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Domestic Abuse Related Death Review
Executive Summary
DHR Sasha/August 2022

Author: Dr Liza Thompson

Commissioned by:
Cumberland Community Safety Partnership

Review completed: December 2024

Sasha was described by her mum and sister as a "one off." They said that Sasha was funny, did not follow the crowd, had a quirky sense of dress and did not care what people thought of her. They said that Sasha knew her own mind, and was not quick to forgive anyone, but would always forgive Brett. Sasha's family said that all she had wanted was her own little family, and professionals who met Sasha recalled fondly how she would always have her outfits coordinated with her baby.

Everyone who has been involved in Sasha's review express their deepest condolences to her family and friends – it is clear that Sasha's death has left a big hole in their lives, and it is tragic that she will miss her beautiful baby growing up.

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Contents

1. The Review Process

1.1. This Domestic Abuse Related Death Review examines agency responses and support given to Sasha, a resident of Town A, prior to her death in August 2022.

1.2. On a day in August 2022, Sasha had expressed her suicidality on social media and to family via text message. Upon receipt of the message, her sister arrived quickly at Sasha's home and found Sasha hanging. Sasha was cut down, an ambulance arrived promptly, and Sasha was admitted to the Intensive Care Unit at Hospital A.

1.3. Tragically Sasha passed away five days later.

1.4. Two weeks before Sasha's death, she had been subjected to threats of "revenge porn"[1] by ex-partner Brett. On 23rd August 2023, he pleaded guilty at Magistrates Court, to "threatening to disclose a private sexual video with the intention to cause distress."[2]

1.5. On 27th July 2023 the Cumbria coroner returned a narrative verdict – finding that Sasha's cause of death to be hypoxic brain injury[3] and ligature strangulation and found that *"whilst Sasha died as a result of deliberate self-suspension, there is insufficient evidence that Sasha intended the consequences of doing so to be to take her own life."*

1.6. This Domestic Abuse Related Death Review examines the involvement that organisations had with Sasha a white British woman in her mid-twenties and Brett a white British male in his mid-twenties – between January 2016 and August 2022. The relevance of this period is that it spans the relationship between Sasha and Brett.

2. Contributors to the Review

12.1 Each of the following organisations contributed to the review.

Agency/ Contributor	Service or project
Children Social Care	Child in Need - s.17 Children Act – from 8th July 2021 to 1st February 2022 Where a child is unlikely to achieve or maintain a reasonable standard of health or development without the provision of services from the local authority – or their health and development is likely to be significantly impaired without the provision of services from the local authority.

[1] Also known as imaged based sexual abuse. The act of sharing intimate pictures of videos of someone either on or offline without their consent, to cause embarrassment and distress. New law to tackle revenge porn - GOV.UK (www.gov.uk)

[2] Criminal Justice and Courts Act 2015

[3] Reduced oxygen flow to the brain.

	Safeguarding Hub – a central multiagency arrangement, reviewing and checking intelligence systems, information sharing and referrals.
Cumbria Constabulary	Response officers – police officers who respond to emergency and non-emergency calls from the public. Multi Agency Risk Assessment Conference– this is a multi-agency forum funded and staffed by police and chaired by Detective Inspector. It is attended by all statutory parties and has voluntary sector representation. The purpose of the Multi Agency Risk Assessment Conference is to share information about high-risk cases, and make actions intended to reduce the risk of harm to the victims.
North Cumbria Integrated Care (North Cumbria Integrated Care)	Midwifery Team – midwives provide care for expectant mothers, from when they first know they are pregnant. There are generally ten appointments offered throughout the pregnancy, to check health and development of the mother and the baby – including blood tests, ultrasounds, and antenatal classes. Health Visiting Team – made up of a team of specialist nurses who offer advice and guidance to parents with children aged 0-5 years old. Health visitors are commissioned to deliver the national Healthy Child Programme. Emergency Department - for serious injuries and life-threatening emergencies.
Integrated Care Board (ICB) on behalf of GP Practice A	General Practice – treats all common medical conditions and refers patients to hospitals and other medical services for urgent and specialist treatment.
Cumbria Northumberland Tyne and Wear NHS Foundation Trust (CNTW)	Perinatal Mental Health – providing a multidisciplinary service for women with mental health problems relating to pregnancy, childbirth, and early motherhood. Caring for women with a range of moderate to severe mental health problems. Community Mental Health Team – providing assessment and treatment by a multi-disciplinary team to patients over 18 years of age. A range of interventions and therapies are offered to suit the individual's needs. Crisis Resolution and Home Treatment Team – a team of experienced mental health staff, including nurses, social workers, psychiatrists, and pharmacy staff. North Cumbria Talking Therapies (referred to in the report as First Step) – offers psychological therapies for mild to moderate depression and anxiety disorders.

