CONFIDENTIAL UNTIL PUBLICATION

Cumberland Community Safety Partnership

Domestic Abuse Related Death Review
Sasha/August 2022
Overview Report

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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1. Introduction

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 expressed suicidal ideation 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.

1.7. The key reasons for conducting a Domestic Abuse Related Death Review are to:

a) Establish what lessons are to be learned from the domestic abuse related deaths, about the way in which local professionals and organisations work individually and together to safeguard victims.

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

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

d) Prevent domestic abuse related deaths and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working.

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[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.

e) Contribute to a better understanding of the nature of domestic violence and abuse.
f) Highlight good practice.

1.9. The Cumbria Community Safety Partnership[4] confirmed the case met the criteria for a Domestic Homicide Review in November 2022.[5] This decision was ratified by the Chair of the Community Safety Partnership, and the Home Office were informed.

1.10. Sasha was not the victim of a homicide (where a person is killed by another). However, this review is framed by the 2016 Home Office DHR Guidance which states:

"Where a victim took their own life and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable."[6]

1.11 During 2024, the Home Office launched a consultation on the use of the title "Domestic Abuse Related Death Reviews"[7] – to take account of deaths which were not directly caused by a homicidal act. The panel agreed to use this title for Sasha's review.

2. Confidentiality

2.1 The findings of this Domestic Abuse Related Death Review are confidential. Information is available only to participating officers/professionals and their line managers, until after the Domestic Abuse Related Death Review has been approved by the Home Office Quality Assurance Panel and published.

2.2 Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Sasha's family.

2.3 Details of the deceased and perpetrator:

Name (Pseudonym)	**Gender**	**Age at time of death**	**Relationship to deceased**	**Ethnicity**
Sasha	Female	Mid-twenties	*Deceased*	White British
Brett	Male	Mid-twenties	*e.g. Partner and perpetrator*	White British

[4] Now Cumberland Community Safety Partnership
[5] As per Section 9 of the Domestic Violence, Crime and Victims Act 2004,
[6] Section 18 Domestic Homicide Review-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)
[7] Consultation: updating the domestic homicide review statutory guidance (accessible) - GOV.UK (www.gov.uk)

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	Relation to deceased:	Relation to perpetrator:
Sasha's Mum	Mum	None
Sasha's sister	Sister	None
Sasha's friend	Friend	None

3. Methodology

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

3.2 Each Independent Management Report 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.

4. **Timescales**This review began in November 2022 and was concluded in May 2025.

4.2. The criminal investigation and subsequent criminal trial for Brett did not conclude until August 2023 and following Home Office Guidance[8] the panel paused the review process pending the outcome of this.

4.3. There was a further delay until October 2023 due to a delay in the panel and Chair receiving the Independent Management Report from Children Social Care.

4.4. The initial draft report was considered by the panel in November 2023, following developments of the report, and some time taken to ensure the family had reviewed the report, fed back to the panel, and agreed alias names, the final report was signed off in July 2025.

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.

[8] Domestic homicide reviews: statutory guidance - GOV.UK

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:

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

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

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

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

v. 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?

vi. Did the agency have policies and procedures for the use of DASH risk assessments[9] and risk management for domestic violence and abuse victims or perpetrators and were those assessments correctly used in the case of Sasha?

vii. 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?

viii. 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?

ix. 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?

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

x. 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?

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

xii. 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?

xiii. 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?

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

xv. 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. Involvement of Family Members and Friends

Name of Advocacy Service	When was offer made and by whom?	Who was the offer made to?	Was the offer repeated/ advocacy taken up?
Advocacy after Fatal Domestic Abuse (AAFDA)[10]	Chair – May 2022	Mum and Sister	Taken up
AAFDA	Chair – referral made on September 2023	Friends	Not taken up

6.1 The Cumberland Community Safety Partnership, the Independent Chair and the review panel extend their deepest condolences to Sasha's family and friends.

6.2 A letter was sent to the family on 1st October 2022 to advise of the review process and introduce the Independent Chair. This was delivered by the police Family Liaison Officer (FLO).

[10] Home - AAFDA

6.3 The Independent Chair met Sasha's mother on MS Teams on 25th November 2022. The Independent Chair also met with Sasha's mother and sister with support from their AAFDA Advocate on 14th July 2023. The family were advised about the purpose of the review, and the terms of reference were shared with them.

6.4 The recollections of Sasha's family and friends are interwoven throughout the review, and the panel are very grateful for the generosity of those the Independent Chair spoke with.

6.5 The family were provided with the final draft report in January 2025, and met with the Chair to discuss the learning, ahead of a final report being completed and submitted to the Home Office in October 2025.

7. Contributing Organisations

7.1 Each of the following organisations contributed to the review.

Agency/ Contributor	**Service or project**	**Nature and source of Contribution**
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. Safeguarding Hub – a central multiagency arrangement, reviewing and checking intelligence systems, information sharing and referrals.	Independent Management Report. Information obtained from Liquid Logic system. Interview conducted with Social Work Team Manager.
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	Independent Management Report. Red Sigma – intelligence and crime system accessed. Sleuth – intelligence and

	share information about high-risk cases, and make actions intended to reduce the risk of harm to the victims.	crime system prior to Red Sigma also accessed. Police works – case and custody system accessed. Interviews with key officers
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.	Independent Management Report. Paper records Symphony Rio, EMIS and PAS also accessed.
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.	Independent Management Report. EMIS Primary Care System Interview with Practice Safeguarding Lead, and with ICB Named GP for Safeguarding
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	Independent Management Report.

	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.	Rio computer systems IAPT records.
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.	Independent Management Report. Accessed files from NGCM Case recording system.

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.	Independent Management Report. Examination of all Sasha's records, including support records, risk assessments, rehousing and move on plans, homeless assessments, and housing application. Interviews with key Officers.
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[11]	Independent Management Report. SystmOne Information requested made to the previous addiction service provider – Greater Manchester Mental Health NHS Foundation Trust.
Riverside Housing	Social Housing, general needs Landlords.	Chronology provided.

8. Review Panel Members

8.1 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, and a representative from Victim Support who provide domestic abuse services locally, Panel members

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

had not had contact or involvement with Sasha and/or Brett. The panel met on five occasions during the review.

