order offences, racially aggravated harassment, being drunk and disorderly and burglary. His criminal record identifies that he has had several court appearances for breaching community-based sentences. He had moved back to Lincolnshire from Derbyshire in early 2019, shortly after his conviction for a domestic related assault on a former partner in late 2018.

2.9 The relationship between the perpetrator and Bethany commenced around March 2019, which is within a very short timeframe following the perpetrator's move back to Lincolnshire. They had

previously known each other when growing up. They found out through social media that they were living close to each other at that time, by the latter part of 2019 Bethany had become pregnant by the perpetrator. Child A, was born in August 2020, by which time the perpetrator and Bethany had separated as a couple but remained in contact with each other and for access by the perpetrator to Child A.

Key practice Periods

2.10 There are numerous contacts with agencies in respect of the subjects of this review. The author and the panel have considered all of those recorded and they consider that the following are four key practice periods of relevance to the terms of reference, given the voluminous nature of the chronology, IMRs and other information presented for review in this case.

Key Practice Period 1: November 2018 -November 2019

2.11 On November 25th, 2018, the perpetrator, who was at that time living in Derbyshire, committed an assault on his then partner. They had both returned home from a night out and the perpetrator inflicted a back injury to the victim taking hold of her and forcing her into a wall. The perpetrator had also picked up a knife during the incident but had dropped it on the floor. Fearful of further escalation, the victim waited until the perpetrator was asleep so she could safely leave and report the incident. He also seriously harmed a pet bird in the incident.

2.12 The victim of the assault had been in a relationship with the perpetrator since late 2017 and there had been one isolated argument prior to this incident in early 2018, when he had grabbed her by the throat. That earlier incident was unreported at the time. The November 2018 assault was referred to the local Derbyshire Multi-Agency Risk Assessment Conference's (MARAC.) The perpetrator was arrested, admitted the assault and was charged with battery. On the 12th of December 2018, he pleaded guilty to the battery and received a community sentence and a restraining order was put in place to protect the victim, which was effective until June 2020. A pre-sentence report identified that the perpetrator was at a medium risk of further offending and presented a medium risk of serious harm to intimate partners, particularly if they ended the relationship. The MARAC referral after assessment did not progress to a local Derbyshire MARAC meeting as per their local policy at the time.

2.13 The perpetrator, although reported as being reluctant and disruptive at his initial appointment with the Probation Service, completed his community order without incident. He was managed by the Derbyshire, Leicestershire, Nottingham and Rutland (DLNR) Community Rehabilitation Company (CRC).

2.14 In March 2019, the perpetrator disclosed to his Probation Officer at DLNR CRC that he was seeing a new partner who was a single parent and he was also staying with a friend that he referred to as 'Beth'. Both were in Lincolnshire. In mid-May 2019, he informed his Probation worker that he was now living with his '*new partner*' and named her as Bethany. He was now living outside of the DLNR CRC area, but his case was not transferred out. On the 29th of May 2019, Bethany is reported as accompanying the perpetrator by taking him to a meeting with his Probation Officer where the

resulting notes of the Probation meeting indicate that the perpetrator seemed to express difficulty in letting go of his former relationship with his previous partner in Derbyshire.

2.15 During June 2019, a Senior Probation Officer noted in supervision with the allocated Probation Officer that the management of the case needed to be transferred out of the DLNR area, given that the perpetrator was now resident in Lincolnshire. In July 2019, the perpetrator provided his Probation Officer with Bethany's address and her date of birth following a request by the Probation Officer. This also included details of her son, DJ.

2.16 By August 5th, 2019, the perpetrator's case management was in the process of being transferred to the Humberside, Lincolnshire and North Yorkshire Community Rehabilitation Company (HLNY CRC) and a 'caretaker' Probation Officer was appointed to support this transitional process between the respective areas.

2.17 The perpetrator failed to make his initial two scheduled appointments with the HLNY CRC and when the DLNR Probation Officer made efforts to contact him, the officer spoke by phone to a person identifying herself as 'Bethany,' who stated that the perpetrator was working and was unable to attend his appointments. Bethany assured the Probation Officer that the perpetrator would contact the service and she would take him to his next appointment.

2.18 During this conversation, Bethany disclosed that their relationship had ended three weeks previously (citing mid to late July 2019) but that they were still friends and she was allowing him to sleep on her sofa, rather than him being homeless. No warnings were given, or breaches of his order made, as the DLNR Probation Officer indicated that the perpetrator was probably 'in a low place' given his current circumstances.

2.19 The perpetrator attended his meeting with the HLNY area Probation Officer on the 21st of August 2019, when he confirmed that he was living at Bethany's home, but they were just good friends, he wasn't currently working and he was seeking his own accommodation. He disclosed that he believed that he had Asperger's syndrome.

2.20 The perpetrator then failed to attend his next appointment with the HLNY Probation Officer on September 2nd 2019, and the DLNR Probation Officer, who was maintaining the oversight and management of the perpetrator's case, attempted to contact him by phone but speaking on this occasion again to Bethany who stated that he was not available as he had a new job working in the arcades.

2.21 On the 18th of September 2019, the perpetrator attended the HLNY CRC office for a planned office visit where he stated that he was still staying with Bethany and that they were getting on well.

Key Practice Period 2: December 2019-November 2020

2.22 The perpetrator failed to attend his final Probation appointment on 3rd December 2019, and although action was considered for the breach, in supervision for the DLNR Probation Officer, it was agreed that it would not be in the public interest to proceed with enforcement action.

2.23 On the 11th of December 2019, the DLNR Probation Officer assessed the perpetrator as presenting a medium risk of serious harm to the public, known adults[7] and a low risk of serious harm to children. The Community Order ended on the 11th of December 2019 and the perpetrator was discharged.

2.24 On the 21st of December 2019, Bethany attended a pregnancy medical examination with a nurse practitioner at her GP practice. The examination notes identify that a co-partner was present throughout, although the partner is not identified. Bethany commented that she had been with her partner for nine months. She presented as being anxious and concerned and although no medication was prescribed, she was signposted to Steps2Change for mental health support services.

2.25 On the 29th of December 2019, Bethany contacted Lincolnshire Police to report an incident involving the perpetrator towards herself. An argument had started at her home when the perpetrator believed that Bethany was messaging someone else which he objected to. She had asked him to leave, he refused and she contacted the Police for assistance. In the interim the perpetrator left of his own accord, but Bethany had sought refuge at her parents' address nearby. The perpetrator then arrived at Bethany's parents address and began arguing with Bethany's father. The perpetrator again left prior to the Police attending.

2.26 Police Officers attended. A Police Protection Notice (PPN), which incorporates the Domestic Abuse Stalking and Honour Based Violence questions (DASH) and risk assessment was completed and identified that this was '*the first reported instance'* to Lincolnshire Police, between Bethany and the perpetrator. The PPN DASH risk assessment showed she was not aware of any previous domestic history involving the perpetrator. The narrative indicates that she had no concerns over controlling and coercive behaviour, there had been no previous violence between them, she was not frightened of further violence and that she was aware of the Domestic Violence Disclosure Scheme (DVDS.) The family know this as Clare's law.[8]

2.27 The perpetrator was not located or seen by the attending Officers; no action was taken against him and the matter was filed by the Police. The risk to Bethany (and DJ) was graded as standard which was agreed by a supervisory officer. The Lincolnshire Police practice for response to domestic abuse incidents, ensures that supervisory Officers triage risk assessments before submission to the Police Safeguarding Hub.

2.28 The supervisor mentioned in their summary for this case, that they had considered the use of DVPN, MARAC and EDAN Lincs[9] referrals, but based on the information provided from the attending Officer they were not necessary on this occasion. This they felt was because this was the first incident between them, there was no violence, no previous abuse history between them and they

[7] This is the classification as per Probation OASys risk assessment tool.

[8] 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.

[9] Domestic Violence Protection Notice, Multi-Agency Risk Assessment Conference, EDAN Lincs, Ending Domestic Abuse Now.

were living apart, Bethany had good local family support and communications. It was noted that Bethany was ten weeks pregnant and that the perpetrator was the father of the unborn child. A referral was made to Children's Services given that Bethany was pregnant and DJ was present at the time of the event.

2.29 On the 30th of December 2019, Bethany attended an antenatal appointment on her own. The perpetrator was named by her as the father of the unborn child. No disclosure was made by Bethany of domestic abuse, although there had been the incident of the previous day and she was asked by the midwife about domestic abuse.

2.30 Children's Services social care team first became aware of the family on the 7th of January 2020, following information received from Lincolnshire Police concerning the incident on December 29th 2019. Bethany was reported to be 10 weeks pregnant at the time. The incident was logged for information in line with procedures due to the incident being graded as standard risk and being the first notification of domestic abuse received by the social care team.

2.31 On the 17th of January 2020, the perpetrator consulted with a GP raising the issue that he was concerned that he suffered with Asperger's traits. He had been missing mental health appointments and he thinks he needs a support worker. He feels he is not in contact with reality and is angry all the time. The GP records indicate that he sounded and looked very anxious. He said that he was single and expecting a child but was living with his stepmother. Medication was prescribed and he was referred to the Community Mental Health Team. The GP noted that he had been given a referral form to Steps2Change[10] in October 2019, but the patient had not contacted them or in fact been referred to the team. The perpetrator was referred to the Community Mental Health Team on the 22nd of January 2020, by his GP for assessment.

2.32 On the 21st of January 2020, Bethany saw her GP as she was concerned with her personal mental health, stating that she was single and living with her 8-year-old autistic son. Bethany was referred to Steps2Change. She was 11 weeks pregnant at that time. No mention of the father of the unborn child was recorded on the notes or domestic abuse enquiry (The IMR author states: that a Routine enquiry by GPs regarding domestic abuse is not recommended, however it is recommended that they should explore a patient's home situation if they present with mental health and anxiety related symptoms. This occurred in this consultation.)

2.33 On the 27th of January 2020, the perpetrator contacted the Community Mental Health Team (CMHT) as he was not happy with the waiting time for assessment. He spoke about wanting to be diagnosed with autism, stating that he felt his anxiety comes from feeling as though he has autism. Staff asked the perpetrator about any risk to himself which he denied, although his relationships were not explored. He was informed that the CMHT does not diagnose autism.

[10] Service provided by the LPFT Trust for a range of talking based therapies for conditions such as depression, anxiety, panic attacks, OCD, phobias.

2.34 On the 28th of January 2020, Bethany attended for a pregnancy ultrasound appointment. On this occasion she was accompanied by the perpetrator. Routine domestic abuse enquires were not made due to the patient's partner being present.

2.35 On the 17th of February 2020, the perpetrator was assessed by the CMHT. The outcome was that he would be allocated a Community Psychiatric Nurse (CPN) and be referred for an autism assessment from the Trusts Autism Diagnostic and Liaison Service[11], although that referral was not made at that time.

2.36 On the 18th of February 2020, the GP spoke with Bethany and re-referred her to Lincolnshire Partnership Foundation Trust (LPFT) on the 19th. This referral was forwarded to the Community Mental Health Team by Single Point of Access (SPA) who forwarded the referral to the perinatal team, in view of her pregnancy and it being the optimum team to triage her needs.

2.37 On the 25th of February 2020, a telephone call was made to the perpetrator at his request by the Community Mental Health Team. The record indicates "*He was noted to be incoherent & would go off on tangents, reported experiencing some paranoia.*" He also stated that he was *currently* living with his girlfriend who was pregnant. Initially he was noted to be guarded when staff asked about this further but he did inform staff that she was four months pregnant and gave her address. He stated to them that he didn't want the address to be "*widely shared.*"

2.38 On the 4th of March 2020, in a telephone call with the perinatal team, Bethany reported experiencing low mood when DJ was born. She also reported that she'd recently separated from the perpetrator and since this, had felt her mood had deteriorated. There was no obvious risk for the unborn child and overall, she seemed to be excited about her unborn baby arriving. She was seen by the perinatal team on the 6th of March and was assessed to not meet criteria for perinatal support and was advised to self-refer for Cognitive Behavioural Therapy.

2.39 On the 18th of March 2020, the Community Mental Health Team contacted the perpetrator by phone, he informed the service that he would not be attending his appointment the next day. It was recorded that he accused staff of not providing him with a crisis service and that if he'd become unwell, he would have "*been hung out to dry*." The caller reinforced that support was being offered and tried to keep him engaged with his appointment to be able to identify the most appropriate support for him. It is not clear why the perpetrator was so animated on this occasion. He subsequently did not attend the appointment and did not answer telephone call from the service on the 23rd of March.

2.40 On the 11th of April 2020, it was noted that the perpetrator had not attended any of his planned appointments since assessment with the local Community Mental Health Team. The Trust discharged him from the service in view of his failure to attend, which was in line with policy and practice for service users who failed to engage.

[11] Pathway service that makes assessment of Autism, Asperger's Syndrome and Atypical autism.

2.41 On the 30th of April 2020, Bethany had a telephone consultation with Steps2Change, with whom she had self-referred. Bethany reported that she had no self-confidence, people judged her, and she was critical of herself and her appearance. She was tending to isolate away from others, but that she felt better when her partner, details of whom were not asked, was with her.

2.42 By the 15thof May 2020, Bethany had received Cognitive Behaviour Therapy (CBT) on two occasions from mental health services, sought and was prescribed by her GP anti-depressant medication. Her antenatal appointments were all attended. There was no reference to the perpetrator and there were no specific questions put to Bethany in that respect, however she was asked by maternity services on 12 occasions about domestic abuse, which she denied.