Victim Support	Independent Victim Advocate (IVA) Service – and Turning the Spotlight – As part of an integrated service Victim Support provides IDVA, IVA and Turning the Spotlight Services. The IDVA service supports domestic abuse victims assessed as high risk of harm. The Independent Victim Advocates (IVA) work with any victim of crime including non-high domestic abuse victims. Turning the Spotlight is a 12-week healthy relationships programme for those displaying harmful/abusive behaviours and where the risk is assessed as non-high. An accompanying 7-week partner programme and 4-week parents/children programme is also offered. Perpetrators and victims are supported by different case workers.
Carlisle City Council	Tenancy Support – The housing team will support tenants in setting up and maintaining their new home, working closely with them to address support needs, and help to develop independent living skills, budgeting and developing support networks. Homeless Team – work to prevent homelessness, manage homeless applications and support in identifying suitable housing options.
Recovery Steps Cumbria	Substance misuse support Prior to recommissioning in October 2021, the alcohol service was provided by Greater Manchester Foundation Trust, and the service was named Unity. From October 2021, the service is provided by the charity Humankind[4]
Riverside Housing	Social Housing, general needs Landlords.

3. Review Panel Members

3.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Sasha and/or Brett. It also included a senior member of the Cumberland Community Safety Team. Panel members had not had contact or involvement with Sasha and/or Brett. The panel met on five occasions during the review.

3.2 The members of the panel were:

Agency	**Name**	Job Title
	Dr Liza Thompson	Independent Chair

[4] Humankind – For fair chances (humankindcharity.org.uk)

Cumberland Community Safety Partnership	Alison Goodfellow Hayley Bishop	Assistant Safer Communities Manager Area Planning Manager
Cumbria Constabulary	Sarah Edgar	Detective Constable Safeguarding Hub
Victim Support	Sarah Place	Operations Manager
Cumberland Council	Tammie Rhodes	Head of Homeless Prevention and Housing Services
North Cumbria Integrated Care	Gemma Qi	Safeguarding - Specialist Domestic Abuse Practitioner (RGN)
Cumbria Northumberland Tyne and Wear NHS Foundation Trust	Sheona Duffy Joanne Sharp	Named Nurse for Adult and Children Safeguarding – Safeguarding and Public Protection Team
Children's Social Care	Michelle Southward Louise Cavanagh	Service Manager for Support and Protect Teams Domestic Abuse Business Manager for Children's
Recovery Steps Cumbria	Lucy Reed	Service Manager

4. Author of the Overview Report

4.1 The Independent Chair and Author was Dr Liza Thompson.

4.2 Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

4.3 Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Cumbria.

5. Terms of Reference

5.1 The full subjects of this review were victim, Sasha and the perpetrator, Brett. The review established whether any agencies identified possible and/or actual domestic abuse that may have been relevant to the death of Sasha.

5.2 If such abuse took place and was not identified, the review considered why not, and how such abuse can be identified in future cases.

5.3 The review focused on whether each agency's response to domestic abuse was in accordance with its own and multi-agency policies, protocols and procedures in existence at the time. If domestic abuse was identified, the review will examine the method used to identify risk and the action plan put in place to reduce that risk. This review will also consider current legislation and good practice. The review will examine how the pattern of domestic abuse was recorded and what information was shared with other agencies.