8.2 The members of the panel were:

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

9. Independent Chair and Author

9.1 The Independent Chair, who is also the author of this overview report, is Dr Liza Thompson.

9.2 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 (IDVA), and later as the Chief Executive of a specialist domestic abuse charity. As well as chairing and authoring DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) and Offensive Weapon

Homicide Reviews (OWHRs). 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 both Rochester and Canterbury Diocese Safeguarding Advisory Panels (DSAPs). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.

9.3 Dr Thompson has no connection with the CSP and agencies involved in this review, other than currently being commissioned to undertake this Domestic Abuse Related Death Review.

10. Publication

10.1 This overview report will be published on the website of the Cumberland Community Safety Partnership.

10.2 Family members will be provided with the website addresses and also offered hard copies of the report.

10.3 Further dissemination will include:

a. Members of the Cumberland DHR Steering Group, which includes Police, Clinical Commissioning Group and the Office of the Police and Crime Commissioner amongst others.
b. The Cumberland Safeguarding Adults Board.
c. The Cumberland Safeguarding Children Multi-agency partnership.
d. The Domestic Abuse Commissioner
e. Additional agencies and professionals identified who would benefit from having the learning shared with them.

11. Background Information

11.1 Sasha met Brett when she 20 years old. Sasha's mum said they were never really in a relationship but they would go out on dates and were never properly together. Everyone the Chair spoke with described the relationship as "on and off". Brett would go out with his friends during the weekend, this would involve alcohol and drugs, and Brett calling Sasha and being abusive. He would come back around on a Monday or a Tuesday, after the alcohol and drugs had worn off, and he was feeling sorry for himself. Sasha would forgive him, until the cycle started again with Brett going out again at the weekend.

11.2 The family told the Review Chair that Sasha did not think in the same way as other people. They described Sasha as quite judgemental and unforgiving, apart from when it came to Brett.

11.3 The family told the Chair that Brett would manage to get back into Sasha's life by getting sympathy from her, and she would often lie to the family about whether she was seeing him again or not.

11.4 Prior to the Covid-19 pandemic, Sasha had travelled abroad to work. Her family stated this was to get away from Brett. However, Sasha's friends recollected that Brett had stayed in touch with Sasha during this time. Sasha had to return to the UK due to the Covid-19 pandemic restrictions.

11.5 Sasha's mother told the Chair that she herself had also been charmed by Brett, and she believed that the Social Worker was also taken in by him. Sasha's mother described Brett as being very charming and said the right things. She mused that she could understand how Sasha thought she could help Brett.

11.6 It was common knowledge that Brett had relationships with other women, and Sasha told her family that Brett had given her a sexually transmitted infection (STI) while she was heavily pregnant. This is corroborated in the chronology where Sasha approached her GP for an STI test at seven months pregnant.

11.7 Often Brett would cancel or change plans when he was due to have contact with the baby, this would impact on Sasha's plans. She would often forgive him when he came back around and said he was sorry. He promised he would co-parent with Sasha, until the next time, when he would let her down again. Sasha's family stated that Brett was not interested in his and Sasha's baby.

11.8 The family said they had always thought that was something "not quite right" about Sasha's moods, and Sasha herself had thought she may have a borderline personality disorder.[12] Sasha had told practitioners that there was a volatile relationship with her mother, however Sasha's mother felt that this was because she always told Sasha the truth, which Sasha did not want to accept, and this led to arguments between them.

11.9 Everyone the Chair spoke to said that whenever Brett was not around, Sasha was happy and stable, and then he would come back, and she would spiral. Sasha's mother recalled that Brett had told Sasha to stop taking medication, he would make fun of her for taking anti-depressant medication. Sasha's mum told her not stop taking them, however Sasha had isolated herself from her family from early July 2022, for around a month. The family believe that Sasha was only seeing Brett during this time.

11.10 Sasha's friends said that all Sasha had wanted was a complete little family, and she would have forgiven Brett any of his behaviours to have this.

11.11 Sasha's mother and sister recalled that Sasha had got back in touch with them all around four days before she took the action which led to her death. Brett's threats to share intimate images of Sasha had happened six days before Sasha got back in touch with the family, and she did not tell the family anything about the threats, which her mother reflected was unusual for Sasha as she would usually share everything.

[12] Also known as emotional dysregulation disorder – a mental disorder characterised by the instability in mood, behaviour and functioning. The exact cause is unknown, however genetic, environmental and social factors are found to all play a role.

11.12 Sasha's sister reflected on Sasha's emotional deregulation, stating she was not always self-aware, would cut people off if they let her down. She would go for long periods without speaking to people and was rigid in her thinking. Sasha's sister wondered if Sasha may have been living with an undiagnosed neurodiverse condition.

11.13 Members of the housing team recollected that Sasha was focused, driven, and was striving to make a comfortable independent home for the baby and herself.

11.14 Professionals remembered Sasha fondly, they described her as happy, vibrant and outgoing, with a lovely warm smile.

11.15 Professionals recall that Sasha had a good relationship with her mother, who was a great support to Sasha and the baby, enabling her to return to work, and actively supporting Sasha to achieve her goals and aspirations.

11.16 Sasha's GP recalled that she was very eloquent in her presentation, and she was aware of what she felt she needed and wanted. She appeared to be a very confident mother and enjoyed the role. She appeared to have a very supportive family and attributed a large amount of her troubles to her physically living a distance away from them. She discussed plans for her and the baby's future.

11.17 Sasha had previous suicide attempts in 2016, she disclosed an overdose, and also an incident where she jumped in front of a taxi following an argument – although it is not recorded who the argument was with. Sasha also reported episodes of binge drinking.

11.18 Children Social Care did not hold any information about Sasha's early life history, she was not known to Children Social Care as a child.

11.19 Sasha had two sisters and a brother, Sasha's mother told Social Workers that Sasha was a lovely child, who did not present any difficulties. She was described as bright, intelligent and had a lovely friendship group.

11.20 Brett was known to have struggled with his emotions and following the death of his baby daughter in 2015, and his mother's death in 2020. Brett would use alcohol and cocaine to block out the pain. Records indicate that Brett used alcohol and cocaine from an early age. Children Social Care had a significant involvement throughout the first sixteen years of his life.

11.21 It is understood from Children Social Care records that Brett's mother felt throughout the years that she had little or no control over her sons, including Brett. He struggled with education and was involved in anti-social behaviour; there appears to be a history of drunk and disorderly conduct. He was involved with the criminal justice system,

receiving a referral order[13]in 2010, and a youth rehabilitation order[14] in 2012 which transferred over to Probation, for oversight, when he turned eighteen years old. Brett also received a suspended sentence for assaulting one of his brothers and causing criminal damage, at this point Brett had to leave his family home due to his behaviour.