2.43 In August, Bethany gave birth to Child A. Her 'birth partner' was her mother.

2.44 On a home visit by Midwifery, the perpetrator was present and no domestic abuse questions were asked of Bethany for that reason, and no concerns were raised by the midwife arising from the visit. Bethany was discharged from Midwifery services later on in August where it was noted that the support around her was from family.

2.45 On the 15th of September 2020, a message was left for Bethany asking her to make an appointment for her mother and baby 6-week checks with a GP and to book for immunisations for Child A. In line with the GP practice policy three further calls were made but there was no response from Bethany.

2.46 On the 23rd of September 2020, Bethany attended for a child development assessment. During this visit the professional asked her about domestic abuse directly and Bethany raised no issues. Signposting was provided to support services and Bethany was encouraged to access this if she felt it was necessary. Bethany was asked about her partner and she stated that she had been in a relationship with him for a year, he was supportive.

2.47 On the 30th of October 2020, in a telephone call to the Crisis Resolution and Home Treatment Team, made by the perpetrator, he stated that he "*was a violent and aggressive person and needed the writer to log him on the system and get him a sedative"*. Staff noted that they tried to ascertain the reason for the call and he was noted to be "*challenging," "terse" & "needed to speak to a superior*." He was advised to seek support from his GP, but he declined stating that he was not physically or mentally unwell and he terminated the call. As he terminated the call the team was unable to establish other personal details.

Key Practice Period 3: November 2020- 17th February 2021

2.48 On the 6th of November 2020, Bethany moved with DJ and Child A to another area of Lincolnshire. Within her witness statement following the assault on her by the perpetrator on November 24th, 2020, Bethany states, "*We moved into a private rented house on 6th of November 2020 and [the perpetrator] comes to stay with us now and then. He chooses to come just at weekends when my elder son is with his dad. Things were initially better between us but then things have deteriorated and we have been arguing a lot recently about Darren and his autism."*

2.49 On the 10th of November 2020, at school, DJ disclosed that the [perpetrator] "*pushed mum over, said swear words*". Staff asked DJ what happened at home and he responded, "*Mum fell down. Mum is upset* [the perpetrator] *was shouting loud and made [Child A] upset*". This disclosure was not shared by the school at that time.

2.50 On the 21st of November 2020, Darren was present at a domestic abuse incident, which didn't involve Bethany or the perpetrator. Appropriate referrals were made to children's services. On the 22nd of November, an anonymous call was made to children's services expressing concerns and a similar call was made to DJ's school the following day. However, the caller also added concerns about DJ's '*stepdad,'* naming the perpetrator and that he "*wants to get rid of Darren and calls him freaky."* The school shared the information with children services (children services records do not include the words '*get rid of him.*') The information held by children's services also contained information from the school, dated the 10th of November concerning the disclosure by DJ that '*Mum's partner pushed her and made [Child A] cry'.*

2.51 Following a review of this information by Children's Social Care, on the 23rd of November 2020, a Child in Need (CIN) process was opened. This CIN process was focused on safeguarding the children from experiencing domestic abuse.

2.52 On the 24th of November 2020, Bethany attended her local Police station and was followed closely by the perpetrator. She was distressed and stated that he had assaulted her and she wished to make a complaint of assault. The allegation was that the perpetrator had dragged her off the sofa and banged her head against the wall, causing swelling. Bethany's injuries were consistent with this. The perpetrator was arrested, admitting the assault. He claimed that he was trying to do a lot of jobs in the house and Bethany was just criticising what he was trying to do, he added that Bethany just viewed him as a part time Dad to their 4-month-old child and only wants him to come around at weekends which upsets him and concerns him in terms of the bond he is building with his child. The perpetrator also cited the difficulties that DJ causes him when he is there and the perpetrator says he feels bullied by DJ. DJ was not present during the incident.

2.53 The perpetrator was not charged but bail conditions were imposed, to prevent him from having contact with Bethany and he was referred to the Criminal Justice Liaison and Diversion Team. Having been referred, the perpetrator was assessed and was identified to have mental health needs as well as accommodation needs. During his assessment in custody, he was noted to have "*erratic"* thought processes and pressured speech. He was also noted to be tearful but smiling at the same time and "*went in-between moods throughout*." He stated that his "*negative thoughts are too easily triggered."* During the Police interviews he was supported by an appropriate adult.

2.54 A Police Protection Notice (PPN) containing the DASH risk assessment was shared with partners. The PPN DASH appears to have acknowledged that Bethany was aware that the perpetrator had been violent to a previous partner as she commented, "*I know that he strangled a previous partner because he told me."* There is no indication that she was signposted to the DVDS, although she had on a previous occasion, which was the previous year.

2.55 On the 30th of November 2020, Bethany was visited at her home by a Social Worker. No concerns were noted regarding the home environment or care of the children. Bethany stated that her relationship with the perpetrator had ended but she was unsure if she wanted to pursue any charges against him. Bethany accepted the offer of a referral to the domestic abuse support service EDAN Lincs and agreed to a safety plan that she would not allow the perpetrator into the property and would call the Police should he come to the house. Bethany said she had support from her mother.

2.56 On the 5th of December 2020, the perpetrator arrived unannounced at Bethany's home accompanied by his stepmother and asked to see Child A. Bethany told a Police officer later that she felt coerced to allow him to enter her home and did not report this to the Police and was contrary to her agreed safety plan with the Social Worker.

2.57 On the 9th of December 2020, Lincolnshire Police received a call from Bethany that the perpetrator was threatening both herself and her mum. She reported there had been a long argument lasting over three hours concerning where Bethany's children will live. This argument had come to a head and he had become violent and aggressive, culminating in the perpetrator assaulting both Bethany and her mother. The perpetrator was arrested and when interviewed denied the allegations of assault but admitted that he did raise his voice to both Bethany and her mother. The PPN DASH risk assessment graded the risk as medium.

2.58 In an assessment with the Criminal Justice Liaison and Diversion Team (CJL &D) on his arrest the perpetrator was noted to be erratic in his thought processes and mood swings, unable to identify how he was feeling. The arrest was noted as being "*similar to the last referral on the 24/11/20*." The perpetrator stated that he felt "*like my emotions are setting fire to my chest*" and that he believed "*his partner's family have reconditioned me to feel a certain way*."

2.59 The team made the recommendation to the CMHT on the 10th of December 2020, that `he should be seen urgently due to his "*presentation being consistent over a period of time, possible paranoia and possible risk to his ex-partner*". The summary was that it was viewed that the CMHT would have the opportunity to meet with him over a longer period and that this would be the most appropriate course of support for him. The CJL&D Team contacted the Trust Safeguarding Team due to concerns around the perpetrator's risk to his ex-partner on the 11th of December 2020. This was in recognition of the perpetrator's risk to his ex-partner and children.

2.60 In Bethany's witness statement, dated 9th December 2020, the perpetrator is quoted as saying to her, "*You can't cope with two kids, you can't cope without me*" and he also states, "*I am going to have to go and live in a tent, if you get me arrest[ed] I will come back for you and your family".* Also, and aimed primarily towards Bethany's mother, but against them all present, *"If anything happens, I'll come for you."* These are demonstrative threats made by the perpetrator, but even in isolation at the time of the statement, they are an apparent indication of his coercive controlling behaviour and are of concern, considering the perpetrator's history and the short period of time between the recent events.

2.61 The decision taken by the Police was that the perpetrator would be released on bail without charge (under investigation) with the same bail conditions[12] as were imposed on the 24th November, not to contact Bethany, not to attend her address, and not to enter the town she was residing in and any contact with his child was to be arranged via a third party. His bail was set for 29th of January 2021. A file was prepared for review by the Crown Prosecution Service for charging advice.

2.62 On December 10th, 2020, EDAN Lincs received a referral for Bethany from Lincolnshire Police.

2.63 On the 11th of December 2020, the perpetrator had a face to face appointment at his GP practice. During the GP's examination he became verbally abusive, aggressive, and left. In the afternoon, he attended this time with his stepfather for mental health symptoms and was referred to a psychiatrist. No mention was made of his arrest two days previously to the GP.

2.64 On the 12th of December 2020, Bethany called the Police to report that the perpetrator was currently outside of her address in a car and had been banging on the front door, thereby in breach of Police bail conditions. The car belonged to his stepmother. Police Officers attended and found the perpetrator in the rear garden of Bethany's property. He stated he could not take the impact on his mental health of not seeing his child anymore and had gone to ask Bethany to let him see Child A. He stated to Officers that he had done the same the previous week and Bethany had let him stay the night on that occasion, so he thought she would do the same again. Officers found that he had a large holdall packed with personal belongings with him.

2.65 The Officers told the perpetrator that he was breaching his Police bail, he was taken back to his stepmother's address where he had been temporarily residing. Bethany confirmed to the Officers that she had let him stay for a night during the past week, as when he turned up, she felt sorry for him, but that afterwards she realised this was a mistake as he tried to "*worm his way back in."* No statement was taken from Bethany.

2.66 The Police IMR comments that other than a breach of Police imposed bail conditions the perpetrator had committed no offences. It was noted however, that Bethany declined to answer the PPN DASH risk assessment questions as she said there was '*no change from those that she had provided 3 days previously*.' The PPN DASH risk assessment was graded as being standard even though there had been the incident a few days earlier. The PPN DASH referral from the incident three days earlier was shared with Children's Services.

2.67 On the 14th of December 2020 in a telephone call between the perpetrator and the CJL&DT, it was noted that the perpetrator was distressed and he stated that he *"spends hours getting lost in his thoughts"* and it was *"breaking me"* but denied thoughts to harm himself when asked. The focus was that his 'on/off partner' won't allow him contact with his five-month-old child. He stated that he had breached his bail conditions by standing outside the home watching his child until the Police were called. He stated, "*she is going to make me a weekend dad."* He was also concerned about the impact of his "*on/off "* partner's 9-year-old son's behaviour, stating that he has ASD and displays

[12] Police are unable to vary the previously set bail conditions unless the subject is charged with an offence.

behaviours such as hand biting and constant crying. He voiced *"I am going to lose my child to the environment he is in."*

2.68 On 17th of December 2020, Bethany had a telephone conversation with an officer from the Housing Benefit department. The case notes for this contact states that Bethany had struggled to get change of address forms submitted as she has been having a bad time in an abusive relationship.

2.69 On the 20th of December 2020, the CIN plan was commenced, having been agreed on the 13th of December. There appears to be no mention within the meeting plan that identified the incident of December 12th 2020. The PPN DASH concerning that most recent incident had been referred to Children's Social Care, although it is possible that delays may have prevented records being updated. A CIN review date was set for a six-week period as 23rd February 2021.

2.70 Bethany spoke to the EDAN Lincs caseworker on December 21st, 2020, for pre-assessment, and during this process it was graded as tier 3 (Medium Risk Cases, with indicators of potential high risk). The triage worker recorded that there was an element of disguised compliance by Bethany on the pre-assessment record. This was due to the conflicting information provided on the referral from the Police and what Bethany was saying.

2.71 It is further recorded by them that Bethany recognised that DJ had witnessed some of the domestic abuse incidents, although she stated there had been no changes in his behaviour. Bethany had stated the arguments had increased recently with the perpetrator, due to him wanting DJ to go to his father's to live temporarily. Bethany had disagreed with this and was seeking advice around her options in respect of Child A. The option of seeking advice from a solicitor was encouraged around Child A. Safety advice was given, and the service noted that bail was in place, and as they had separated, they lived separately, so the perceived risk to Bethany was reduced from the perpetrator. Bethany was signposted to mental health services as she had indicated some high level anxiety during the pre-assessment. Follow-up contacts were made by EDAN Lincs over the next few days, but there was no further engagement and the case was closed to EDAN Lincs on the 11th of January 2021.

2.72 On the 22nd of December 2020, EDAN Lincs raised with Children Services what they described as "professional curiosity" due to the conflicting information provided by Bethany to that which was recorded on the most recent PPN DASH received by their service on the 10th of December. The referral of the 9th of December incident indicated that there had been a breach of the bail conditions "*which the client allowed*." Bethany stated that there hadn't been any breaches of bail conditions and that there had only been one incident, but on the referral, it stated that there have been "*a few other previous incidents."*

2.73 On the 3rd of January 2021, Bethany contacted Lincolnshire Police on two occasions to report that the perpetrator had been outside her address shouting at DJ's father, who was returning DJ home. She stated that she had let the perpetrator into the house in order to see Child A. There had been an argument outside of the house between the two men before the perpetrator left. Whilst the Police attended the address, the perpetrator had returned but left before the Police could apprehend him.

2.74 Also on January 3rd of 2021, the perpetrator attended an urgent treatment centre asking to see "*the cleverest person*" available because of his mental health. He was seen by a health professional whom he informed that his ex-partner brought him back to the area and that he stayed with her overnight, however, she had called the Police and told them he had done something that he hasn't done. The perpetrator was asking to be "*put on the screen to show he has been to department."* He left without assessment.

2.75 The perpetrator was arrested on January the 3rd at his stepmother's home address for the earlier breach of Police, post charge bail conditions but also for assaulting his stepmother and stepfather, after he had returned to the premises drunk and started an argument with them. His step-parents declined to make a complaint of assault following his arrest, and the Police IMR indicates that there was insufficient evidence to proceed without their evidence. The Police did, however, keep the perpetrator in custody overnight in relation to the breach of bail where he was put before the next available court, January 4th, 2021. A PPN DASH risk assessment of medium risk, concerning the assault on his stepparents was raised, noted as being the first incident involving him and them. The PPN DASH in respect of Bethany was shared with Children's Services.

2.76 In her statement of January 3rd, 2021, Bethany spoke of her fear of the perpetrator and that she had permitted him to see Child A.