5.4 Specific issues which were considered, and if relevant were addressed by each agency in their Individual Management Reports:

a. Were practitioners aware of the effects of domestic abuse – specifically stalking and harassment – on Sasha's mental wellbeing?

b. What consideration was given to the risks of suicide in peri-natal women?

c. Did agencies work together to gauge an understanding of Sasha's experiences prior to her death?

d. How accessible were the services to Sasha and/or Brett?

e. Were practitioners sensitive to the needs of Sasha, knowledgeable about potential indicators of domestic violence and abuse and aware of what to do if they had concerns about a victim or perpetrator? Was it reasonable to expect them to fulfil these expectations?

a. Did the agency have policies and procedures for the use of DASH risk assessments[5] and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Sasha?

b. Were these assessment tools, procedures and policies professionally accepted as being effective? Was the victim subject to a Multi-Agency Risk Assessment Conference or other multi-agency forums?

[5] Dash risk checklist quick start guidance FINAL.pdf (safelives.org.uk)

c. 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?

d. Did actions or risk management plans 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?

e. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

f. Was anything known about the perpetrator? Were there any injunctions or protection orders that were, or previously had been, in place?

g. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? How was the information recorded and shared, where appropriate?

h. Are there other questions that may be appropriate and could add to the content of the case? For example, was the domestic homicide the only one that had been committed in this area for a number of years?

i. Are there ways of working effectively that could be passed on to other organisations or individuals?

j. Are there lessons to be learned from this case relating to the way in which this agency works to safeguard victims and promote their welfare, or the way it identifies, assesses, and manages the risks posed by perpetrators? Where can practice be improved? Are there implications for ways of working, training, management, and supervision, working in partnership with other agencies and resources?

6. DHR Methodology

6.1 The detailed information on which this report is based was provided in Individual Management Reports (IMRs) completed by each organisation that had significant involvement with Sasha and/or Brett. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

6.2 Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the Review Panel. Neither the Independent Management Report Authors nor the Senior

Managers had any involvement with Sasha and/or Brett during the period covered by the review.

7. Summary Chronology

7.1 In July 2020, Sasha self-referred to First Steps for support around anxiety and depression. Sasha was referred for Cognitive Behavioural Therapy, there was a 12-week waiting list. In October 2020, Sasha was contacted about the therapy, and she declined this, as she stated the difficulties had resolved. She was discharged to her GP.

7.2 On 30th December 2020, Sasha spoke with her Midwife about her partner Brett's alcohol intake. He was drinking heavily and using cocaine regularly. She stated that he was depressed but refused to get help. The Midwife was concerned about Sasha and the unborn baby's welfare, so made a referral to the safeguarding hub. There is no evidence that Sasha's GP was contacted about the concerns.

7.3 Sasha contacted First Steps via online referral on 2nd January 2021, stating she had anxiety following the loss of her job, and being pregnant. The records indicate that Sasha did not respond to First Steps' attempts to contact her.

7.4 On 4th January 2021, Children's Social Care contacted Sasha, records indicate that she was very open and honest about her situation. She was recorded as being 12 weeks pregnant. She told social workers that if Brett did not stop using drugs and alcohol, she would end the relationship with him and would not allow him contact with the baby. Children's Social Care agreed to leave the Midwife and Health Visitor to monitor the situation and recorded that she believed Sasha would be open and honest with them about her situation.

7.5 Sasha had a telephone consultation with her GP on 1st February 2021 and was provided with a medical certificate. There was a lack of exploration with Sasha about the cause of her anxiety. A further medical certificate was given on 11th March 2021. Sasha had contact with the Midwife and the Nurse Practitioner over the coming few weeks and was not asked about the mental health issues she had been sharing with the GP. These were missed opportunities for professional curiosity.

7.6 At the end of March 2021, the midwife was made aware of Brett's behaviour's and requested a Domestic Violence Disclosure Scheme (DVDS) disclosure[6] for Sasha. The DVDS panel agreed for a disclosure to Sasha to be given, with the support of the midwife.