11.22 Brett was in a relationship with a previous partner in 2013, which was punctuated with periods of domestic abuse. Children Social Care became involved with the partner's child due to Brett's behaviours. In 2014, this previous partner fell down the stairs following an argument with Brett, although she stated she was not pushed. The ex-partner took an overdose in 2014; she had no mental health issues prior to the relationship with Brett.

11.23 Brett and the ex-partner had a child in 2015. Also, during 2015, Brett was physically violent towards the ex-partner while in public, although they were not in a relationship at the time. A Multi Agency Risk Assessment Conference[15] was triggered, and following further Children Social Care involvement, the ex-partner decided to end the relationship with Brett. He did not engage with the child and family assessment. It was agreed that contact with the baby would be supervised, however Brett did not choose to have any contact with the baby.

11.24 The baby passed away due to Sudden Death Syndrome[16] and Brett had not had contact with the baby prior to the baby's death.

11.25 During 2016 further concerns were raised by Brett's mother when she contacted police, indicating that Brett was struggling with alcohol and drugs, and was becoming aggressive. He was very tall and intimidating, and it was felt that his levels of aggression had increased since the death of his baby.

11.26 Sasha and Brett met and started a relationship soon after.

12. Equality and Diversity

12.1 The panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, maternity, race, religion and belief, sex

[13] An order available for young offenders who plead guilty to an offence – whereby the young offender is referred to a panel of two trained community volunteers and a member of the youth offending team. It can be for a minimum of three months or a maximum of twelve months.

[14] A court order given to a young person under the age of 18 – when they are sentenced for committing a criminal offence. The order can be made for up to three years.

[15] MARAC – a local meeting where representatives from statutory and non-statutory services discuss cases which have been identified as high risk of death or serious injury due to domestic abuse SafeLives-Marac-Overview-June-2024.pdf

[16] Sudden Infant Death Syndrome (SIDS) where a baby dies suddenly or unexpectedly, when they are less than one year old, and seemed to be healthy. This often happens during their sleep.

and sexual orientation[17] – and which of these characteristics may have shaped Sasha's life experiences.

12.2 The panel agreed that the characteristics of sex would have shaped Sasha's experiences – as she was a woman, affected by male violence, and a mother.

12.3 Gender is the term used to refer to the socially constructed cluster of characteristics,[18] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[19]

12.4 Attributed masculine characteristics include toughness and the expectation that men will be violent.[20] Germaine Greer argues that women are expected to be submissive in order to fulfil male fantasies of what is female "normality."[21] This includes an expectation of the inevitability of male violence[22] and the belief that women need to be protected by other men from this violence.[23]

12.5 The fear of male violence in society and in the home therefore puts men in the position of either predator or protector of women. Jennifer Nedelsky argues that this culture of male violence is a constitutive force which shapes women's and men's lives.[24] Women take the fear of male violence for granted; they structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[25] Yet many in society continue to deny the gendered nature of violence against women.[26]

12.6 The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation, and shame, exists on a deeper level. Elizabeth Stanko argues that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should behave.[27] This gendered view about women's involvement in male violence which dictates that "good women avoid sexual and physical abuse; bad women don't"[28] is prevalent throughout institutional, societal and individual relationships.

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[17] Equality Act 2010
[18] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56
[19] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265
[20] Hearn, J *The Violence of Men* (1998) p.36
[21] Greer, G *The Female Eunuch* (1993) p.11
[22] Stanko, E *Intimate Intrusions: Women's Experience of Male Violence* (1985) p.9
[23] Nedelsky, J *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2011) p.210
[24] *Ibid* p.204
[25] Stanko, above n 7 p.70
[26] Monckton, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender* (2014) p.19
[27] Stanko, above n 7 p.72
[28] *ibid*

12.7 There is also a societal expectation upon women to be caregivers and Martha Fineman argues that "women's historic roles in the family anchor them to that institution in ways that men's historic roles do not."[29]

12.8 The role of a "mother" is a universally possessed symbol[30] and has a value attached to it. Motherhood itself is affected by gendered norms to a greater extent than fatherhood.[31] As Alison Diduck argues, there is an assumption in the relationship between a mother and her child of "never-ending love…timeless and universal duty… (a) romantic ideal…"[32] This gendered expectation of motherhood structures the mothers' lives inside and outside of the home – and more acutely when the mother is also a victim of domestic abuse.

12.9 Mothers are expected to protect children even if the family's difficulties are caused by other people.[33] A failure to measure up to this expectation can easily be construed as "pathological",[34] potentially leading to the removal of the children from the mother's care.[35]

12.10 Although the challenges Sasha faced with mental ill health are not included in the Equality Act's protected characteristics, it could be argued that Sasha's struggles with her mental health, particularly during the perinatal period - made her vulnerable and would have shaped her life experiences.

12.11 Perinatal mental health is the emotional and psychological wellbeing of women during pregnancy and after birth. NHS England define Perinatal mental health problems as those which occur during pregnancy or in the first year following the birth of a child.[36]

12.12 Perinatal mental illness affects up to 27% of new and expectant mothers and covers a wide range of conditions. Left untreated, the mental health issues can have significant and long-lasting effects on the woman, the child, and their wider family.

12.13 Sasha's family told the Chair that she had always been susceptible to mental health struggles, her mood was often up and down, and she would isolate herself from family and friends if she perceived a slight from them. She may have been susceptible to perinatal mental health issues.