2.77 On the 4th of January 2021, the perpetrator was dealt with at the Magistrates' Court for the assault that occurred on the 24th of November 2020, having entered a plea of guilty. The perpetrator was granted bail by the court to re-appear on January 12th, 2021, for sentencing. He was subject to bail which included conditions not to contact Bethany or go to her address. As his parents refused to allow him to their home, the perpetrator went to a Salvation Army shelter immediately, where he was reported as being distressed but where he was given temporary accommodation from January 6th.

2.78 On the 11th of January 2021, the court Probation Officer (National Probation Service) carried out safeguarding checks for a pre-sentence report for the perpetrator's next court appearance. It was ascertained that Bethany's children now had a Social Worker. As well as predictive risk tools, identifying that the perpetrator was in a high percentage category of reoffending, the assessment identified that as he had failed to adhere to his bail conditions, and there had been several Police call outs during December 2020 and January 2021, risks were further elevated. In addition to those factors, it was apparent that the perpetrator was not willing to accept that the relationship was over. The perpetrator had expressed negative attitudes towards DJ, blaming the child for the problems in his relationship with Bethany. The Probation Officer provided information regarding those safeguarding concerns and risks in relation to Bethany's children to the Social Worker involved.

2.79 On the 12th of January 2021, the perpetrator re-appeared at the Magistrates' court and having previously pleaded guilty to the assault on Bethany, he was sentenced for assault by beating to a 24-month Community Order with an accredited programme (Building Better Relationships) and a 20-day Rehabilitation Activity Requirement. At this appearance he was also made subject to a

Restraining Order, which was enforced as active until 11th of July 2021 and prohibited him from contacting Bethany directly, or indirectly, other than through a third party for child contact (for Child A) and not to go to her address. This sentence was in respect of the assault of November 24th, 2020, not the more recent incidents which remained under investigation awaiting advice from the CPS.

2.80 In a HLNY CRC Probation Service meeting held with the perpetrator on 19th of January 2021, it was clarified that he was living in temporary supported accommodation and had no current work but was actively seeking employment. His relationship with Bethany had ended and there was a restraining order in place. It was also noted about the concerns for his mental health and his anger management issues. He was under the Community Mental Health Team.

2.81 On the 25th of January 2021, in contact with a health visitor, Bethany stated that she no longer had any contact with the perpetrator and a restraining order was in place. Bethany shared that she did have an EDAN Lincs worker, although she wasn't currently working with the service but was aware of the contact number, but she had good support from her mother and that she also has a Social Worker. Bethany stated she was actively looking to move home to be nearer to DJ's school.

2.82 On the 28th of January 2021, in a telephone call between the Social Worker and the perpetrator, he stated that he had broken his bail conditions six times and only on one of these occasions did he go to Bethany's house. The rest of the time Bethany collected or met him. He said he asked for the restraining order as he needs to be in a better place, but commented that he did not know why she has not talked to him since the restraining order and said he felt she has two possible agendas "*She thinks that I will kidnap my child, as I have a right to my child as I am [their] father. or she is going for abandonment so she does not have to let me see [them].*" He stated that in the future he would like to have mediation and see his child and that he has done some reading and has been a psychology student for a *few years so is aware of the importance of child attachment and he want to be part of that. He blamed "Bethany for starting arguments and that Bethany's mother was possessive and to blame for all this"*, "*she started all of this*". When asked about DJ he responded", *"No comment, I need to be in positive place to discuss him."*

2.83 On the 29th of January 2021, the perpetrator answered his bail. He was charged in respect of the incidents of December 9th, 2020, and bailed to appear at the Magistrates Court on the 17th of February.

2.84 On the 2nd of February in a telephone conversation with the community mental health services, the perpetrator reported that he felt that he had got a positive outcome from court, the presumption being a reference to the incident of the 24th of November 2020, although he was concerned that his ex-partner and her mother were going to try to stop him from seeing his child and that they'd tried to accuse him of "*other silly thing which were thrown out'.* He stated that he has not been in contact with his ex-partner and "*has not fallen into the trap of her making out she needs him,"* so she can then report him. He had completed the initial assessment form for his autism assessment and put this in the post.

2.85 On the 4th of February 2021, EDAN Lincs notified Lincolnshire Police that Bethany had declined domestic abuse support. On the 10th of February 2021, Probation completed the risk assessment, risk management plan and initial sentence plan for the perpetrator for his existing court order.

2.86 On the 11th of February, the Social Worker met with Bethany and her mother and a Family Network Meeting was held. They discussed the recent breach of the safety plan. Bethany stated that she regretted allowing the perpetrator into her property and she will not allow this to happen again, she stated the relationship was "*definitely over*."

2.87 On the 16th of February 2021, at the Salvation Army hostel, the perpetrator spoke to his key worker and asked to use the phone to speak with his GP. He seemed very stressed and agitated and it was clear he was becoming anxious about his court appearance the following day. He was also getting stressed about not seeing his child and stated he thought about killing himself to teach his ex and her mum a lesson as he thought that they would have to explain that it's their fault if he did so.

Key Practice Period 4: 17th February 2021- May 2021

2.88 On the 17th of February 2021, the perpetrator appeared at the Magistrates Court in respect of the two assaults committed on 9th December 2020, on Bethany and her mother. He was sentenced to a further 24-month Community Order with the same Building Better Relationships requirements that he had been sentenced to on 12th January 2021. The pre-existing Community Order was fully revoked and replaced with an identical Order, to expire on 16th February 2023. No pre-sentence report was ordered by the Court The Court also imposed a further Restraining Order prohibiting any contact whatsoever with Bethany, only that he was allowed child contact via a 3rd party with the Order to run until the 16th of August 2021.

2.89 On the same day the 17th of February 2021, DJ's paternal grandfather contacted Lincolnshire Police to report that the perpetrator had approached him at a local bus stop and had been verbally abusive towards him, but what concerned him was that the perpetrator stated, "*you do something or I'll do it,"* in relation to DJ allegedly waking the perpetrator early in the morning. The grandfather was concerned that the perpetrator was possibly back in Bethany's home.

2.90 The Police conducted welfare and safeguarding checks, visiting Bethany and the children. The Officers were satisfied that she had not seen or heard from the perpetrator since he was issued with the Restraining Order. Bethany was advised to contact the Police as soon as she had any issue or contact with the perpetrator and was provided with stay safe advice. A PPN in relation to DJ was not submitted in respect of the incident. Lincolnshire Police had no further record of contact with the victims, perpetrator or families from that date until the date of the murders.

2.91 On the 23rd of February 2021, a Child in Need Review meeting was held via 'Teams' and was attended by Bethany, her mother, and the children's Social Worker. DJ was reported to be happy and no further disclosures were made about domestic abuse. Safety plan to remain in place.

2.92 On the 25th of February 2021 an induction meeting with the perpetrator post-sentence was held by phone with a Probation Officer. The Probation Officer noted concerns over his use of language

during the conversation. The perpetrator stated that he was not in a current relationship and had fully admitted the offence on Bethany and was open to Probation supporting him and wanted the restraining order. Also, on the 25th of February, the Salvation Army night concierge noted how, on a number of occasions recently, the perpetrator was returning to the shelter under the influence of alcohol and that his mood was also very low.

2.93 Also on the 25th of February in an email to the Local Authority housing team concerning his application for accommodation the perpetrator indicated within the email, these two relevant quotes: "*I have a child." "I've fought tooth and nail already to stay in their life, your system and your opinion will not change the course of my future in my child's life*."

2.94 On the 4th of March 2021, in a face to face appointment with the Community Mental Health Team, the perpetrator voiced an opinion that he felt as though he was thinking too much about the future and struggled to know what path to take. He stated that he was not 'getting into any issues with his ex-partner,' although he does miss his child. The narrative indicated that he "*wants to work with services as his ex-partner involves him in situations that get him mixed up and not able to think straight which has caused him problems as her family don't like him and make it harder, he states for his ex to see his point of view."*

2.95 On the 5th of March, the perpetrator had telephone contact with the Probation Service, no concerns were raised. In further contact with his Probation Officer by phone on March 10th, the Officer noted that the perpetrator had had no contact with his child but had spoken to the Social Worker. Review of risks was to monitor his drinking and relationship status and encourage and motivate him to engage with mental health services and access all relevant treatment services.

2.96 On the 11th of March, staff at the Salvation Army hostel raised a concern from the Chaplains about the perpetrator's mental health, in particular the 'very real threats' he was making regarding his girlfriend's family and her older son's family. He said in the following relevant quotes that they were *"all wicked"* and there *"wasn't a good one among them."* He said that *he has things to sort out and "line up" in his mind, then, if they are still the same, he will kill the 'whole blood line*."

2.97 The Salvation Army IMR states that on the same day a Police Officer was attending the centre on another matter. Staff consulted with the officer indicating their concerns about the comments made by the perpetrator. The officer advised that people made threats all the time and it did not mean they would carry them out. Staff seemed re-assured by that response and took this no further. No referrals were made concerning this information and the Police IMR author has carried out research and can find no trace of any officer visiting the centre at this time.

2.98 On the 16th of March 2021, in a face to face appointment with the Community Mental Health Team, the perpetrator discussed his childhood and how he'd entered into a positive relationship but had destructive behaviours as he was "*unable to cope with the relationship due to limited life experience of positive relationships".* He reported that the relationship broke down in January 2021, due to *"strain placed on the relationship by his partner's son, who has ASD, and his biological father."*

2.99 On the 24th of March 2021, a CIN meeting was held via Teams - Bethany, the children's Social Worker and school contributed through information that the Social Worker had obtained by contact with them. There was a discussion concerning contact between Child A and the perpetrator. Bethany stated she would not initiate any contact as that was up to the perpetrator, but she agreed that it needed to be supervised and not by family members because of the restraining order. On the 29th of March, the issue of whom could facilitate and supervise visits was discussed between the Children's Social Worker and Probation. Probation was given, the date of the next CIN meeting and confirmed that a representative would attend.

2.100 On the 8th of April 2021, a home visit was made to Bethany by the children's Social Worker. Bethany stated that she had heard nothing from the perpetrator and she felt that things were going well for her and the children. She discussed about not wanting Child A to have contact with the perpetrator as there was no one suitable to supervise the contact. She expressed concern about the perpetrator coming to her home as he did not get on with DJ. The Social Worker gave her suitable advice.

2.101 On the 12th of April 2021, the Steps2Change [13]records indicate that the only risk identified was that which the perpetrator presented about himself during the telephone assessment. He reported he wasn't good at communicating with others on emotional levels and that *"happiness scares me."* He stated that he felt, *"frustrated, angry, anxious, down, low, depression and numb"* and that he'd been feeling this way all his life. Although a child safeguarding screening tool was completed and was based on what the perpetrator disclosed. There was no evidence of a child protection enquiry nor any acknowledgment that the child was open to children's services.

2.102 On the 13th of April 2021, in a risk assessment completed with the Community Mental Health Team in an outpatient's appointment and completed by an advanced practitioner, the perpetrator denied being any risk to himself or to others and was summarised as being of no homicidal or suicidal risk at that time. He was showing self-evidence of presenting better than previously.

2.103 On the 30th of April, in a planned appointment with his Probation Officer, there was some downturn in the perpetrators emotions in that he alluded to being down as he was not able to see his child and had not heard from social care in that respect. He had been offered cognitive therapy but had declined, although the Probation Officer encouraged him to take this offer up. The Probation Officer emailed the Social Worker asking if contact had been made with the perpetrator by Children's Social Care.

2.104 On the 5th of May 2021, the Probation Officer spoke to the perpetrator who was sounding *"very flat and tired"* but confirmed that he had heard from the Social Worker, but that his phone had failed and he was awaiting further contact. The Social Worker had sent an email to the Probation Officer on May the 4th confirming contact with the perpetrator had been made but would take place on another occasion due to his phone not working.

[13] Steps2Change (S2C) provides a range of evidence based talking therapies for problems such as depression, anxiety, post-trauma reaction, panic, phobia, and Obsessive-Compulsive Disorder (OCD).

2.105 The next CIN meeting took place on the 7th of May 2021, but at this point the perpetrator was not aware of that fact as contact did not appear to have been made with him by the Social Worker. The Probation record indicated *"The attempts to contact him by the Social Worker have been fraught with difficulty."*

2.106 On the 7th of May 2021, the Building Better Relationships (BBR) Treatment Manager's assessment was that the perpetrator was possibly not suitable for the BBR programme as it was thought that he did not have the ability to cope in a group environment and the integrity of the programme's design meant that it could not be delivered on a one to one basis.

2.107 By the 11th of May 2021, it was apparent that the perpetrator has become increasingly frustrated with not seeing his child and the Probation Service noted that he had demonstrated his frustration in contact with the children's Social Worker the previous day. There is no corresponding record within the Children's Social Care records concerning the communication with them by the perpetrator. It was apparent that the perpetrator was becoming increasingly frustrated with what he perceived to be a lack of progress to enable him to see his child. The Probation Officer took steps to seek progression for the perpetrator's requested autism assessment with an anticipated waiting time for assessment of 18 months.

2.108 On the 14th of May the perpetrator contacted Steps2Change and spoke to an administration officer and expressed that he needed "*urgent support*". He was noted as being unhappy and the record indicates that he "*started speaking various different words without purpose*." The administration officer, who was not a clinician, suggested that if his need was urgent that he should dial 999, but he then said it wasn't that urgent but felt that if he continued in this way, he would not be capable of commencing his therapy. The administration officer had no previous knowledge of the caller but signposted him to urgent services. The information concerning the call was immediately passed to a clinician by the administration officer who was concerned about the nature of the call. Contact with the perpetrator was attempted on a few occasions by a clinician, but there was no response from the perpetrator. A letter was then sent to him inviting contact.