7.7 A MARAC referral was first made in May 2021; however, this was downgraded to medium. The Victim Support IDVA was allocated to Sasha, and following an initial conversation, Sasha decided she did not need to engage with the IDVA service at that point. The IDVA challenged the downgrading of risk as the MARAC was heard on 17th June 2021. criminal

[6] Often referred to as Claire's Law – has introduced procedures that can be used by police to disclose information about previous violent or abusive offending – where this may help protect their partner from violent or abusive offending. DVDS guidance (accessible) - GOV.UK (www.gov.uk)

history was shared, and police involvement with Brett and his ex-partner. An action was made for consideration of peri-natal services for Sasha, and she was referred into the Safeguarding Hub.

7.8 Sasha met with First Steps in early June 2021 and was referred to a psychological wellbeing practitioner. Sasha was supported with techniques to reduce anxiety. Also in June 2021, Turning the Spotlight received a call from Sasha requesting support for her and Brett.

7.9 The MARAC referral had led to police dealing with an offence of stalking. Following a delay in speaking with Sasha, police met with her at home on 1st July 2021. At this point, Sasha and Brett were back in a relationship and Sasha did not wish to provide a statement. Sasha blamed the situation on her being pregnant, and on Brett's drinking at the time. A few weeks later, a No Further Action decision was made due to the lack of evidence.

7.10 Sasha cancelled her First Steps appointment on 30th June 2021, stating she would continue after the back was born, a new appointment was made for the end of July 2021.

7.11 Sasha was induced on in early July 2021, and her baby was born the same day, the Children Social Care duty team were advised, and the Social Worker attended the Ward to complete a safety plan with Sasha before she left the Ward. The baby was made subject of a Child in Need Plan. Brett was not permitted to have unsupervised contact and was not permitted to stay at Sasha's mothers house – where Sasha was currently living – for more than three nights per week.

7.12 Postnatal care was provided to Sasha in the community following the birth. The couple also agreed to engage with Turning the Spotlight, and Brett would self-refer to First Steps.

7.13 The social worker visited Sasha on 12th July 2021, the baby was doing very well. Sasha and the social worker discussed domestic abuse at length.

7.14 0n 28th July 2021, Sasha attended her session with First Steps as planned. She reported that her relationship with Brett had ended and stated that Children Social Care input was adding to her stress.

7.15 On 29th July 2021, a Turning The Spotlight Support worker allocated to Brett attempted to call him, but this was unsuccessful.

7.16 The social worker visited Sasha on 30th July 2021 and recorded the baby as thriving. Sasha was not happy with Children Social Care's continued involvement. She stated that there was no domestic abuse within the relationship.

7.17 The Turning The Spotlight Support Worker attempted to contact Brett on 9th and 17th August 2021 with no response.

7.18 The social worker visited Sasha on 17th August 2021. Sasha stated she had yet to register the baby, because Brett was currently prohibited from entering the area where the registry office was located, however she was still unsure of whether to include Brett on the birth certificate. She stated he had been out drinking with his friends again, so she hadn't seen him. The same day Sasha attended her planned First Steps session, she was supported with relaxation, mindful breathing, and grounding.

7.19 On 18th August 2021, the Turning The Spotlight support worker spoke to Sasha, who agreed to a meeting on 2nd September 2021, although she did not attend this.

7.20 Sasha had sessions with First Steps on 1st and 2nd September 2021. She is recorded as maintaining progress with strategies. Brett started First Steps sessions on 2nd September 2021.

7.21 Sasha completed all six of her Cognitive Behavioural Therapy sessions. She stated that that her anxiety had improved, she was discharged from First Steps.

7.22 During this time the status of the relationship between Sasha and Brett was uncertain, Sasha is recorded as wanting to make it work, but Brett was recorded as going out with his friends and not committing to the relationship.

7.23 In late September 2021, Sasha was housed in temporary accommodation by the local authority, following Sasha approaching as homeless. Sasha was living within a supported housing scheme, where it is recorded that she felt safe and supported. She was provided with emotional and practical support during this time. However, during the days when Brett had care of the baby, Sasha told professionals that she felt low in mood.

7.24 On 8th October 2021, the social worker spoke to Brett, who confirmed he did not want to be in a relationship with Sasha but wanted to have contact with the baby. The social worker undertook a Child in Need Plan visit on 12th October 2021, it is not clear whether the couple were seen together, but it is recorded that they were no longer in a relationship.