12.14 The early postnatal period is a high-risk period for new and recurrent episodes of mental health, particularly of severe mental illness – with around 1-2 women in 1000 support

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[29] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56
[30] Fineman, M "The Neutered Mother" *University of Miami Law Review* 46 (1992) pp.653-54
[31] Boyd, S "Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility" *Windsor Yearbook of Access to Justice* 25 (1) (2007) p.65
[32] Diduck, A *Law's Families* (2003) p.83
[33] Scourfield, J "Constructing Women in Child Protection Work" Child and Family Social Work 6 (2001) p.82
[34] Clarke, K "Childhood, Parenting and Early Intervention: A Critical Examination of the Sure Start National Programme" Critical Social Policy 26 (2006) p.701
[35] Scourfield above n8 p.78
[36] NHS England » Perinatal mental health

in the first few months following their child's birth. Common mental disorders such as depression and anxiety represent a significant component of treatment needed in the postnatal period.[37]

12.15 Perinatal mental disorders are associated with deaths from suicide and substance misuse. When mental disorders intersect with poverty, physical health complications. Interpersonal violence, and other forms of disadvantage, women with mental illness are more likely to experience life threatening complications, and suicide attempts then those with no mental illness.[38]

12.16 Suicide risk is particularly related to depression during the perinatal period,[39] and is drastically increased in women with moderate to severe mental illness compared with no psychiatric illness history.[40] Suicides most often occur in the second half of the first postpartum year, and often woman may not have been receiving active psychiatric treatment at the time of her death.[41]

12.17 At the point where Sasha's gender, mental health and maternity intersected, and Brett threatened to send explicit images of her, the situation became overwhelming and Sasha took her own life.

13. Chronological Overview

13.1 In July 2020, Sasha self-referred to First Steps for support around anxiety and depression. Sasha had a telephone assessment, and reported suicidal thoughts for around five years, but stated she managed these thoughts with internal resources. She described recurrent depressive disorder, which had not responded well to medication previously, and which had recently been exacerbated due to moving back home with her parents. There was a treatment planned with a High Intensity Practitioner. They contacted her the following day, and it was agreed that Sasha would undergo Cognitive Behavioural Therapy,[42] there was a waiting list for 12 weeks. In the meantime, a contingency planning was discussed. 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.

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[37] Howard, ML and Khalifeh, H "Perinatal Mental Health: A Review of Progress and Challenges" *World Psychiatry* Vol.19 Issue 3 p.265-412

[38] Knight et al (eds) *Saving Lives, Improving Mother's Care – Lessons Learnt to Inform Maternity Care from UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2014-2016* Oxford (2018) p.314

[39] Grigoriadis, S et al "Perinatal Suicide in Ontario Canada: A 15 Year Population Based Study." *Canadian Medical Association Journal* (2017) 189 pp.1085-92

[40] Johanssen, B et al "All-Cause Mortality in Women with Severe Post-Partum Psychosis Disorders" *American Journal of Psychiatry* (June 2016) 173 (6) pp.635-42

[41] Kalifeh, H etc al "Suicide in Perinatal and Non-Perinatal Women in Contact with Psychiatric Services: 15-year findings from a UK National Inquiry" *Lancet Psychiatry* (2016) 3: pp.233-242

[42] This is a talking therapy that can help manage problems by changing the way a person thinks and behaves.

13.2 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. He had lost a baby from SIDS five years previously, with a previous partner. The Midwife was concerned about Sasha and the unborn baby's welfare, so made a referral to the safeguarding hub. Attempts were made to contact Sasha. The Clinical Lead in the safeguarding hub gathered information about Sasha and Brett. There is no evidence that Sasha's GP was contacted about the concerns.

13.3 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.

13.4 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. Sasha planned to stay with her mum for the first few months after the baby was born. 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.

13.5 Sasha approached her GP the following day, asking for help with her anxiety. She was not keen on medication and asked for counselling. It was documented that she had no suicidal ideation. Sasha was given contact information for self-help contacts and contact details of the Crisis Team.

13.6 On 1st February 2021, Sasha had a phone consultation with the GP and discussed her anxiety, she was provided with a prescription for a month and a Fit Note.[43] There is a lack of exploration of her reasons for anxiety recorded.

13.7 Brett also requested a Fit Note from his GP at Practice B in February 2021. He identified his primary need as a "depressive disorder." Brett was prescribed Mirtazapine and was also referred to Cruse Bereavement service.

13.8 First Steps sent an acknowledgment letter to Sasha, regarding the online self-referral and asking her to make contact. A letter was also sent from First Steps to her GP. Following no contact from Sasha, First Steps sent a follow up letter to the GP on 12th February 2021, advising the case was closed.

13.9 On 11th March 2021 Sasha was sent a text message by her GP Practice, asking if she would like a new Fit Note. This was a procedure during the National Covid-19 restrictions to divert patients onto online consulting. Sasha replied the same day, requesting a new Fit Note – stating ongoing issues, but awaiting counselling through the Midwifery team. Sasha also shared ongoing issues with her ears. A

[43] A statement of fitness for work, provided by a General Practitioner – also known as a medical certificate.

Fit Note was sent to Sasha by 3.30pm the same day, and by 4pm Sasha had received a call by the Advanced Nurse Practitioner regarding her ear problems. The Nurse did not ask any questions about the mental health issues, which was a missed opportunity.

13.10 On 25th March 2021, Sasha completed the online consultation regarding Candida[44] and she received a call back the same day. The GP concluded likely thrush; however, Sasha was due to see the Midwife later the same day so advised to ask for a swab at her Midwifery appointment. Again, there was no professional curiosity employed in terms of asking about her mental health during this call back.

13.11 On 31st March 2021, Sasha had a telephone consultation with her midwife. She is recorded as 23 weeks pregnant, with the pregnancy recorded as going well.

13.12 Also on 31st March 2021, the Midwife has recorded information shared by police regarding Brett's prolific and recent police involvement. This included convictions for assault, Actual Bodily Harm,[45] theft and drug possession. Most recently, Brett had been arrested for attempted murder and Grievous Bodily Harm.[46] These offences were pending a criminal trial and Brett was currently on bail. There were also reports of aggressive and threatening behaviour towards his mother and grandmother whilst under the influence of drugs. The Midwife was concerned that Sasha was unaware of the extent of Brett's criminal activity, and that Sasha was under the impression that Brett was currently not drinking or using cocaine. The Midwife requested a Domestic Violence Disclosure Scheme disclosure[47] for Sasha.

13.13 There were missed opportunities to progress these referrals prior to Sasha giving birth to the baby. A strategy meeting should have been held considering the information that was presented to Multi Agency Risk Assessment Conference by health, police, and children's services – prior to the birth.

13.14 On 1st April 2021, and following many attempts to call Sasha, the GP was able to contact Sasha for a follow up mental health consultation. Sasha described increasing anxiety and stated she had been referred for counselling but there was a long wait.