2.109 On the 18th May a further CIN meeting was held virtually by Microsoft 'Teams'. Bethany, and the Children's Social Worker attended. The school attended for the first time. Although there was a discussion at both the practitioner event and the IMR presentation day, about when the school first became aware of their being in place a formal CIN plan for DJ, it is fair to say that the Social Worker did obtain information from them to assist the CIN meetings. Bethany reported that she had not had any further contact from the perpetrator. There were no plans in place for contact between the perpetrator and Child A but Bethany was aware that he did want to see Child A.

2.110 On the 27th of May 2021, in a planned office visit with the Probation Service, the perpetrator was reported as being frustrated about his accommodation as he wanted somewhere that he could see his child. He wanted to impress that *he* was a good father, *whereas*, his ex-partner was always on her phone, inferring she was not attentive to his child. He also expressed unhappiness about the Social Worker stating that he was a risk to his child and was against him having contact with his child

and that all he wanted to do was to see Child A. When asked about Bethany he stated that he was not bothered about her and said he knew the relationship was not good.

2.111 The Probation Officer was concerned about how he presented and for this reason contacted the Salvation Army to check on how the perpetrator had been whilst residing there and if there were any concerns. The response to Probation from the hostel was that there were no problems in relation to his residing there, he was quiet and it was recorded that there had been no issues.

2.112 At 20:29 hrs at the end of May 2021 the East Midlands Ambulance Service informed the Lincolnshire Police Force Control that they had received a call to report someone had been stabbed at an address in Lincolnshire.

2.113 Police Officers attended the premises where they discovered Bethany lying in the lounge area. Significant wounds were apparent to her entire body and Officers commenced CPR. Other Officers discovered DJ in his bedroom also with significant injuries, both Bethany and DJ were pronounced deceased at the scene. The infant present was unharmed and identified as being Bethany's youngest child, Child A.

2.114 It was apparent that both Bethany and DJ had been stabbed in what was an horrific attack. The Police commenced a murder investigation and a suspect was immediately put forward as being Bethany's former boyfriend (the perpetrator), and enquiries were commenced to locate and arrest him. He was detained the following day after attacking and injuring an off-duty Police officer who had attempted to arrest him.

Section Three – Overview and analysis

3.0 Overview

3.1 Bethany loved her children and wanted to secure the best future possible for them both. There is unequivocal evidence that Bethany put DJ's interests ahead of her own. When she became pregnant with the perpetrator's child, her priority was the safety and well-being of both her children and despite the violence and disruption to her life, directed against her by the perpetrator, she remained of the mind that he should continue to have access to his child but at the same time, little or no contact by him with DJ. Her views were balanced and fair.

3.2 It was apparent from some of the agency reports and conversations with practitioners that Bethany was alert to the fact that DJ's behaviours were beyond the capability of the perpetrator to contend with. It is also apparent that the perpetrator 'weaponised' DJ's behaviour and was also seemingly intent on driving a wedge between Bethany and her family, in particular Bethany's mother. The perpetrator prioritised and focussed on his own needs. Undoubtedly, he did need support from professionals, but this also relied on his acceding to the support offered for his mental health and other circumstances and this seemed to be almost an excuse for his behaviour as

opposed to him making any headway with the support. However, it appears that the perpetrator's mental health became the focus to support being offered to him by agencies, and the needs of Bethany and DJ became lost within the wider picture of those professionals trying to work with him.

3.3 Questions that should and could have been asked by professionals across several agencies concerning safeguarding did not happen frequently enough, nor was there adequate communications between the core agencies holding such information.

3.4 The review does acknowledge that there were significant blockages to services and processes during part of the period subject of the timeframe, given the Covid-19 Pandemic and the nationally imposed lockdowns and associated restrictions which will, out of necessity, have had some impact on the timeliness of referrals, and also joined-up responses to emerging issues.

3.5 What is apparent throughout the analysis of the agencies' information that in some of them it is raised that the perpetrator perceived DJ as a problem between him and Bethany, but when Child A was born, this manifested itself in a more prominent manner. He had, however, resented DJ from early in the relationship with Bethany. This resentment of DJ identifies his exercise of coercive control and that in his view his personal needs and interests should come ahead of everybody else. This does not seem to have been explored in any depth, despite the later CIN process.

Analysis

3.6 This analysis seeks to explore holistically all of the questions raised within the terms of reference as opposed to referencing each individually. This is to help the reader to understand the analysis better and to be able to focus on the learning, by utilising a number of key learning themes which have been identified and encompass the points and are detailed below. The NHS Mental Health Homicide Review will capture any of the questions that are relevant to their review in their report.

Domestic Abuse Analysis

3.7 The Office of National Statistics (ONS) reported that in the year ending March 2021, domestic abuse offences accounted for 18% of the recorded crime for England and Wales.

3.8 Statistics for the year ending March 2020, identified that around a half (49%, 341 offences) of all homicide cases resulted from a quarrel, a revenge attack**,** or a loss of temper. This was a similar proportion compared with previous years. This proportion was higher where the principal suspect was known to the victim (60%), compared with when the suspect was unknown to the victim (40%).[14]

3.9 The Vulnerability Knowledge and Practice Programme (VKPP) '*Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021'*, a joint research project between the Home Office and the National Police Chief's Council, identified that of the 215 deaths

[14] National homicide recording statistics.

from 2,028 incidents sampled between the 23rd of March 2020 and the 31st of March 2021, 49% of deaths concerned current or ex-intimate partner, with child deaths representing 12% of the cases.

3.10 Section 1 of the Domestic Abuse Act 2021 defines Domestic Abuse. It also sets out that children are victims of domestic abuse that is perpetrated against their parents or carer. It is not known what the impact of the household domestic abuse had on him as DJ was never asked or spoken to about it. The Child Safeguarding Practice Review panel briefing (September 2022) on Multi-agency Safeguarding and Domestic Abuse, states that : *'A light-touch literature review of the considerable amount of research in relation to domestic abuse and child protection was conducted alongside the case analysis. It highlighted a range of resources, but also revealed a lack of research on the lasting impact of domestic abuse on children and young people. This includes a lack of focus on how children and young people are able to recover from the abuse they have experienced, and the support they need to do this.'*[15]

3.11 Following the perpetrators November 2018 violent attack on his partner and his animal cruelty, his pre-sentence report of 2018 identified that the perpetrator was a medium risk of further offending and presented a medium risk of serious harm to known adults (intimate partners), particularly if they ended the relationship. There is no recorded evidence of any intervention taking place in relation to addressing his thinking and attitudes that were relevant to his domestic abuse. In the terms of reference for this report at i) it states: *'Ensuring that relevant historic information and previous offending is researched and used to inform current assessments of risk needs to be addressed.'* it is not apparent that the evidence of the risk of domestic abuse and serious harm from this first known offence of serious harm to intimate partners was projected into any assessment. In particular following the subsequent offences of domestic abuse to Bethany, her mother and family. The escalation factors were significant, given the perpetrators lack of understanding of the effects of domestic abuse. As part of the learning from the rapid review the information about the earlier violent offending was known in Lincolnshire by Probation but this was not shared and therefore not available for analysis of risk by other agencies.

3.12 On the 29th of December 2019, the first reported 'domestic' incident occurred between the perpetrator and Bethany. The incident was attended and dealt with by the Police and a PPN DASH risk assessment identified there had been no threat or use of violence. The risk assessment stated that Bethany was not aware of any previous domestic abuse history concerning the perpetrator, but that she 'was aware' of the Domestic Violence Disclosure Scheme (DVDS). The level of Bethany's awareness of these is not known and was a missed opportunity for the Police to have signposted the DVDS to her. Ticking a box on the PPN DASH is not an effective assessment of knowledge and understanding. Equally, the perpetrator was not located and had no contact with the Police and consequently he was never spoken to, which should have occurred.

3.13 The supervision of the PPN DASH risk assessment for this incident does appear to be an effective triage practice, however, the fact that Bethany was reported as being ten weeks pregnant

[15] Child Safeguarding Practice Review Panel (CSPRP) (2022) Multi-agency Safeguarding and domestic abuse. https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

should have raised the threshold of the risks posed to her. The referral to Children's Social Care was a good decision as it also identified that DJ had been present during the incidents.

3.14 The Domestic Violence Disclosure Scheme (DVDS) known more commonly as Clare's law, has two elements:

> The "Right to Ask." Under the scheme an individual or relevant third party (for example, a family member or agency) can ask the Police to check whether a current or ex-partner has a violent or abusive past. If records show that an individual may be at risk of domestic abuse from a partner or ex-partner, the Police will consider disclosing the information. In the year ending March 2020, 11,556 'right to ask' applications were applied for in England and Wales. 4,236 (37%) applications resulted in disclosure.
>
> The "Right to Know." This enables the Police to make a disclosure on their own initiative if they receive information about the violent or abusive behaviour of a person that may impact on the safety of that person's current or ex-partner. This could be information arising from a criminal investigation, through statutory or third sector agency involvement, or from another source of Police intelligence. The Police must satisfy several tests before a decision to disclose is made under the scheme – that the disclosure is necessary to protect the person from being the victim of a crime, that there is a pressing need for the disclosure, and that the interference with the perpetrator's rights is necessary and proportionate for the prevention of crime. In the year ending March 2020, 8,591 'right to know' applications were applied for in England and Wales. 4479 (52%) applications resulted in disclosure.

3.15 Under the new (proposed) guidance, which was under consultation until July 2022 and due out in early 2023, the Police will be required to disclose information on perpetrators quicker. This will mean victims and potential victims should have the information that could be critical to their safety faster. The updated guidance also sets out best practice for managing applications that are received online to help protect applicants.

3.16 The guidance, which is primarily aimed at Police and criminal justice agencies in England and Wales, who are involved in the investigation of criminal behaviour, is also relevant to organisations and agencies working with victims (including children) or perpetrators of domestic abuse who have statutory safeguarding duties. The Police IMR highlighted that more training was required for frontline Officers in relation to DVPN, DVPO and also the DVDS[16] scheme, during the practitioner event it was clear that there was a real deficit in knowledge by practitioners across all agencies of these tools to tackle domestic abuse. Bethany and DJ's family feel that Clare's law disclosures should also be able to be made to connected family members of victims and not just in those cases where it is a child DA victim or the adult is a vulnerable adult.

3.17 When Bethany attended an antenatal appointment on her own on the 30th of December 2019, the perpetrator was named by her as the father of the unborn child. No disclosure was made by Bethany of domestic abuse after she was asked by the practitioner. The midwifery service did ask

[16] DVPN-Domestic Violence Protection notice (used in an emergency). DVPO-Domestic Violence Protection Order (longer term civil order). Domestic Violence Disclosure Scheme.

Bethany on 12 occasions about domestic abuse. The review chair suggests that when the domestic abuse question is asked, if it could be probed further and suggests that midwifery services receive PPN DASH risk assessments from the Police[17] and also referrals from all other agencies aware of domestic abuse, albeit, it is accepted that it may not have been available in the immediacy for this appointment as it was only the previous day, but is a potential good support in the safeguarding processes for the victim.

3.18 On the 23rd of September 2020, in a child development assessment, the practitioner asked Bethany about domestic abuse directly and she raised no concerns. When questioned in more detail about her partner, Bethany stated that she had been in a relationship with him for a year, he was supportive and aware of her anxiety. Further contacts by Bethany with Children's health (0-19) services concerning Child A indicated that the perpetrator visited her, but did not live with her, although his full details or address were not sought or established.

3.19 On the 10th of November 2020, in the unsolicited disclosure made by DJ to staff at school concerning apparent abuse by the perpetrator to his mother, this was not referred to Children's Social Care at that time. This was a missed opportunity to have identified signs of domestic abuse emerging from the relationship and the potential effect on DJ and also Child A. Although this was monitored by the school, this was done as a single agency.

3.20 The most concerning episode arising from this sequence of events is the subsequent anonymous call to DJ's school. At the IMR presentation day it was confirmed by the school that this was an unknown person making the call. The anonymous caller also stated that the perpetrator made the comment, *"Wants to get rid of Darren and calls him freaky."* The school shared the information with Children's Social Care and included the earlier disclosure made that month by DJ concerning the perpetrator pushing Bethany over, which had not previously been shared. Children Social Care had also received this information themselves by presumably the same anonymous source. The Children Social Care record does not include the words '*Get rid of Him.'*

3.21 These disclosures are of concern, given that they were not shared further between other statutory agencies, for example Probation and health, where it would have been possible to look at the occurrences as to the effect of domestic abuse on DJ, but also with the wider implications to Bethany. The CIN process was commenced at this time.

3.22 The next day a violent domestic abuse incident occurred at Bethany's home when she was holding Child A. In her witness statement of November 24th, she stated*, "[the perpetrator] comes to stay with us now and then. He chooses to come just at weekends when my elder son is with his dad. Things were initially better between us but then things have deteriorated and we have been arguing a lot recently about Darren and his autism*." She also stated; *"I know that he strangled a previous partner because he told me."* The PPN DASH was shared with children social care and a notification sent to the school through Operation Encompass and the perpetrator arrested, interviewed, but not charged at this time and bailed. There was no reference to the Domestic Violence Disclosure Scheme being discussed or any discussion about an application for a domestic violence protection order. At

[17] This was put in place post the deaths in 2022 by joint working from United Lincolnshire Hospitals NHS Trust and Lincolnshire police.

the practitioner event a Police officer present mentioned that the supervisor triaging the PPN DASH was going to grade the risk as high but after speaking to the officer who had actually attended this it remained as a medium risk. A high risk grading would have assisted in keeping Bethany and her children safe.