7.25 On 18th October 2021, Sasha called police stating that Brett had assaulted her. The baby could be heard crying in the background, and Sasha stated Brett had tried to push her down the stairs. The police attended and returned both Sasha and the baby to the supported housing scheme. Sasha did not wish to provide further evidence. A Multi Agency Risk Assessment Conference referral was made following the incident, this took place on 28th October 2021.

7.26 Between 28th and 31st October 2021, the Children Social Care Prevention and Crisis Support Officer, and the Homeless Accommodation Officer both spoke to Sasha, and Sasha's mother about the current situation. Sasha was offered a permanent tenancy.

7.27 During this time, the Turning The Spotlight support worker offered to help Sasha access a local women's group. Sasha also spoke to her GP about her low mood. Brett was seen by

the social worker during this time, and stated he was having contact with the baby but did not want a relationship with Sasha. Brett also engaged with Turning The Spotlight during this period. Both parents were advised by the social worker that if they restarted their relationship, the baby would be made subject of a Child Protection Plan.

7.28 Sasha's GP referred her to CNTW Crisis Team in early November 2021, due to her very low mood. They contacted her the same day, she denied suicidal ideation but wanted support with anxiety – which she stated was due to ongoing Children's Social Care involvement. Sasha continued to be low on the days when Brett had the baby, and she told practitioners she missed Brett.

7.29 Sasha engaged with her first Turning The Spotlight session on 8th November 2021. She was able to identify healthy and unhealthy relationship traits.

7.30 On 16th November 2021, the social worker undertook a visit to Sasha, the baby was doing well, and Sasha was feeling slightly better following her medication starting to work. Brett had started to change dates and times for when he was going to have the baby and was becoming unreliable. By 1st December 2021, Brett had stopped following the co-parenting plan, he was in a new relationship and had not seen the baby for two weeks.

7.31 Sasha met with the social worker on 13th December 2021, she was feeling better as her medication had started to work. She said she was starting to go out with friends on the days when Brett had the baby.

7.32 In January 2022, Sasha was supported with a moved into long term independent accommodation. She was provided with tenancy sustainment support, and was reported as being very happy in the tenancy. She was in a positive place mentally and was getting on well with her mum.

7.33 Sasha was to be closed to Turning The Spotlight at the end of January 2022, due to a lack of involvement in the programme. The Child in Need involvement was closed in early February 2022. Brett was closed to Turning The Spotlight in mid-February.

7.34 On 17th March 2022, Sasha was seen face to face by her GP. She raised a concern that she had bi-polar disorder due to spontaneous behaviours, including issues with gambling. The GP referred her to the CMHT. She described her relationship with Brett as amicable.

7.35 Sasha followed up with the GP practice on 29th March 2022. She told the GP that she was feeling "fobbed off" by CMHT, although there is no record of the GP asking why she felt this way. Sasha was advised to restart her medication, and a review appointment was book in for two weeks' time.

7.36 On 14th April 2022, Sasha attended her GP practice for a mental health review. She said she was tolerating the anti-depressants but requested an increase in dose.

7.37 Sasha took a paracetamol overdose on 22nd May 2022. She was conveyed to ED, where she declined support from the Mental Health Liaison Team, who were situated in the hospital. She was discharged home. The following day her Health Visitor contacted Sasha, who denied ongoing suicidal thoughts.

7.38 Sasha's family state that during June and July 2022, Sasha then distanced herself from them following an argument. They believe that during this time, she was back in a relationship with Brett. Her friends also confirmed this.

7.39 On 9th August 2022, the Health Visitor completed a home visit to review progress and discuss Sasha's mental health as per NICE guidelines.[7] Sasha reported no altered mood and was engaging well with universal services.

7.40 The following day, Sasha called police, Brett had contacted her just before midnight having been consuming alcohol all day. He was abusive and threatened to share an intimate video he had of her, which had been taken without permission. Sasha requested support for a civil injunction again Brett and a referral into Victim Support. The risk was graded at medium, however upon review the DASH omitted some high-risk indicator questions, for example Sasha having a baby under 18-months, and the question around stalking and harassment.