13.15 On 6th April 2021, the Domestic Violence Disclosure Scheme (DVDS) Panel agreed to make the disclosure to Sasha about Brett's criminal history. The plan

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[44] A type of yeast that can be caused by infections when it grows uncontrollably.
[45] S.47 Offences Against the Person Act 1861 – where the injury can be anything more than a graze or minor bruising.
[46] S.20 Offences Against the Person Act 1861 – one of the more serious offences, where wounding may lead to permanent damage to the victim.
[47] 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)

was for the Midwife to be present when Sasha was spoken to by police. There is no evidence that the GP was updated about the DVDS.

13.16 On 14th April 2021, the GP contacted Sasha for a follow up call, and following many attempts was successful in speaking with her. Sasha stated that she had no thoughts of deliberate self-harm. The following day, Sasha called 111 regarding urinary symptoms and requested tests for chlamydia and gonorrhoea. Sasha submitted samples and the tests were returned as negative. There was no documented exploration with Sasha about the reason for requesting these tests, considering she was seven months pregnant.

13.17 On 7th May 2021, Sasha's Midwife referred Sasha into First Steps. The GP was advised. However, Sasha did not respond to contact attempts from First Steps. Sasha was sent a letter from First Steps on 12th May 2021, advising of the referral and asking for a call back from Sasha, and a follow up letter on 19th May 2021 stating she had been discharged due to no contact. The GP was also updated.

13.18 On 17th May 2021, the Safeguarding Hub contacted the Midwife to confirm there would be no further action taken, as it was not deemed that the case reached thresholds for safeguarding involvement.

13.19 The same day, Sasha contacted the Midwife, with further concerns about Brett's behaviour. He had started to drink to excess and was visiting the property of a known drug dealer. He had started to call her in the middle of the night, whilst intoxicated, and was verbally abusive. She stated she was fearful for her safety and was concerned that he would break her parent's windows while she was staying with them. He stated he would take his own life if she did not allow him to have contact with the baby following the birth, although was also questioning the paternity of the baby and stating he wanted a test. She had blocked his number, but he was calling her from other numbers. Sasha noted her parents as being supportive, but she was feeling stressed, anxious, and low in mood. Sasha denied any thoughts of harming herself, stating the medication was helping. Sasha was advised to change her phone number, and a plan was made by the Midwife to complete a DASH at the next appointment. In the meantime, Sasha would stay with friends if she felt unsafe at her mother's house. Following this call with Sasha, and subsequent completion of a high-risk DASH, the Midwife made a Multi-Agency Risk Assessment Conference referral for Sasha.

13.20 Alongside the Multi Agency Risk Assessment Conference referral – and following advice from the NCIC Safeguarding Team – the Midwife worked with Sasha on a safety plan, including signposting to support services, all with Sasha's consent. It was agreed that all Midwifery appointments would be completed face to face, ensuring the discussions were in a safe environment. The baby was considered a victim, and Sasha was encouraged to keep a diary of incidents via the Bright Sky app.[48]

[48] Bright Sky app | Hestia

13.21 On 25th May 2021, an offence of stalking was recorded. The Safeguarding Hub Detective Constable called Sasha, following receipt of the Multi Agency Risk Assessment Conference referral. Sasha was too upset to speak and agreed to an Officer visiting her home address to give an account of the unwanted contact. Actions and advice were added to the incident log for the attending officer to provide to Sasha. A meeting was booked for 27th June 2021, for police to take Sasha's statement.

13.22 The Cumbria Police Safeguarding Hub reviewed the midwife's Multi Agency Risk Assessment Conference referral and downgraded this to a medium risk, it was therefore not raised as a Multi-Agency Risk Assessment Conference referral and instead was passed to the medium risk IDVA. A crime of Stalking was also recorded from the Midwife's information.

13.23 On 25th May 2021 Sasha had a telephone triage appointment with First Steps, having self-referred to the service. She reported anxiety and worry as her main problems. Sasha discussed some difficulties in her relationship, and this was further explored by the practitioner. She denied abuse or controlling behaviours but acknowledged that she had blocked his contact by phone or social media and planned no further contact. The record reflects that Sasha's partner details were not requested, which would have been expected. Therapy and support with mental health services was planned.

13.24 Also on 25th May 2021, Victim Support challenged the decision to downgrade the risk from high to medium. This was following identification of Brett's details on the Domestic Violence Disclosure Scheme panel list.

13.25 The IDVA spoke with Sasha on 25th May 2021. Sasha stated she had blocked Brett's phone and online and had therefore not heard from him. She was staying with a friend outside of the area, but when she returned, she would keep her windows and doors locked, with her phone charged in case of emergencies. She stated she was worried about child contact, and the IDVA spoke to her about registering the birth and explained how the family courts and contact centres work. Sasha said Brett had a drinking problem, she said he kept promising to change but never did and as a couple they were always going around in circles. Sasha asked for some time to decide if she wanted IDVA support.

13.26 On 26th May 2021, the Midwife was advised that the Multi Agency Risk Assessment Conference referral had been declined as it did not meet the threshold. The reasons for this were recorded as; Crime had been recorded for Stalking which would be investigated, Sasha had gone to stay with a friend out of County for a few days so she was away from the situation, this was recorded as the first incident between Sasha and Brett, Sasha was living with her mother who was recorded as being supportive of the relationship ending, no threats of violence disclosed, Sasha

had been given safety advice, a SAFE[49] alert was on the family home, and Victim Support were informed in order to offer Sasha support. The Midwife did not update the North Cumbria Integrated Care Safeguarding team for support in challenging this decision with police, which was a missed opportunity.

13.27 On 31st May 2021 Sasha was contacted by police, she confirmed she was back home, and she agreed to a call to make an appointment for the officer to visit to gather an account from her.

13.28 The medium risk IDVA unsuccessfully tried to call Sasha twice on 3rd June 2021. The medium risk IDVA made a referral to the Multi Agency Risk Assessment Conference on professional judgement,[50] which was accepted, and Sasha was therefore allocated to a Multi-Agency Risk Assessment Conference IDVA, who attempted to make contact on 4th June 2021. Following some liaison with the Midwife, the Multi Agency Risk Assessment Conference IDVA was able to get through to Sasha, who was not answering any calls from unknown numbers to due harassment from Brett. Sasha declined support from the IDVA service, however asked for information about Turning the Spotlight.[51]

13.29 On 7th June 2021, the Community Midwife was advised by Victim Support that Sasha had declined their support.

13.30 On 9th June 2021, Sasha met with First Step for the initial meeting, and stated she was no longer in a relationship with Brett. First Step's updated the Specialist Mental Health Midwife that Sasha would be referred to the psychological wellbeing practitioner.