3.23 When the perpetrator went to Bethany's home on the 5th of December 2020, he had been taken to the address by his step-mother, in breach of his bail. In Bethany's statement of December the 9th 2020 she said, *'that she was scared what he would do if she did not do what he wanted'*. This is a striking example of the perpetrator exercising coercion and control over Bethany and this should have been understood and considered by agencies. The fact that the perpetrator was able to stay, on this and probably other unreported occasions, is indicative of the coercive pressure he was placing on Bethany.

3.24 When the incident of the 9th of December 2020 occurred, what is apparent is that the perpetrator had in fact remained at her home since December 5th. This fact was not broadened out in her statement to include the obvious controlling element being exercised by the perpetrator. Taking all the facts as known of the 5th of December 2020, and the 9th of December 2020, into context, the risk to Bethany, DJ and now Bethany's mother, both of whom was clearly by his own admission the root of the perpetrator's anger, was high. The element of control on the part of the perpetrator was in plain sight and the statement taken from her was mostly focused to the breach of bail, yet the perpetrators actions raised a more sinister motivation by the perpetrator.

3.25 The PPN DASH assessment of December 9th was identified as being of medium risk. The panel chair considers this to have been a missed opportunity to have raised the risk to high and thereby the multi-agency response to what was now a credible high risk, given the repetition factors. By identifying the risk as high, the risks posed could have placed the family into a more co-ordinated and dynamic safeguarding position. The decision taken by the Police to release the perpetrator on bail without charge (under investigation) with the same bail conditions afforded her no additional safety to that of before. Had a more holistic approach been made to the actual risks to the family, then this would have raised the threshold for a decision and support the processes across other statutory and relevant agencies.

3.26 On the 12th of December 2020, when the Police attended Bethany's address, no statement was taken from Bethany by the Officers. What this occurrence again identifies is the persuasive and coercive control that the perpetrator had. Although not dwelling on the fact that the perpetrator was not arrested, the PPN DASH was again identified as medium risk. In looking at that perspective, the escalation of the breaches of his bail and his persistent attempts, successful or otherwise, to get into Bethany's home, should have raised the risk threshold for both her and the children. This was the third notified occurrence in three weeks. Bethany stated in answer to the PPN DASH questions which noted, *"no change from those that she had provided 3 days previously".* Her declining to re-answer the questions should have further raised the curiosity of the Officers as to how to help Bethany and give her and her children the support they needed.

3.27 The PPN DASH was shared with Children's Services, both children were at home when the incident of 12th December occurred. The Police IMR identifies that the incident was also referred to

the officer dealing with the previous investigation of assault. This was understandable, but the matter should also have been dealt with on its own merits. The Police IMR commented that the three incidents in close succession, raised obvious concerns as to how a person on bail can re-offend, breach the bail conditions and not be arrested for a breach. This review entirely endorses that view.

3.28 The decision not to arrest on the 12th of December meant that the escalation in incidents was not able to be considered by a Police custody officer, an investigating officer or the CPS independently of the reporting Officers and was another missed opportunity to have given the impetus for multi-agency safeguarding. Officers did not appear to have again considered the use of a Domestic Violence Protection Order (DVPO), albeit the perpetrator was on Police bail, but the two can be used in parallel.

3.29 On the 14th of December, the perpetrator informed the CJL&D that he had breached his bail conditions by standing outside Bethany's home watching his child until the Police were called, referencing the incident of December 12th. He also stated, *"I am going to lose my child to the environment he is in."* It is surprising that this did not trigger communication with other agencies, for example the Police or children social care, given his admissions to his bail breaches, which was indicative of his abject disregard for them. The CJL&D representative at the practitioner event supported this point.

3.30 The 'professional curiosity' raised by EDAN Lincs in respect of the conflicting information provided to them by Bethany on the 22nd of December 2020, and that contained within the PPN DASH of the 9th December, raises questions concerning how much influence the perpetrator continued to have over Bethany and the effect that this was having on her interactions with agencies. There was little doubt that the perpetrator was regularly breaching his bail and the inference was that Bethany was being pressured by the perpetrator to do so. Bethany had no further contact with EDAN Lincs, there were numerous attempts by a caseworker to contact her and consequently no targeted domestic abuse intervention was completed with her, which was out of the control and influence of EDAN Lincs. It seems that EDAN Lincs do not appear to have been made aware of the incident of December 12th, 2020.

3.31 The perpetrator was continuing to be relentless in his harassment of Bethany as evidenced in the incident of January 3rd, 2021. The perpetrator had again returned to her home where she stated she felt obliged to allow him access to see Child A, indicative of entire control on his part. She also admitted to the Officers in a statement she made that day that the perpetrator had been at her home on December 24th. In later disclosures made to a Probation Officer by the perpetrator it becomes evident that he spent time at her home throughout December and beyond. His presence may have influenced her confidence and her opportunity to have responded to the EDAN Lincs attempts to communicate with her.

3.32 The DASH risk assessment of medium risk, concerning the assault on his parents on January 3rd, 2021, was appropriate on its own, however, the reality was that taken as a whole, the events of January 3rd should have elevated the risks holistically to all parties by the perpetrator. Bethany's risk alongside the children was undoubtedly high. The perpetrator was clearly failing to comply with his

bail and the escalation of such occurrences was only too apparent. Appropriate referrals were made by the Police to Children's Services but there was no referral to EDAN Lincs[18], other than for the perpetrators mother, who did not engage with the service, but she also declined to support the Police concerning the assault on her.

3.33 In her witness statement of January 3rd, 2021, Bethany spoke of her fear of the perpetrator and that she had permitted him to see Child A despite the fact that she knew he was breaching his bail. What becomes apparent from this is that the element of coercion and control on the part of the perpetrator was tangible and as this was the third occasion that the threat of violence had occurred within a relatively short timescale and on the 3rd of January 2021, there were in fact three separate incidents involving the perpetrator. This raises the question of why was the risk not raised and given that perspective, should that elevation of risk have not raised the threshold for referral to MARAC? Those key factors are, repeated incidents of behaviour in succession, two events of a domestic abuse nature on one day and a clear inference of coercion and control by the perpetrator against Bethany where her actions were made to facilitate the breach of his bail, out of her fear of him.

3.34 On the 4th of January 2021, the perpetrator entered a plea of guilty in respect of the assault on Bethany on November 24th and was granted bail by the Court, to re-appear on January 12th, 2021, for sentencing. The perpetrator was also subject to, from this date, a Restraining Order. On the surface it appeared that he complied with the Restraining Orders going forward, until the day of the murders, however, a review post death of Bethany's received telephone calls, text messages and social media found that the perpetrator was continually breaching the Restraining Orders contacting her through these means. None of that contact was sought by Bethany. He had sent nearly 900 messages over the bank holiday weekend before the deaths, including one which said: "*You destroyed my life and have the cheek to say I ruined yours."* Professionals need to be aware of this covert and hidden form of harassment and coercive controlling behaviour by perpetrators. The family told the review chair that they believed that restraining orders are not effective.

3.35 Also occurring on the 4th of January was an assessment by the CJL&D, this took place by phone with the perpetrator. Critically, this did not include the use of safeguarding tools and therefore, no account was taken of DJ or Child A in those assessments and there was no communication with Children's Services. It is the Trusts policy to ensure those tools are used and this was an omission.

3.36 On the 25th of January 2021, in contact with a health visitor, Bethany shared that DJ had witnessed DA that didn't involve her or the perpetrator. However, the effect of DJ's exposure to domestic abuse from November 2020 between Bethany and the perpetrator was not explored by all agencies involved. Taking into account of DJ's needs, he was nevertheless a child whose voice should have been heard in more detail given the openness and transparency of his disclosure to the school in November 2020. Bethany was at risk and suffering victimisation, positive action was still required of all agencies. It must be born in mind that the Children Act (1989) highlights the 'risk of significant harm', and section 120 of the Adoption and Children Act (2002) extended the definition of 'significant harm' to children to include the harm caused by witnessing or overhearing abuse of

[18] Lincolnshire Police's referral processes for Officers to EDAN Lincs changed from 3rd Dec 2020. It meant Officers could simply ask a question re consent for referral, and the safeguarding hub would send the PPN where they say yes direct to EDAN Lincs.

another, especially in the context of domestic abuse. This is also a feature within the Domestic Abuse Act 2021 of the harm to children in a DA household, which is what was clearly occurring for DJ and Child A.

3.37 On the 29th of January 2021, the perpetrator was charged with further offences in respect of the assaults on Bethany and her mother on the 9th of December 2020. The perpetrator informed his Probation Officer that they (citing Bethany and her mother) were trying to stop him from seeing his child and that they'd tried to accuse him of *"other silly things which were thrown out*." He had not been in contact with his ex-partner and "*has not fallen into the trap of her making out she needs him,"* so she can then report him. It is clear on reflection that the perpetrator was then and on other occasions trying to minimise his behaviour and undermine Bethany, which was his way of trying to control her.

3.38 When a Probation Officer completed the risk management plan and initial sentence plan for the perpetrator on the 10th of February 2021, the Spousal Assault Risk Assessment (SARA) was not completed. Although this appears to have been an error, it was a critical part of the assessment, the SARA providing a checklist to aid professional judgement decisions, by combining actuarial and dynamic risk factors relevant to intimate partner violence. In addition, the risk management plan, intended to identify how the risk of serious harm would be managed and reduced, did not refer to all the agencies involved or outline their role in managing the risks presented. It also did not highlight how the interventions identified would address the thinking and behaviour linked to the risks presented by the perpetrator. These plans were made for the Community Order imposed on January 12th. These were not pre-sentence reports (PSR)for the forthcoming court appearance of the 17th of February. It is important to note though that Probation can only prepare PSRs if requested by the court. Also, worthy to note a PSR had recently been prepared and therefore the assessment from January would still have been considered relevant but would not have included the offence within it that the perpetrator was now going to court for on the 17th of February.

3.39 On the 17th of February 2021, the perpetrator appeared at the Magistrates Court and the Crown Prosecution Service, submitted to the Magistrates, brief knowledge of the history between the perpetrator and Bethany, this added value to understanding the case as a whole, seeking that the Magistrates should have a complete understanding of the events dating back to November 2020. It was argued that without that knowledge the Magistrates might find it difficult to properly understand the other evidence in the case. However, this did not include all of the information known by all agencies, or the risks to the children as no child safeguarding screening tools were completed, which would have led to DJ and Child A being identified and appropriate actions taken in additional safeguarding considerations.

3.40 The court dealt with all the offences together. Taking all matters into consideration, the perpetrators sentence was effectively no different than that of the 12th of January 2021, other than the elongation of the sentence timeline, there was no additional penalty imposed. The family were quite clear to the panel chair that they felt that the court should have sent the perpetrator to prison on this occasion. This point raised by the family, was discussed at both the practitioner event and the IMR presentation day and the thoughts of those present were, although fully understanding the family's feelings, that based on the information the court had presented to them (which wasn't all of

the information held by agencies, including no mention of all of the breaches of bail) that the court made an understandable decision. It was emphasised to review chair that this was a specialist Domestic Abuse Court. When the family were re-visited to go through the report, they were still very strong in their views that sending the perpetrator to prison was the right course of action at this court hearing.

3.41 On this same day, the 17th of February 2021, DJ's paternal grandfather contacted the Police, following what he felt were threats made towards DJ when he was confronted by the perpetrator. The response to ensuring the safeguarding of both Bethany and DJ by the Police was immediate, with a home visit and safeguarding advice given, which was good practice. However, what this lacked in process was that no PPN was submitted. This was another missed opportunity to have ensured that key agencies were notified, specifically Children's Social Care, and given it came on the same day as his court appearance, this had potentially more sinister undertones in terms of a threat to DJ.

3.42 By the 11th of May, it is apparent that the perpetrator has become increasingly frustrated with not seeing his child and had remonstrated with the Social Worker. The Probation Officer took steps to help him with communications support but the perpetrator was by now of the viewpoint that not only was Bethany and her family standing in his way, but that barriers were being put in his way by everybody. In view of the perpetrators continued assertion that he wanted some urgent support for his autism, and with the fact that the BBR programme manager had queried suitability for the BBR programme which lead to a delay, this meant that at no time did any work take place with the perpetrator to try and alter his behaviour as a perpetrator of domestic abuse. No offence focused work was done with him following his first conviction for domestic abuse in 2018, and then nothing was done again following the court conviction firstly in January 2021 and then again in February 2021.

3.43 A Women's Aid report (2016) *'Nineteen child homicides tells the stories of 19 children who were killed by a parent who was also a perpetrator of domestic abuse in circumstances of child contact.'* This report highlights the extreme danger during periods of separation, not just to children, but in some of the cases mothers were also killed. The report comes up with key themes that are also relevant to this review into the deaths of Bethany and DJ:

Five Key Themes

- *The importance of recognising domestic abuse harm to children*
- *Power and control dynamics of domestic abuse*
- *Understanding Parental separation as a risk factor*
- *The way in which agencies interact with families with domestic abuse*
- *Supporting non-abusive parents and challenging abuse parents.*

3.44 The analysis of the domestic abuse in the lives of Bethany and DJ has shown some clear areas of learning that professionals and agencies need to heed and take forward.

Child in Need Process

3.45 A 'child in need' is defined by the Children Act 1989 *'as a child who is unlikely to achieve or maintain a reasonable level of health or development, or whose health and development is likely to be significantly or further impaired, without the provision of services; or a child who is disabled.'* Children in need may be assessed under section 17 of the Children Act 1989 by a Social Worker. Under the Children Act 1989, local authorities are required to provide services for children in need for the purposes of safeguarding and promoting their welfare.