7.41 The Health Visitor called Sasha on 16th August 2022 to arrange a home visit. Sasha was upset and tearful, she stated she did not realise the Health Visitor would be informed, she declined further support, stating she had shared concerns with friends and Brett had reported he had deleted the images – although Sasha did not believe him.

7.42 Around ten days later, police were called to Sasha's address following a call from Sasha's sister. Her sister had been alerted to her state of mind following posts on social media and via text to family stated she would take her own life. Sasha had attempted suicide by hanging and was taken to hospital and was admitted to the Intensive Care Unit (ICU). She died five days later.

7.43 In August 2023, Brett admitted "threatening to disclose a private sexual video with the intention to cause distress". He was given a 24-month order which included 15 days of rehabilitation, a 30 day "building better relationships" course[8] and 201 hours of unpaid work. The defence counsel excused his behaviour by stating that "people do things in the heat of an argument" and that it was not certain that this act had led Sasha to complete suicide. When summing up, the magistrates told Brett to "think about your behaviour in the future."

[7] Quality statement 1: Identifying risk | Early years: promoting health and wellbeing in under 5s | Quality standards | NICE

[8] Quality statement 1: Identifying risk | Early years: promoting health and wellbeing in under 5s | Quality standards | NICE

8. Conclusions

8.1 Brett's risk of harm towards Sasha, and her risk of harm towards herself were not fully recognised by any agencies throughout the scoping period. Although there were MARAC referrals, there did not appear to be any proactive or impactful outcomes from the actions made at the MARAC meetings. Not all agencies were made aware of the MARACs having occurred, which raises an issue about communications following MARACs.

8.2 Brett appeared to have been assessed by Children's Social Care, as providing "good enough" care for the baby and was not identified as a risk to the baby or to Sasha – as the baby's mother. He sporadically engaged with the Child in Need process, Turning The Spotlight, substance misuse services, and counselling – he did not complete any of the programmes he was expected to complete as part of the Child in Need Plan. Although there was some challenge from the social worker towards Brett in September 2021, generally the focus was placed on Sasha, to manage Brett's behaviour, and to remove herself when his behaviour became problematic.

8.3 The lack of expectation placed on Brett, is linked to a widespread issue, where social care professionals sideline fathers,[9] instead focusing their expectations on mothers.[10] Sasha expressed her distress on many occasions, at having social workers involved in her, and her child's life – which was something she highlighted as causing her mental health to decline.

8.4 One example of this was the social worker's attendance at the Maternity Ward, directly after the birth of the baby. The reason for this stemmed originally from Sasha contacting her Health Visitor about Brett's behaviour – this call had been approximately six weeks prior to the hospital visit – and the intention of the social worker's visit at hospital was to provide information about a Child and Family Assessment and inform them that Brett could not have unsupervised contact with her baby before Sasha and the social worker had made a safety plan. The visit may not have been punitive towards Sasha, however her mother explained to the Independent Chair that it had felt heavy handed to Sasha who had just given birth, and also unnecessary as there was no immediate child protection issue raised or identified which would require an emergency response. Considering Sasha's history of mental ill health, and the risks known to peri-natal women around post-natal depression[11] and psychosis[12] – Children Social Care could have managed this more sensitively and proportionately, by visiting at home with the Health Visitor.

8.5 There was no consideration of Brett's behaviour being coercively controlling, and Sasha's mental health issues were not considered in the context of coercive and controlling behaviour. She disclosed emotional dysregulation, which would have been further exacerbated by the

[9] The Myth of Invisible Men

[10] Thompson, L "Impossible Expectations? Abused mothers' experiences of the child protection and family court systems" *Child and Family Law Quarterly* (2020) Impossible expectations? Abused mothers'experiences of the child protection and family court systems

[11] Depression in pregnancy

[12] A mental health problem that causes people to perceive or interpret things differently from those around them

mind games and controlling behaviour which Brett was clearly displaying, in plain sight. There does not appear to have been a connection made between Sasha's deteriorating mental health, and Brett's behaviours. There was also no obvious link made between this, and the baby's birth which would have exacerbated the situation by introducing further issues of dependency and connection between the couple.