13.31 On 9th June, the Officer in Charge (OIC) on the stalking case was moved to a new post, and the case as reallocated to another officer.

13.32 On 11th June 2021, the Health Visitor attended the family home to complete an antenatal assessment. Sasha was noted as being excited about the birth, and at this point stated she had resumed the relationship which she was happy about. She stated she had good support from both maternal and paternal families. The Health Visitor was concerned about the conflicting information shared by Sasha, compared with the information provided by the Community Midwife, and she noted that a safeguarding discussion was required.

13.33 On the same day, Sasha was visited by the Community Midwife and the police; to share the information they had gathered within the Domestic Violence Disclosure

[49] A police system used to record incident logs. A SAFE alert is an alert put onto the control room system, which highlights priority for call, or other actions required when a call comes in, depending on the particulars of a case.

[50] This is where the risk assessment indicators do not amount to 13 out of 25, however the professional involved identifies that the indicators which *are* present pose a high risk to the victim.

[51] Turning the Spotlight - Victim Support

Scheme. Sasha was informed of four incidents relating to violent offending but details around Brett's drug related convictions were not shared. The Midwife reported that Sasha stated she was aware of the information shared within the DVDs, despite previously denying Brett had any police involvement. Sasha stated she and Brett had resumed their relationship, but she would be remaining at her parent's property with Brett staying overnight to help when the baby is born.

13.34 Following the information being shared via the Domestic Violence Disclosure Scheme, Sasha indicated that she and Brett would like to work with Turning the Spotlight, to improve their relationship.

13.35 There was a discussion regarding a possible referral to the Safeguarding Hub given that the relationship status had changed again, but when reviewing previous referrals that had not met threshold it was noted that Sasha remained living with her parents which was seen by the Hub as a safety factor and therefore no referral was made on this occasion. The communication between professionals continued to be effective in order to support Sasha and the unborn baby.

13.36 On 16th June 2021, the Turning The Spotlight Lead received a call from Sasha requesting support for her and Brett. She stated she was due to give birth in six weeks and that Children Social Care were involved due to Brett's past.

13.37 On 17th June 2021, Sasha's case was heard at Multi Agency Risk Assessment Conference. Brett's criminal history was shared, along with history of involvement with Children Social Care, and police involvement with Brett and ex-partner. The current situation was shared, where Sasha had disengaged with IDVA. An action was made for consideration of peri-natal services for Sasha, and she was referred into the Safeguarding Hub. Sasha had indicated to Midwife that she intended returning to the relationship. Sasha was closed to the Victim Support IDVA service.

13.38 The Turning The Spotlight lead assessed that Brett was too high risk for the service. Senior IDVA shared the Midwife's contacts with the Turning The Spotlight Lead, as the Midwife had been in the most contact with Sasha.

13.39 On 20th June 2021, the stalking case was allocated to a new officer, who contacted the previous OIC to ascertain which actions needed to be completed.

13.40 Sasha had a session with First Steps on 22nd June 2021, they shared resources regarding anxiety with her.

13.41 On 25th June 2021, the new OIC contacted Sasha and made an appointment to visit two days later, during this phone call Sasha mentioned that she was trying to sort things out with Brett and stated there were lots of issues at the time of the incident which were to blame. The appointment on 27th June 2021 did not happen.

13.42 On 25th June 2021 Practice A received a copy of a discharge report from Hospital A, from her admission in relation to medical monitoring of the pregnancy. There were no safeguarding risks highlighted but it was noted that "partner" had depression and drank three bottles of vodka per week in addition to cocaine. No record of who partner was, and there was no follow up action taken by the practice.

13.43 Also on 25th June 2021, Sasha was referred into antenatal day assessment unit by her GP due to obstetric cholestasis.[52] She attended alone and was discharged with an agreed care plan and appointment for the following week. There was no evidence of routine enquiry during the session, regarding either her relationship or her mental health.

13.44 Sasha was admitted the following day for observation and monitoring, because of the obstetric cholestasis. She was noted to be happy, however then became visibly upset at the prospect of waiting ten days to be induced. She wanted to self-discharge but was advised not to. There was no exploration about her mental wellbeing and sudden change in emotional state. She discharged later that day, however due to poor record keeping, it is not clear whether this was a planned discharge or her own discharge. Record keeping is imperative for all nurses and midwives to enable accurate accounts of interventions as noted within the nursing and Midwifery code of conduct as well as North Cumbria Integrated Care Maternity Safeguarding Guidance for Electronic Safeguarding Record Keeping (2021) which notes that all care plans and risk assessments should be reviewed at all antenatal contacts. There is no evidence of any review of the safeguarding risk assessments during this admission.

13.45 Sasha continued to attend outpatient clinics as per her care plan for the next few days. There was no routine enquiry during these attendances. She stated she was feeling low in mood, and an urgent referral was made to the perinatal mental health team for additional support. Maternity services recognised and responded to Sasha's need for support with her mental health.

13.46 On 30th June 2021, Sasha spoke with the Turning The Spotlight Lead and advised that the birth of her baby would be induced the following week. She stated that Brett was on bail for GBH against another male, and that there had been no police involvement for them as a couple. Following this call, the Turning The Spotlight Lead contacted the Midwife, who was unaware of the Victim Support professional judgement referral at Multi Agency Risk Assessment Conference and did not know that a Multi-Agency Risk Assessment Conference had been heard for Sasha. The Midwife expressed her ongoing concern about the relationship and intended following up with the Safeguarding Hub to determine if they would be reviewing the case closure.

13.47 The same day, the Turning The Spotlight Lead called Sasha, who stated she did not want the police involved, but wanted to work with Turning The Spotlight as her and Brett continued to disagree about things. Sasha agreed to a call two

[52] This is a liver condition which can affect pregnant women.

weeks later, following the birth of her baby. The Turning The Spotlight Lead advised she would also call Brett.