3.46 On the 23rd of November 2020, a Child in Need (CIN) process was opened, with a focus to safeguard DJ and Child A from experiencing domestic abuse. Before contact with Bethany was able to take place, Children's Social Care was notified of the violent physical abuse incident that happened to Bethany by the perpetrator on November 24th, 2020. It is worthy of note here for learning, that although there are throughout the country voluminous cases quite rightly of child protection plans and child in need cases for domestic abuse, that the Child Safeguarding Practice Review Panel (CSPRP) (2022) paper on Multi-agency Safeguarding and domestic abuse states: '*There appeared to be an assumption that simply naming 'domestic abuse' as a concern for a child is enough for all practitioners to understand the situation and respond appropriately. This is an overly simplistic, optimistic and, at times, dangerous assumption that leads to potentially avoidable harm to children and non-abusing parent.*[19]*'* This was the case for DJ, Child A and their mother Bethany.

3.47 When the CIN commenced in November 2020 and until May 2021, the Probation Service IMR identifies that the Section 17 assessment and CIN meeting minutes were not shared with the Probation Officer managing the perpetrator's Community Order. This was a significant gap in process and communication, but there was no apparent escalation process actively utilised by HLNY CRC to address this shortfall.

3.48 The Child and Family Assessment and visits were completed within timescales. There was evidence of good partnership working with DJ's school, albeit debate about when they became aware that an actual CIN process was in place has already been mentioned earlier in this report. The Probation Service, as already mentioned, was not initially invited to the CIN meetings. There is no evidence of further communication with the Children's Health Service following initial information being sought at the point of screening of the referral on the 23rd of November 2020, or that the health visitor was invited to the CIN meetings. No evidence of involvement from Mental Health Services either. It should be expected practice that all relevant professionals are included in the CIN process.

[19] Child Safeguarding Practice Review Panel (CSPRP) (2022) Multi-agency Safeguarding and domestic abuse. https://www.gov.uk/government/publications/multi-agency-safeguarding-and-domestic-abuse-paper

3.49 During the home visit by the Social Worker on November 30th, Bethany said that although her relationship with the perpetrator had ended, she was unsure if she wanted to pursue any charges against him. A safety plan was put in place between her and Children's Social Care, however, this was in reality a superficial plan as there had been no apparent safety planning for Bethany through the intervention and support of other agencies. It is important that when considering safety planning in particular if there is controlling and coercive behaviour being displayed that the onus and responsibility is not left to the victim solely to be the one to stop the perpetrator returning to the house.

3.50 The Child in Need initial plan was agreed on the 13th of December 2020. The children were to be visited by the Social Worker every three weeks and the focus of the CIN plan was to safeguard the children from experiencing domestic abuse. Why the perpetrator or DJ's biological father were not included as participants within the CIN process at this time is not clear.

3.51 During the telephone call on the 28th of January 2021 between the perpetrator and the Social Worker, the perpetrator stated that he had *broken his bail conditions six times* but only on one occasion did he go to the house himself, placing the impetus for the breaches on Bethany, stating that she collected or met him. This was not the first time that the perpetrator placed the blame on Bethany with limited acceptance of his own liability for causing the arguments between them, adding that in respect of Bethany's mother", "*she started all of this*". When asked about DJ he responded, "*No comment, I need to be in positive place to discuss him."* The Police were never informed in relation to his breaches of bail and they should have been.

3.52 On the 23rd of February 2021, a Child in Need Review meeting was held via Microsoft 'Teams', this was attended by Bethany, her mother and the Social Worker. (It should be noted that Bethany's mother does not remember being involved in a Teams meeting.) There does not appear to have been any reference made to the court proceedings of the previous day, which is of great concern to the review chair. Information concerning the perpetrators sentencing was intrinsic to the ongoing safety plan although this may not have affected the plan. There was no mention of what information other agencies may be aware of and how they could also be used to safeguard the children and ultimately Bethany as well.

3.53 At the CIN meeting on March 24th, 2021, a topic of discussion was the perpetrators contact with Child A and how that could be facilitated. Bethany's perspective was that she was not responsible for arranging or facilitating this in view of the restraining order. On the 29th of March this was discussed between the Social Worker and the Probation service, the Probation Officer indicated that they would attend the next CIN meeting, and although the meeting went ahead, Probation did not attend. The review chair acknowledges that access to children should be reached by an agreement between the parents and if this is at an impasse, it is a matter for the Family Court to determine. However, this was a case where the perpetrator was not seeking legal advice. The panel came to the conclusion that Bethany was amenable to the perpetrator seeing his child as her personal experience of how this worked with DJ and his father was a positive one.

3.54 On the 8th of April 2021, during a home visit to Bethany by the Social Worker, she voiced concern that she did not wish Child A to have contact with the perpetrator in her home as he did not

get on with DJ. The perpetrator was telling the Probation Service and Children Social Care that he wanted to see child A. Although he was not escalating this wish, there was the potential for the escalation of the risk of him forcing his way to see Child A. Especially as no agency was looking to support his request and that this had been a recurring theme for many weeks.

3.55 On the 12th of April 2021, Steps2Change records indicate that the child identified on the safeguarding screening tool was not open to Children's Services as reported to the practitioner by the perpetrator. This was clearly incorrect as the CIN process was ongoing since November 2020, which given the passage of time is disconcerting. LPFT should have clarified this with Children Services rather than rely on what the perpetrator told them.

3.56 There followed a number of communications between the Probation Service and Children's Social Care during April and May 2021, concerning the CIN process in respect of access by the perpetrator with Child A. It is apparent that those lines of communication were blurred and no progress was made as the CIN meetings remained superficial in respect of the agencies represented.

3.57 The Probation Service IMR comments that *"the attempts to contact him [the perpetrator] by the Social Worker have been fraught with difficulty*." The panel chair has a contrary viewpoint that efforts could have been made by Children's Services to communicate with the perpetrator as alternative contact was feasible through the Salvation Army hostel and this happened on one occasion.

3.58 The CIN meeting of the 18th of May 2021, did not include Probation and no apparent additional information concerning the perpetrator despite communications between Probation, Children's Social Care and the perpetrator in the interim. The record indicates that there were still no plans in place for contact between the perpetrator and Child A. The reality is that no progress had been made in that respect in the six months since the inception of the CIN process and it was making limited headway.

3.59 Working Together 2018, in relation to CIN states: *'Where the local authority children's social care decides to provide services, a* ***multi-agency child in need plan*** *should be developed which sets out which organisations and agencies will provide which services to the child and family. The plan should set clear measurable outcomes for the child and expectations for the parents. The plan should reflect the positive aspects of the family situation as well as the weaknesses. inform, in writing, all the relevant agencies and the family of their decisions and, if the child is a child in need, of the plan for providing support*.'

3.60 It is acknowledged that the Social Worker was active in this case and did communicate with Bethany on a regular basis and also other agencies. However, having examined all of the CIN records (separate minutes are not completed as the information is captured within the child and family progress plan which is updated at the meeting) and following the feedback from professionals including the Social Worker and their team manager, at the practitioners event and those professionals at the IMR presentation day, it is clear that the CIN process in this case was not robust or multi-agency in its make up as expected by the Children's Act 1989 and Working Together 2018. Limited analysis of risk or progress took place and limited involvement of the fathers in the process.

Multi-Agency Information sharing

3.61 The lack of joined up multi-agency information sharing during the domestic abuse incidents and the CIN process have already been highlighted in this report. There were though, numerous other examples of a lack of adequate information sharing. In March 2019, the perpetrator disclosed to the Probation Service in Derbyshire, that he was seeing a new partner who was a single parent and was also staying with a friend that he referred to as 'Beth'. Both were in Lincolnshire. There is no record of any accompanying checks being made through Lincolnshire Police or other agencies and given that the perpetrator was being actively managed by Probation Services at that time for his conviction for domestic abuse, this raised significant safeguarding considerations which do not appear to have been considered, particularly in respect of the 'single parent' element as he disclosed. There is minimal doubt that the perpetrator was referring to Bethany, and not to two different people as he alluded to. With the perpetrator moving to Lincolnshire, it is not clear as to why, by April 2019, that the management of his sentence by Probation was not transferred to the HLNY area.

3.62 In July 2019, the perpetrator provided Bethany's address and her date of birth following a request by the Probation Officer and included details of her son, DJ. Again, no domestic abuse or safeguarding checks were made of other agencies. Equally, in relation to this information, there is no record of any consideration of disclosure being made to Bethany with regards to the perpetrators previous convictions in accordance with the Domestic Violence Disclosure Scheme. This was another missed opportunity to have broadened the reach of the safeguarding for Bethany and DJ. This information could have been relayed to her directly by Probation or signposted by Probation through the Lincolnshire Police Safeguarding hub.

3.63 By August 2019, the perpetrators case management was then in a joint management arrangement, the perpetrator was at a medium risk of further offending and presented a medium risk of serious harm to intimate partners, particularly if they ended the relationship. It is also noted that partners in Lincolnshire were unaware the perpetrator was being supervised in Lincolnshire for the purpose of information sharing.

3.64 On the 25th of February 2020, in communication with the Community Mental Health Team, the perpetrator wanted to establish the next steps in his autism assessment. He reported he was 'currently living' with his girlfriend who was pregnant, this was the first time that he had made mention of his partner and unborn child to the Community Mental Health Team. Initially he was noted to be guarded when staff probed the relationship but when he provided her name, he expressed that he didn't want the address to be "widely shared." What this highlights is that only a single agency was aware of where the perpetrator was actually living. It is also of note that when examining later events, it is possible that the perpetrator was making use of Bethany's accommodation when it suited him. When looking at the wider issues concerning accommodation, it is apparent that there is a lack of information sharing concerning where the perpetrator was living and the assessment of medium risk, he posed of serious harm to intimate partners in the latter part of 2019 through to January 2021.

3.65 The Criminal Justice Liaison and Diversion Team noted the perpetrator's arrest of December 9th as being "*similar to the last referral on the 24/11/20".* What is of concern is that the record from the CJL&D identifies "*presentation being consistent over a period of time, possible paranoia and possible risk to his ex-partner*." The assessment summary was that it was viewed that the Community Mental Health Team would have the opportunity to meet with him over a longer period and that this would be the most appropriate course of support for him. Whilst the CJL&DT was clearly being progressive, the dynamics of the escalation of the perpetrator's behaviour and sharing that information was missed. Although it is accepted that CJL&D's focus will be the perpetrator's mental health and that he came to their attention through him being in custody, where the Police were the lead agency, there was though minimal consideration of Bethany and DJ and the focus was again to the perpetrator.

3.66 On the 1st of March 2021, at the mental health clinic, the perpetrator disclosed that he had had met Bethany on January 3rd, 2021. This raises further concerns about the events of January 3rd and again a lack of inter-agency information sharing.

3.67 Probably the most significant lack of information sharing in the whole case is the threats voiced by the perpetrator whilst in the Salvation Army accommodation to the Officers there. This threat was about his girlfriend and her family. The threats were tangible, in particular that he said that he has things to sort out and "line up" in his mind, then, if they are still the same, he will kill the "*whole blood line*." Not mentioned in the IMRs shared with the review but in the statement the chaplain made for the criminal court and in the evidence, he gave at the court the perpetrator said to the chaplain "*He [The perpetrator] said they were all in on it, in the injunction, and I'm going to stab them.*" It is somewhat disconcerting that it is said that this information was said by the hostel to have been passed to a Police officer, but on behalf of this review Lincolnshire Police have enquired into who this officer maybe. There is no record of a Police officer visit to the hostel and there was no record by the hostel of the officer's name. Bethany and DJ's family found it unbelievable that this information wasn't formally shared with other agencies. The review chair and the panel have a similar feeling that this was incredibly crucial information that needed to be shared.

Perpetrator Risks to Bethany, Darren and Family

3.68 Taking events in the chronology and the background of the perpetrator, they identify that he had a troubled and disruptive childhood and that this continued into his early teens. He was convicted of serious offences aged just 19 and served a lengthy custodial sentence for physical violence. This earlier extremely violent behaviour never seems to have been taken into account in any future assessments of him or thought about in terms of the DVDS scheme to share with Bethany.

3.69 The perpetrator had trouble forging relationships, which is emphasised in the incident in Derbyshire in 2018, in which it was later reported that he had trouble letting go of even though he was at that time, (May 2019), in a relationship with Bethany. The previous violent domestic incident should have been an indicator of future behaviour.

3.70 The records identify that the perpetrator failed to make his initial two scheduled appointments at the HNLY CRC during the caretaking period from DLNR CRC and when the matter was explored, Bethany identified herself as acting on behalf of the perpetrator. The fact that it was decided not to enforce breaches by the perpetrator at that point, gave little consideration to the risk that the perpetrator now presented to Bethany, a single mother of DJ and potentially fed the perpetrator's view that he could breach court orders, bail conditions, restraining orders as nothing was done about these.

3.71 On October the 10th 2019, at the perpetrators initial meeting with the newly appointed Probation Officer from the HNLY CRC, acting in a caretaker role, the perpetrator disclosed that he had had many jobs since coming to Lincolnshire. Little was explored in this regard and the disclosure itself raises several questions concerning the perpetrator, if accurate, about his employability and his personal circumstances. What does appear to take priority from herein, is the impetus concerning the perpetrators mental health, which on one hand was an important consideration for his welfare and support within a community context, but as an apparent priority, it placed the safeguarding perspective for Bethany and DJ on the back foot.

3.72 On the 11th of December 2019, as the Community Order ended, the DLNR CRC assessed the perpetrator as presenting a medium risk of serious harm to the public and known adults and a low risk of serious harm to children. Throughout the course of the Order there was no evidence of any domestic abuse prevention work or offence-focussed work taking place. There was also no recorded evidence of any safeguarding checks, home visits or domestic abuse checks being made with regards to the perpetrator's relationship with Bethany and DJ. It is of concern that responsibility was placed on Bethany to account for his absences and ensure that he attended Probation contacts.