8.6 At the point where Sasha's mental health, Brett's coercive behaviour, and the birth of the baby intersected – Sasha's risks of harm, from Brett and herself, would have been at its highest. This does not appear to have been recognised by professionals or responded to appropriately.

8.7 The lack of recognition of Brett's coercive and controlling behaviour extends to the coroner court, where Sasha was simple described as living with "life stressors", and the Magistrates court, where there was no mention of ongoing domestic abuse, or coercive control – despite Brett admitting to behaviour which was very clearly an extension of his ongoing controlling behaviours. Although this review focuses on the agency involvement prior to Sasha's death, it will be making recommendations regarding the lack of recognition – and naming - of Brett's controlling behaviours even after they had caused Sasha's death.

9. Lessons to be Learnt

9.1. Cumbria Constabulary

9.1.1. Officers should be encouraged to recognise increase in risk of suicide where a mother is in her perinatal period. Learning from this review will be shared with police staff to assist with this learning.

9.1.2. The new Intelligence and Crime System will be introduced in 2025. Within this system, the DARA is built in. This is a risk assessment which replaces the DASH for police officers. To assist with embedding the DARA, the force will utilise the College of Policing e-learning to train all current staff. The force's learning and development team will replace the DASH input with DARA input into local training. This development is linked to a recommendation in a recent local DHR.[13]

9.1.3. During the period November 2023 to April 2024, an exercise saw weekly dip samples of domestic abuse cases which had No Further Act decisions. This included scrutiny of the safeguarding forms and DASHs linked to the case.

9.1.4. New DA Matters[14] training is in place across the force, and this includes learning regarding suicide, and deaths which appear to be suicide, which are linked to domestic abuse.

[13] DHR Ella | Westmorland and Furness Community Safety Partnership

[14] Provided by Safe Lives

9.1.5. In May 2024, the force launched RAPID – this is a clear framework for all officers dealing with domestic abuse cases. The acronym means; Response, Action, Prevent, Investigate, Detain. This was launched across three weeks, during this time toolkits, advice, and guidance was shared across the workforce. During the launch, further information was shared regarding victim/survivors' difficulties in leaving the relationship with their abuser. Also, a Minimum Standards of Investigation to assist officers, alongside information about victim blaming language.

9.1.6. All Sergeants are currently trained as domestic abuse Evidence Review Officers (EROs). There is training on this within their Sargeant's course, and also through online training for acting Sergeant, and for refresher training.

9.2. Northeast, North Cumbria Integrated Care Board (NENC ICB)

9.2.1. Primary Care staff should be encouraged to link in with Children's Social Care.

9.2.2. It is also important that GPs and Practice staff record names of family members, particularly when information is shared about a partner behaving in an abusive manner.

9.2.3. The discharge form from Midwifery should have triggered the discussion at Practice A's safeguarding monthly meetings, alongside the health visiting service. Since the scoping period, a new safeguarding administrator role has been introduced, who now review all discharge forms, and would have included Sasha on the safeguarding monthly meeting agenda.

9.2.4. NCEC ICB will share the Jane Monckton Smith's Suicide Timeline with GP practices, alongside learning from this review, in order to encourage primary care practitioners to consider how domestic abuse impacts risks of suicide.

9.3. North Cumbria Integrated Care

9.3.1. NCIC have launched the "How safe do you feel?" Campaign which encourages all staff to ask routinely regarding patient's safety and wellbeing. Domestic abuse champions training has been implemented, with the aim of educating all NCIC staff to recognise and respond to victims of domestic abuse. The introduction of the Health IDVA will assist with this.

9.3.2. Whilst risk mitigation and management plans were implemented by NCIC, it is not clear from records how often these plans were reviewed and updated. NCIC Maternity Services policy requires that assessments are reviewed at every contact, but records do not evidence that staff were compliant with this.