13.48 The OIC on the stalking offence case attended Sasha's home on 1st July 2021. At this point Sasha did not want to support a prosecution or provide any evidence. She stated her and Brett had been going through a rough patch at the time of the offence, with Brett drinking, he would call her during the night and keep her up. She blamed being pregnant on the stress and the worry, which she said was made worse by lack of sleeping. She said he would often become abusive by texts and calls around the anniversary of his baby's - and also his mum's – deaths. Sasha said she had started speaking to him again for the sake of the baby, but they would not be getting back together. She was living with her parents, and he had to make contact through her parents. Sasha stated *"I think, at the moment I don't want to do anything about this or provide a statement for police. If he gets worse again, I will report it as I want to protect the baby. The baby is due Wednesday next week and I want him to have a chance and see his kid."*

13.49 Sasha cancelled her First Steps appointment on 30th June 2021, and they followed up with her the next day. She stated she wanted to continue the sessions after the baby was born, and they booked an appointment for 28th July 2021.

13.50 On 4th July 2021, Sasha contacted the Maternity Unit as she was concerned about a lack of foetal movement, she attended and was visibly upset, stating she was in pain and wanted to have an early induction. A plan was made to admit her, for an analgesia[53] and cardiotocography monitoring.[54] Sasha agreed to this plan, but one hour later she requested discharge home. There was no evidence of routine enquiry or professional curiosity regarding this request, and quick change of mind – this is of concern considering the previous safeguarding concerns.

13.51 Following the Multi Agency Risk Assessment Conference, the North Cumbria Integrated Care Safeguarding Team contacted the Safeguarding Hub and advised that due to what was shared at the Multi Agency Risk Assessment Conference, the case was now being sent out for a child and family assessment and was awaiting allocation. This highlights good use of the Multi Agency Risk Assessment Conference system.

13.52 Sasha attended the maternity unit as planned, for induction of labour the following day. She was alone again, as Brett was watching football with friends. She was on the phone to him throughout the evening, and he was expected to attend the following day for the birth. The Midwife advised the Safeguarding Hub that Sasha was in for the birth, and the Social Worker emailed a letter to the Midwife to pass to Sasha advising that a Child and Family Assessment would be required. At this point, Brett was on the Maternity Unit with no issues.

[53] Pain killers

[54] Used in pregnancy to monitor foetal heart rate and uterine contractions.

13.53 The Safeguarding Hub reviewed Sasha's case on 7th July 2021, as per the Multi Agency Risk Assessment Conference action, this resulted in a new referral to Children Social Care, for a Child and Family Assessment to be undertaken. Within the referral it is stated that despite Sasha receiving a disclosure via the Domestic Violence Disclosure Scheme she has chosen to resume the relationship very close to the birth of her baby, and that this decision did not prioritise the safety of her baby.

13.54 Sasha was induced on 8th 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.

13.55 Postnatal care was provided in the community following the birth, this involved visits to Sasha's mothers house where she was living with the baby. Following the Child and Family assessment, the Social Worker updated the Midwife, to advise that the family would be on a Child in Need plan. Part of the plan included that Brett would not have unsupervised contact with the baby and would not stay overnight at Sasha's mothers house for more than three nights per week. The couple also agreed to engage with Turning the Spotlight, and Brett would self-refer to First Steps.

13.56 On 9th July 2021, GP Practice A received a report about the Multi Agency Risk Assessment Conference meeting which had been held on 17th June 2021. There are no details of the perpetrator on the Multi Agency Risk Assessment Conference report, this is standard practice. Since the scoping period of the review, the ICB have begun working with the Multi Agency Risk Assessment Conference Steering Group, to improve the quality of information sharing from Multi Agency Risk Assessment Conferences to GP Practices. However, the GPs are advised to contact the Multi Agency Risk Assessment Conference Coordinators if they require further information about a referral.

13.57 The Social Worker visited Sasha on 12th July 2021, the baby was doing very well. The Social Worker and Sasha had a long discission about domestic abuse, and Sasha/Brett's relationship. They both agreed to attend Turning The Spotlight.

13.58 On 15th July 2021, Sasha's mother contacted the Midwife with concerns that Sasha had been drug screened, following concerns being raised about Sasha using antihistamines to sleep. Sasha's mother was angry that Sasha had been treated like a criminal, and that she had poor care during her pregnancy. She stated that Sasha was "just being hormonal" when she had reported Brett's behaviour, and that professionals had "blown it out of proportion." Sasha's mother was given the complaints policy. However, it is of concern that Sasha's care was discussed with her mother, as this was a potential breach of confidentiality, as there was no evidence that Sasha had consented to this information being shared.

13.59 This does also highlight that at this time Sasha's family did not feel that Brett was abusive. This can be corroborated by the conversation between the Chair and Sasha's mother, who stated that Brett had made them all believe him, and that she

was as taken in by Brett as Sasha had been. This contact was not shared with any other professionals which was a missed opportunity to explore the family dynamics with Sasha.

13.60 On 20th July 2021, Brett contacted the Turning The Spotlight Lead, stating he wanted to engage with the programme and confirming that he was motivated to do so. He stated that he wanted to prove he could bring up his child, and that Social Workers were currently completing a parenting assessment. The Turning The Spotlight Lead agreed to assess the couple and asked Brett to be honest about what had been happening - Brett agreed with this. The following day, a Turning The Spotlight support worker tried to call Sasha, with no success.

13.61 On 24th July 2021, a No Further Action decision was made on the stalking offence, due to lack of evidence.

13.62 The Primary Health visiting assessment was completed on 26th July 2021, with no concerns. Sasha's midwife spoke with Sasha's GP about Sasha using antihistamines to sleep, and this was also discussed with the Social Worker who was in the process of completing the Child and Family Assessment. Brett was recorded as seeking help, Sasha stated she had good family support. She asked for help with stopping the use of the antihistamines, and there was no consideration of a referral to Recovery Steps for this. The Health Visitor contacted the Social Worker the following day, who spoke about the Child in Need plan. The Social Worker stated that the parents had signed a safety agreement, but this was not shared with the Health Visitor, which was a missed opportunity, although the Health Visitor was invited to the Child in Need meeting. The requirement for Sasha to sign a safety agreement also represents poor practice, as it inappropriately paced responsibility on Sasha for managing Brett's behaviour, rather than holding him accountable for his own behaviour.