3.73 On the 30th of October 2020, when the perpetrator contacted the mental health Crisis Resolution and Home Treatment Team, staff tried to ascertain the reason for the call, he was noted to be "*challenging", "terse" & "needed to speak to a superior*". This was not an uncommon trait of the perpetrator; he was demanding and frequently confrontational to professionals to get what he wanted.

3.74 In the aftermath of the assault by the perpetrator on Bethany on the 24th of November 2020, the perpetrator was at great effort to seek attention to his needs as opposed to those of Bethany. He made it clear that he regarded himself as being a 'part-time dad' to their child and that he was only welcomed at weekends. In fact, this was entirely contradictory and a falsehood projected by him. His obvious dislike for DJ meant that when DJ was at his biological fathers at the weekends, he could have time with Bethany without DJ being present but did not go there when DJ was at home. He cited the 'difficulties' that DJ causes him when he was there, stating he was bullied by him, which was a worrying statement in itself and Bethany's and DJ's family were flabbergasted when they heard that he had made this statement.

3.75 There are an overwhelming number of instances recorded by a number of different agencies of the perpetrator highlighting his disturbing thoughts about how he felt about DJ. This report has highlighted those notified to the review, plus other threats to Bethany and her family, see some

examples in the table below that covers the time period between October 2020 and May 2021, and the panel chair in their experience believes that there will also be numerous other instances:

Comment made by perpetrator	To which agency
Saying stepdad says, "Wants to get rid of Darren and calls him freaky".	To School and CSC (Not including the words to CSC of 'Get rid of him.')
Perpetrator cited the difficulties that he has with DJ when he is there (at Bethany's house) and he feels bullied by him (DJ).	To Police
"I know that he strangled a previous partner because he told me"	To Police
Perpetrator threatening Bethany and her mother (assaulted them both)	To Police
"…if you get me arrested, I will come back for you and your family" also "if anything happens, I'll come for you"	To Police
Perpetrator had expressed negative attitudes towards Darren, blaming the child for the problems in his relationship with Bethany	To Probation
Blamed Bethany for starting arguments and that Bethany's mother was possessive and was to blame for all of this "she started all of this "	To Social Worker
Concerned about the impact of his 'on/off' partners 9-year-old son's behaviour, stating that he has ASD and displays behaviours such as hand biting and constant crying. He voiced "I am going to lose my child to the environment he is in"	To LPFT
- "you do something or I'll do it" -in relation to Darren allegedly waking him early in the morning	To Police from DJ paternal grandfather
– very real threats he was making regarding his girlfriend's family and her older son's family – "all wicked," "wasn't a good one among them." " He has things to sort out and" line up" in his mind, then, if they are still the same , he will kill the" whole blood line."	To Salvation Army
Strain placed on the relationship by his partner's son, who has ASD, and his biological father.	To LPFT

3.76 If agencies had looked at this together holistically, possibly through the CIN process or by his Probation Officer, they would undoubtedly have come to the conclusion that DJ, Bethany and her mother were at high risk of significant harm from the perpetrator. But neither the Social Worker nor

Probation Officer were aware of this information in any totality. If all information had been shared between agencies the risk assessment would have been more robust and the risk presented managed more effectively. This could also have taken place at MARAC as the risks looked at holistically could have tipped the risk into the MARAC high risk category.

3.77 As already mentioned earlier in this report (3.38) there was a deficit in the Probation risk management plan and the Spousal Assault Risk Assessment (SARA) was not completed.

3.78 On the 16th of February 2021, at the Salvation Army hostel, the perpetrator spoke about killing himself in order to teach Bethany and her mum a lesson as '*he thinks they would have to explain that it's their fault if he did this*'. This was the day before his next Court appearance. This is again indicative that the perpetrator placed responsibility for events on Bethany and her family and the threat of suicide is another of the key indicators identified in research concerning the homicide timeline. This information and later disclosures by the perpetrator needed referral to both his probation officer and also the police.

3.79 On the 25th of February 2021, the Salvation Army night concierge noted how, on a recent number of occasions, the perpetrator was returning to the shelter under the influence of alcohol. There was evidence that his behaviour was changing along with breaches of rules of his residency.

3.80 In a planned office visit with the Probation Service, on the 27th of May 2021, the perpetrator was reported as being frustrated about his accommodation, expressed unhappiness about the Social Worker stating that he was a risk to Child A and was against him having contact with his child. It was apparent that his beliefs concerning Bethany were that she was manipulating the situation. Although the Probation Officer contacted the Salvation Army hostel to check on how the perpetrator was presenting, the Probation Officer was informed that there were no problems in relation to his residing there, he was quiet and there had been no issues. This was not a factual response as it was apparent that the perpetrator's behaviour had changed, he had been absent on the 23rd of May, had reported spending all his money and there had been very recent changes in his movement activity.

3.81 By the time that the perpetrator was again absent without authority from the Salvation Army hostel on the 30th of May, he was already making his way to Bethany's home, a matter that was unknown to anybody and although you could not predict what he would go on to do –there were flags around his behaviour, mental health and threats to others in the preceding 6 months.

Bethany Vulnerabilities

3.82 When Bethany attended a pregnancy examination on 21st of December 2019 at her GP practice, the examination notes identify that a partner was present throughout, but the 'partner' was not identified, this is a matter that should have been addressed. Given that she presented as being anxious and concerned, safeguarding opportunities for her, DJ and her unborn child were not explored.

3.83 On the 11th and 13th of May 2020, Bethany had telephone consultations with her GP practice. No discussions about her partner took place on this occasion and there was no discussion concerning domestic abuse, although that it is more than likely that specific questions in that respect were not asked of her. The focus was on her mental health as she was experiencing more depression, the root of which was not explored. By the 15th of May she had received some urgent professional support from mental health services which was good practice, especially considering the COVID-19 restrictions to those services at that time.

3.84 In August 2020, Bethany gave birth to a baby (Child A.) Her 'birth partner' during the delivery was her mother. No mention was made of the perpetrator. The perpetrator was, however, present at the first home visit conducted five days later by the Midwifery Services, perhaps indicative of him being in residence with Bethany. At that time, DJ was staying with his maternal grandparents. Bethany was discharged from Midwifery Services on August 12th where it was noted that the support around her was from family and no safeguarding concerns were raised, even though they asked on numerous occasions they were unaware of any domestic abuse concerns.

3.85 When DJ returned home from his maternal grandparents, the perpetrator "*started to cause problems.*" Bethany expressed her concerns about the perpetrator's views of DJ, whom he considered to be presenting bad traits that he believed would be picked up by Child A. There is no information recorded anywhere that any professional or agency gave the perpetrator any advice on how to communicate with DJ better, this might have improved how he responded, thought and behaved to DJ.

3.86 One question from the terms of reference that hasn't been answered in this section, relates to the impact of COVID-19 on the deaths. In relation to Bethany, DJ and the perpetrator there would appear that there was impact to practice from COVID-19, whilst accepting that the CIN meetings were held using 'Microsoft Teams'. There was also an impact to health involvement with Child A for example missing their inoculations. Which the family attribute to the perpetrators controlling behaviour.

3.87 The TOR sections h), i) & k) highlight issues relating to cross border information sharing in cases of domestic abuse, and MARACs. There were two actions from the Rapid Review Action Plan that have been progressed during the process of this review with a view that they may inform some of the recommendations. The findings from the first action *"Exploration of how domestic abuse perpetrator history is transferred between areas and made accessible to those working to safeguarding children needs to be considered"* discovered that partners were assured about information sharing and cross border information transfer in relation to victims, but less so in relation to perpetrator history. As a single area like Lincolnshire, it would be difficult to resolve this by themselves and therefore may be a point for a national recommendation in relation to supporting this work.

3.88 The TOR section n) asks if agencies have in place policies and procedures for domestic abuse and safeguarding. The IMRs and this review give assurance that these policies and procedures are in place. Further work needs to be done to ensure individuals knowledge is improved and the use of safeguarding assessment tools are used appropriately.

Section four – Conclusions, Lesson to be learnt-learning Themes and Recommendations

4.0 Conclusions

4.1 The perpetrator is a physically violent man. His lengthy prison sentence as a 19 year old is evidence of this. He has previous convictions and a history of a domestic abuse related offences before he met Bethany. This continued towards her within a few months of commencing a relationship with Bethany. The level of his risk to her, DJ and Bethany's family was underestimated by professionals throughout.

4.2 What is unequivocal in the analysis is that the lines of communication between agencies was not sufficient to fully understand the risks he posed. No single agency carries the responsibility for any omissions, although there are obvious required improvements in agency specific practices, which need to be addressed. One way is through Operation Encompass which shares domestic abuse incident data from Police to schools (primary and secondary). Lincolnshire Police launched this in January 2020 with support and assistance from Education and Children's Services within Lincolnshire County Council. This includes an automated information sharing process, from the front line direct to the Designated Safeguarding Lead in school. The Police safeguarding hub backs up the scheme with partners where for example a child may not be in school (missing education), or the parents refuse to provide the details for their child's school – there are processes in place to ensure that a notification goes to the school. Data is available through the force and is shared with key partners, and through updates to partnerships where required. The force is looking to build on the success of Operation Encompass to include Early Years / Childcare for example in the future and is endorsed by this report and encouraged by the partnership. These notifications are also now already in place for Midwifery Services.

4.3 Opportunities to have addressed a more thorough understanding of the perpetrator's risk towards Bethany and DJ, whilst outlined within the chronology of the respective agencies' records, became secondary to the perceptions of the needs of the mental health of the perpetrator, which he manipulated to his advantage. The review does not suggest that his needs were not relevant, indeed they were intrinsic to the overall picture, but those needs became the primary driver and not the warning signs for adequate safeguarding to Bethany and DJ.

4.4 In 2019, Professor Jane Monkton-Smith with the University of Gloucestershire published research titled '*The Homicide Timeline'*. It stated that the eight steps discovered in almost all the 372 killings studied were:

- *A pre-relationship history of stalking or abuse by the perpetrator.*
- *The romance developing quickly into a serious relationship.*
- *The relationship becoming dominated by coercive control.*

- *A trigger to threaten the perpetrator's control - for example, the relationship ends, or the perpetrator gets into financial difficulty.*
- *Escalation - an increase in the intensity or frequency of the partner's control tactics, such as by stalking or threatening suicide.*
- *The perpetrator has a change in thinking - choosing to move on, either through revenge or by homicide.*
- *Planning - the perpetrator might buy weapons or seek opportunities to get the victim alone.*
- *Homicide - the perpetrator kills his or her partner, and possibly hurts others such as the victim's children.*

4.5 The 'Homicide Timeline' research bears a striking similarity to the events within this review. This research is a useful tool for agencies discussing potential warning signs within relationships and the points evidenced are useful references to examine the potential progression of cases and thereby look at the risks against the current risk assessments in existence and consider the escalation of risks. Lincolnshire County Council are promoting that professionals in MARAC use the Homicide Timeline when assessing risk. At present the Homicide timeline is not endorsed by the College of Policing so not part of their programme of learning.

4.6 In June 2022 Women's Aid published a report[20] urging action to be taken in the Family Court following the 'Harm Panel' report from 2020. Although the Harm Panel and Women's Aid report is focussed on the Family Court, it is relevant to this review in relation to the narrative and actions that highlight the risks of domestic abuse and homicide that take place when couples are separated and there is a child access consideration. The report recommends multi-agency training in these cases and is worthy of consideration by the Lincolnshire safeguarding partnerships and the Lincolnshire Local Family Justice and Local Criminal Justice board to consider implementing. *'Renewed attention should be placed onto the Harm Panel's recommendations for multi-disciplinary training for all participants in the family justice system, which should include a significant cultural change element, to tackle biases, myths and stereotypes around domestic abuse, child contact and parenting. Currently, different groups of professionals working in the Family Courts receive different training. The Harm Panel identified a significant weakness in the knowledge and skills of Social Workers who are undertaking risk assessments and other related direct work with children and their families where domestic abuse is alleged, suspected or known.'*

4.7 At an early stage there was an obvious opportunity to ensure that Bethany was advised and made aware of the Domestic Violence Disclosure Scheme by both the DLNR and HLNY CRCs, who were talking to her, and then the Police following the domestic abuse incidents. This did not happen, and although Bethany may have been aware of his previous violent relationship, she was probably unaware of his physical violent past. The animal cruelty is also a significant factor in terms of his future risk profile.

[20] Women's Aid. (2022) Two years, too long: Mapping action on the harm panel's findings. Bristol: Women's Aid

4.8 The controlling element of the perpetrator's behaviour to Bethany raises a further question of whether the perpetrator was stalking[21] and harassing[22] Bethany. Coupled with coercion and control, it does become apparent that other solutions and action could have been taken against the perpetrator in both mid, and late December 2020, and then again in early January 2021. This may have been a more effective process than the actions taken, and on occasions not taken, concerning his all too frequent breaches of Police bail. DVPOs and Stalking Protection Orders which were introduced in 2019[23], and came into operation in January 2020 following the guidance being issued, provide additional tools for managing the risk posed by perpetrators, by enabling Courts to impose a range of conditions including notification requirements.

4.9 The PPN DASH risk assessments maintained a 'medium' threshold throughout the repeated domestic abuse and child protection occurrences of November and December 2020 and into January 2021, even at supervisor's review, the exercise of coercion and control was not identified even though there were clear indicators of this behaviour on the part of the perpetrator. Those signs were missed, even though they were part of the evidence formally obtained from Bethany in her witness statements.