9.3.3. There was a lack of professional curiosity evidenced throughout contacts with Sasha. Incorporating Sasha's wider contextual situation was necessary to ensure

holistic assessment and mitigation planning. Since the scoping period, Cumbria Safeguarding Adult's Board and Cumbria Safeguarding Children's Partnership have collaborated to create professional curiosity training for all partner agency staff. Learning from this review will be shared to raise awareness of this training and encourage attendance at this training.

9.3.4. Since the scoping period for this review, NCIC have introduced an Alcohol Care Team, who work with staff, hospital patients and partners to help with the assessment and management of alcohol related problems.

9.3.5. Where there are alcohol related hospital admissions, the Alcohol Care Team can undertake assessments. Where required they also assist with discharge planning, relapse prevention strategies, and linking in with community services to provide continuation of care.

9.3.6. The team work alongside Recovery Steps and are funded by the NENC ICB. The initiative was introduced in response to a rising issue with alcohol related deaths. The positive impact of the work of the team, in working across agencies, could be extended beyond alcohol, to include substances. The review will make a recommendation for this to be considered by the ICB.

9.4. Victim Support

9.4.1. There could have been further and deeper exploration when disclosures were made by both Sasha and Brett. For example, when Sasha made a comment about "walking on eggshells" and Brett was uncomfortable attending the Turning The Spotlight sessions as he knew Sasha was also being supported by Victim Support. This indicates the need for continuous and dynamic risk assessment – particularly in this case, around suicide risk in during the perinatal term.

9.4.2. Case recording was poor, therefore deeper discussions may have happened and not been recorded. This is another area of learning for Victim Support.

9.4.3. Victim Support Cumbria's IDVA and IVA services now use a merged suicide timeline and DASH risk assessment tool when assessing risk of domestic abuse victims and survivors that present with fluctuating mental health illnesses and are involved with Children Social Care. However, although there is clear evidence of a thorough and good understanding of domestic abuse, in relation to suicide, there was little evidence in Sasha's case, of staff understanding the increased risks of suicide for women during perinatal term.

9.5. Recovery Steps Cumbria

9.5.1. Since the scoping period of this review, Recovery Steps Cumbria have implemented a revised safeguarding recording tool, within their electronic recording system. This

includes a comprehensive review of any domestic abuse concerns, links to the DASH RIC, includes a Multi-Agency Risk Assessment Conference referral mechanism and safety planning section.

9.5.2. Alongside this, Recovery Steps Cumbria have introduced Multi Agency Risk Assessment Conference leads, who have developed an internal training session to support all staff to use the DASH RIC assessment.

9.5.3. Routine enquiry has also been introduced to enquire about safeguarding concerns at intake, and during assessment.

9.5.4. Learning from this review will be used to highlight the developments detailed above.

14. Recommendations

Multi Agency Recommendations

14.1. Assurance will be sought from all agencies involved in this review, that all relevant staff have attended, or are booked onto Public Health's Suicide Prevention training, or equivalent.

14.2. The panel recommend that where a statutory review involves a death where someone is suspected to have taken their own life in the context of domestic abuse, Cumberland Public Health's Suicide Prevention Team will be represented on the panel – from the inception of the review through to completion.

14.3. A learning tool will be developed for multiagency training and awareness, which will share Sasha story and highlight the following specific areas of learning:

a. Awareness of risk indicators of suicide, including perinatal mental health, domestic abuse and ongoing harassment
b. Ongoing and consistent assessments of risk
c. Invisibility of men
d. Non-recent risk – and triangulation of information
e. Post separation abuse – and the use of child contact to continue control.

North Cumbria Integrated Care

14.4. NCIC employees to be trained on the impact of unconscious bias.

Children Social Care

14.5. Suicide is the leading cause of maternal death during pregnancy and up to a year after birth, this needs to be clearly understood, and other complicating factors considered

when triangulating risk and considering timeliness of safety planning. Perinatal suicide prevention training will be rolled out to all practitioners within Children Social Care.

14.6. Coercive and controlling behaviours continue after a relationship has ended. Risk assessments of perpetrators must be completed when considering family time with their own children to ensure that safe arrangements can be put into place. Risk assessment models will be reviewed, and training delivered to ensure risk assessments are being completed by practitioners within Children Social Care.