4.10 The fact that the perpetrator was seemingly, repeatedly returning to Bethany's home, at times remaining there, was an obvious indicator of the escalation of the risk of harm. This escalation should have been identified and the associated level of PPN DASH risks could have been raised to high. This would have brought Bethany's case into MARAC arrangements and given the domestic abuse incidents the integrated managed support required. This would also have placed both DJ and Child A in an integrated area of safeguarding, running in parallel with safeguarding Bethany. Coupled with the opportunities for the Police to have sought additional charging decisions from the Crown Prosecution Service, this would have provided further safeguarding opportunities for Bethany and the children. It can be reasonably well-argued that the charges he faced did not actually address his offending profile towards Bethany between November 2020 and January 2021.

4.11 The panel chair does acknowledge that the decision taken to conduct a CIN in November 2020 was well judged. However, it is appreciated that the timing of the CIN was within the period where activities were dictated by the legislation and the Governments advice concerning the COVID-19 pandemic. There was evidence that the school, and even if they feel they were unknowing, were collaborative partners in the Child in Need plan and supported the Social Worker to capture DJ's voice and explore his world.

4.12 It is concluded that the Child in Need plan in this particular case was not robust, it was not multi-agency and should have represented the view of the perpetrator and DJ's father at an earlier stage, irrespective of whether it was appropriate not to facilitate their attendance. Agencies that should have attended, in person or otherwise, did not, or were not considered as part of the

[21] Whilst there is no strict legal definition of 'stalking', section 2A (3) of the Protection from Harassment Act 1997 sets out examples of acts or omissions which, in particular circumstances, are ones associated with stalking.

[22] Offences under section 2 of the Protection from Harassment Act 1997 as amended.

[23] https://www.gov.uk/government/publications/stalking-protection-act-statutory-guidance-for-the-police

process, and this prevented accurate and current information being shared and the risk properly understood and planned for.

4.13 Throughout the span of this review, it is apparent that a considerable amount of time and effort went towards the perpetrators support and mental health needs and that in the midst of this, Bethany's safeguarding needs became somewhat secondary. There was apparently little work by agencies to 'target harden' her, the needs of her children or her home, following the initial attack on her in November 2020.

4.14 Overall, there was a distinct lack of joined up working in this case which could have been gripped and addressed and when considering the wider issues, MARAC might have been the most suitable forum, this was never considered or identified by any one agency involved when there were obvious warning signs that there was a high risk to Bethany, DJ and her family.

4.15 Although there was in place a CIN plan and a Social Worker who was actively working on the plan, the most concerning aspect of the events is that no agency acted to address the perpetrators abject dislike of DJ and raise the threshold of that specific concern. It was frequently narrated in records that the perpetrator considered DJ as the wedge in his relationship and when Child A was born, that view was omnipresent. It is though accepted by the report author that individuals such as the Social Worker were not aware of the extent of this until after the murders. However, as already mentioned in this report's analysis section, the failure to share the threats made by the perpetrator by the Salvation Army was very concerning. As is the missed opportunity to look at the perpetrator's comments about DJ in a multi-agency forum.

4.16 The phrase 'professional curiosity' is synonymous with reviews. This review makes the observation that what this curiosity equates to in this case is that there have been occasions where agencies have not considered the wider safeguarding implications. There are opportunities for the Lincolnshire Safeguarding Children Partnership and the Safer Lincolnshire Partnership to address how multi-agency professional events can broaden practitioner's knowledge and ensure that information sharing protocols are dynamic and are regularly reviewed to ensure safeguarding functions remain a priority.

4.17 In the National Child Safeguarding Practice Review panels 2020 Annual report, *'Patterns in practice, key messages and 2021 workplan.'* the report makes the following comments:

> *'From our analysis we have highlighted six key practice themes to make a difference in reducing serious harm and preventing child deaths caused by abuse or neglect. These themes are not new, but they are amongst the most urgent, and also the most difficult. We expect these six themes to be a focus for shared learning with safeguarding partnerships, and nationally, to improve the safeguarding system*.'
>
> *'Six key practice themes to make a difference*
> *1. Understanding what the child's daily life is like*
> *2. Working with families where their engagement is reluctant and sporadic*
> *3. Critical thinking and challenge*
> *4. Responding to changing risk and need*

5. Sharing information in a timely and appropriate way
6. Organisational leadership and culture for good outcomes.'

4.18 Although these six themes are not the only ones to consider and there are others that have featured in this review, almost all of these key practice themes outlined in this annual report other than the leadership and culture one are clear learning that arises out of this review as well.

4.19 Lessons to be Learnt-Learning Themes

- Partnership use and knowledge of the DVDS, DVPN and DVPO processes.
- Partnership understanding of stalking, harassment and coercive controlling behaviour.
- Partnership understanding that DA is always harmful to children.
- Engagement by agencies to ensure they have strategies to interact effectively with reluctant and vulnerable victims.
- Understanding and reducing the risks of perpetrators to victims and their children of DA. Including a greater understanding of the homicide timeline.
- Improvements to local Child in Need processes and inclusion of multi-agency partners, in particular those delivering adult services.
- Improvements to multi-agency information sharing to also include the voluntary sector information.

Recommendations

4.20 A few agencies have not made any recommendations within their IMRs, but the majority have and these recommendations are outlined below and need to be enquired on in the future by the SLP and LSCP as to progress to implement:

Lincolnshire County Council Children Services- i) PNC checks submitted by children's services practitioners will routinely seek disclosure to include all information relating to a person's offending history and make clear this is not limited to just information from the preceding two years. ii) Children's services staff to be supported to ensure attendance and contributions from all relevant agencies at multi-agency meetings and in children's plans. iii) Internal Children Services review of MOSAIC[24] recording and reporting of CIN meetings and attendance of partner agencies.

Lincolnshire Community Health Services-i) A monthly audit is undertaken of all safeguarding referrals completed by LCHS Urgent Treatment Centre staff to ensure all safeguarding procedures have been followed. ii) Professional curiosity has been included in further LCHS safeguarding mandatory training, and safeguarding supervision for all staff within LCHS. The LCHS safeguarding team also provides an advice hub for contacts from any LCHS staff members who have experienced concerns from a contact with a patient where their aggressive behaviour may be linked to possible domestic abuse and potential harm to others.

[24] Children Services IT system that is used to record their management of cases.

Lincolnshire Police- It is accepted that there are gaps in front line Officers' knowledge of DVDS, DVPN's and DVPO's and Lincolnshire Police have instigated further DA Matters [25]training to all front line staff commencing in February 2022 where the use of DVPNs and DVDS will be covered. The subject of DVDS has been the subject of significant internal communications and recently been re-circulated to all front line Officers and staff via a formal briefing mechanism.

Lincolnshire Partnership NHS Foundation Trust- i) The Trust to review how known risks and risk management plans identified within the Police custody environment translate from the CJL&D 'Assessment of Needs and Outcomes' into the 'Clinical Risk Framework' (where other LPFT services are involved or later become involved) to ensure the Clinical Risk Framework is a complete record and reflection of risk.
ii) For Steps2Change Service Manager, in consultation with the Trust Safeguarding team, to review their Referral Screening Protocol and consider if changes are required to improve consistency amongst the screening staff in identifying and recording safeguarding and risk history when it is recorded on the separate clinical system RIO. iii) The Trust's Head of Safeguarding to meet with the Trust Named Doctors for Safeguarding and the Trust Medical Director to review the process of how a safeguarding concern disclosed within an outpatient's appointment is cross referenced with the record and the care coordinator to ensure it has already been identified and actioned.

GP Practice- i) The names of those who attend appointments with patients should be asked as well as their relationship and recorded in the patients record. ii) Recording the names of those who attend appointments, and the reason for this, is discussed within the level 3 safeguarding training delivered by the CCG safeguarding team. Clinical staff at the practice are in the process of booking on to sessions of this.

United Lincolnshire Hospital Trust-The Safeguarding Midwives will continue to remind all Midwives via their annual Midwifery Mandatory Training Safeguarding sessions to document all safeguarding information on the Electronic Maternity system in addition to any paper documentation and inform the Safeguarding Midwives if they become aware of any domestic abuse within a relationship so that the appropriate flags can be placed on the pregnant woman's records so that they would be visible to those accessing the system.
Probation Service- have in place an in-depth action plan to address the findings of their Serious Further Offence review. This recommendation from the Probation review though is totally relevant to this report.
'Whilst learning has been identified in terms of how practitioner practice could be improved in terms of multiagency working; it remains unclear as to why Probation services were not involved in the Child in Need process or whether the concerns of the supported housing provider were shared and acted on. It is the view of the Reviewing Manager that these questions need to be answered, not as a means of blame, but so that lessons can be learnt, and any necessary improvements made, in terms

[25] Domestic Abuse Matters,' a bespoke cultural change programme for police officers and staff in England and Wales. It has been designed to transform the response to domestic abuse, ensuring the voice of the victim is placed at the centre, and controlling and coercive behaviour is better understood. The programme is designed to have long-term impact: changing and challenging the attitudes, culture and behaviour of the police when responding to domestic abuse.

of how agencies can work together more effectively to protect potential victims, particularly in domestic abuse cases which are not subject to formal multiagency arrangements such as MARAC, MAPPA or Child Protection.'

Salvation Army- i) Staff within the Hostel need to be confident in their responsibility to report disclosures of concern robustly and consistently. The service has evidence of regularly reporting safeguarding concerns appropriately, however, in this case staff felt reassured by (1) how the perpetrator presented within the service and (2) the response from the Police Officer which impacted the extent to how they reported the concern. ii) Further training is being delivered to staff at the Hostel in reporting concerns and will be monitored through regular service reviews.

East Lindsey District Council- A review of training needs in Public Sector Partnership Services and the Councils has begun.

Special School- (i)Additional training has since been given to school staff on Domestic Abuse and the indicators for pupils and families.(ii) Safeguarding leaders have already improved procedures for sustaining routine contact with all parents whose children with special educational needs and disabilities travel independently to the school.

4.21 Recommendations from this report:

Recommendation 1 The Safer Lincolnshire Partnership (SLP), Lincolnshire Domestic Abuse Partnership (LDAP) and the Lincolnshire Safeguarding Children Partnership (LSCP) need to coordinate the raising of professionals' awareness, knowledge and understanding of: i) the Domestic Violence Disclosure Scheme, Domestic Violence Protection Notices and Domestic Violence Protection Orders (to be led by Lincolnshire Police). ii) The risks following separation of harassment and stalking. iii) Coercive and controlling behaviours iv) The fact that domestic abuse is always harmful to children. (Utilising the lives of Bethany and Darren would help understand as a case study and each agency to support the learning by also delivering agency specific guidance.)
Recommendation 2 The Lincolnshire Domestic Abuse Partnership and the Local Safeguarding Children Partnership should seek assurance from partners that when they work with victims of domestic abuse, who are unable to or reluctant to engage, that they consider the best individual, or agency, who could facilitate this engagement, in order to ensure that any risk posed to the victims and their children in these families is properly assessed and the victim can be suitably supported**.** (As an example, this may be through Lincolnshire Children Social Care tool 'Family Seeing' as it may be a family member best placed as it was in this case to make more use of Bethany's mother or through the MARAC process and an IDVA.)
Recommendation 3 i) The Lincolnshire Safeguarding Children Partnership must seek assurance from Children Social Care that they have made changes to the local Child in Need processes which makes them more inclusive and that all relevant agencies, including those providing services to adults, are included

more consistently in the process and meetings. This also includes the consideration for the meetings to have records taken. ii) The Safer Lincolnshire Partnership and the Lincolnshire Domestic Abuse Partnership should seek assurance from all agencies that their staff are aware of the impact that Domestic Abuse has on Safeguarding Children. That the agencies also ensure that any perpetrator risk assessments feed into the safety planning around any children in the family.
Recommendation 4 I) The Lincolnshire Domestic Abuse Partnership must seek assurance from those agencies, who are working with perpetrators of domestic abuse, that they are able to co-commission with them services that will provide a robust response with perpetrators to try and alter their abusive behaviours and prevent future domestic abuse ii) The Lincolnshire Domestic Abuse Partnership must also seek assurance that those supporting and working with perpetrators of domestic abuse are fully trained to ensure that interventions target and manage their abusive behaviours.
Recommendation 5 i)The Lincolnshire Domestic Abuse Partnership and Lincolnshire Safeguarding Children Partnership should engage with the Local Criminal Justice Board, to promote that they use the learning from the deaths of Bethany and Darren as a case study to raise awareness and understanding of the domestic abuse risks involved in these cases. ii) Lincolnshire Safeguarding Children Partnership & Lincolnshire Domestic Abuse Partnership to explore with the Local Family Justice Board, provision of the multi-disciplinary training recommended by the Harm Panel, with a particular focus on coercive and controlling behaviour, including the ways that perpetrators utilise private law children proceedings as part of this behaviour.
Recommendation 6 The Safer Lincolnshire Partnership and Lincolnshire Safeguarding Children Partnership should seek assurance from partners that their information sharing systems, ensure that in cases of domestic abuse, information is being shared in a timely and appropriate manner and that the voluntary sector are included as an integral part of information sharing for safeguarding adults and children. This should include the agencies reminding individuals of their duty to share information and ensure these individuals have an opportunity to be fully trained in information sharing.

4.22 The review chair feels that the last words in this report should be those of the family. DJ's father said*. "No sentence in the world will be enough for what he has done to my son and Beth."* Bethany's parents said, *"their lives, will never be the same again*" and spoke of their "*pain and emptiness*". Bethany's sister said that the perpetrator had "*ruined our family's life forever".*