13.63 During the Child and Family Assessment, Brett stated that he lived with his stepfather as both of his parents were deceased, and that he had attended a Pupil Referral Unit[55] as a child. A chronology and/or genogram of Brett's childhood would have allowed an exploration of his early years' trauma, which would have allowed the multi-agency services responding to Sasha to understand the impact of Brett's early years experiences on his adult behaviours, and in turn the effects of these on Sasha. Research indicates there is a key link between Adverse Childhood Experiences (ACES) and perpetration of domestic abuse.[56]

13.64 During the Child and Family assessment, the Social Worker noted that Sasha was referred to the perinatal mental health team due to issues around anxiety when pregnant. She was discharged and had shared that she did not believe that she had post-natal depression, this was taken on face value, and information later in

[55]This is a type of school in the UK which caters for children who are not able to attend a mainstream school

[56] Are Adverse Childhood Experiences (ACEs) the key link between mental health and domestic abuse? - For Baby's Sake % (forbabyssake.org.uk)

the year suggested that Sasha had wondered if she did in fact have post-natal depression. This raises a question of whether post-natal depression was explored, and/or revisited with Sasha on later occasions, giving her the opportunity to think it through, and make decisions at her own pace.

13.65 On 27th July 2021, the Turning The Spotlight Support Worker tried to contact Sasha again – she sent text messages and WhatsApp message, with no success.

13.66 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.

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

13.68 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. The Social Worker recorded this as a concern as Sasha was unable to recognise that domestic abuse is not always physical, and that Brett's previous violence to female family members including an ex-partner, along with his temper, anger issues and unpredictability when intoxicated, were a concern.

13.69 Sasha had a phone consultation with the GP Practice on 16th August 2021, for contraception.

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

13.71 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.

13.72 On 18th August 2021, the Turning The Spotlight support worker spoke to Sasha, who agreed to a meeting on 2nd September 2021.

13.73 Between 24th and 27th August 2021, there are records of the GP Practice trying to contact Sasha to register the baby with the surgery. The baby was coming up for their first set of immunisations.

13.74 On 31st August 2021, Brett was referred to Addiction Services, for his support with his alcohol use. Brett disclosed using a bottle of vodka at weekends.

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

13.76 On 2nd September 2021, it is recorded that Brett had started to attend First Steps sessions.

13.77 Sasha had a Child in Need Plan visit on 2nd September 2021, she stated she had not seen much of Brett as he was out drinking and not prioritising her or the baby. The Social Worker spoke to Brett about this, who stated Sasha was in a mood, so he had taken himself away. The Social Worker challenged this and reminded Brett that he was responsible for his own actions.

13.78 Also on 2nd September 2021, the Turning The Spotlight support worker tried to contact Sasha as planned, for the initial assessment. There is no record that she was successful in contacting Sasha.

13.79 On 3rd September 2021, Sasha attended her six-week post-natal appointment at the GP Practice. This was well documented and included discussions about Sasha's mental health, and suicide risk. The Health Visitor increased Sasha's medication and planned a two-week review call with her.

13.80 On 6th September Brett requested that the planned Turning The Spotlight assessment be pushed back as he wasn't in the best place emotionally. He stated he had been drinking at the weekend. He had fallen out with Sasha, and communication was currently not very good between them. The police were taking no further action against him for Grievous Bodily Harm. The Turning The Spotlight appointment was moved to 9th September 2021. At this appointment, Brett claimed to have split from Sasha. He stated she was very up and down, and at time she would not speak to him for days. He admitted to having a problem with binge drinking, he liked to go out at the weekend, and admitted to lying to Sasha about this. He stated he had anxiety but would be prepared to attend a Turning The Spotlight group, but that he had dyslexia and had concerns about looking bad in front of other group members.

13.81 The Social Worker contacted Sasha on 9th September 2021. Sasha stated she did not want to encourage contact between the baby and Brett as he had shouted at her in town. Sasha stated that child contact should be supervised by her family until Brett could meet the expectations of the Child in Need Plan.

13.82 Brett's Turning The Spotlight support worker updated the Social Worker, that Brett stated they had split up, but that he still wanted to complete the healthy relationship programme. The next group was due to start in October 2021, and in the meantime, the support worker would be doing sone one to one work with Brett. The Social Worker also confirmed with drug and alcohol services and First Steps that Brett was engaging with their services.

13.83 First Steps confirmed with the Social Worker that Sasha had completed a full programme of Cognitive Behavioural Therapy. Sasha stated her anxiety had

improved and her relationship with Brett had ended. Sasha was discharged from First Steps, and the GP was also informed.

13.84 On 16th September the Turning The Spotlight Support worker texted Sasha to offer her a place on the Turning The Spotlight programme which was starting in October 2021. This went unanswered and was followed up with another text on 21st September 2021. Sasha responded to this text and agreed to start the Turning The Spotlight programme. It was agreed that they would have a call the following week to do the initial assessment.

13.85 On 16th, 20th and 21st September 2021, the Turning The Spotlight support worker tried to unsuccessfully contact Brett. Eventually he made an appointment for 23rd September 2021.

13.86 On 21st September the Social Worker undertook a Child in Need Plan visit. Sasha stated the relationship was not going well. Sasha said Brett had been out with his friends a lot. Brett had stated he would not give his friends up and did not seem to be ready to settle down. Sasha became upset as she wanted the relationship to work.

13.87 On 22nd September 2021, Sasha called Carlisle City Council (CCC) for housing advice, stating she had fallen out with her mother and could no longer stay at the family home. She was currently staying with a friend and did not need temporary accommodation at that time.

13.88 On 23rd September 2021, Brett contacted the Turning The Spotlight worker to cancel the appointment as he was caring for the baby while Sasha was finding somewhere else to live.

13.89 CCC provided temporary accommodation for Sasha and the baby. Upon arrival to the scheme, non-recent domestic abuse issues with Brett were disclosed by Sasha; a DASH risk assessment and referral had already been made to Multi Agency Risk Assessment Conference and appropriate information sharing and contacts were made to inform wider safety assessments and support offers. Immediate domestic abuse support from specialist domestic abuse officers was offered and informal contact maintained open until Sasha left the service in line with her wishes.

13.90 During her period of residence in the temporary accommodation, Sasha engaged well with the wide range of support on offer from the teams; and was open about her worries, needs, goals and aspirations concerning housing, safety, money matters, employment and also longer-term goals and aspirations around friendships, relationships, positive parenting, training and a desire to become self-employed to be a future role model for her baby.

13.91 It is clear Sasha felt safe within the scheme and trusted key support staff sufficiently to open up to them about her worries around post-natal depression, relationships

and positive aspects such as her future plans. Case notes indicate emotional support given throughout her period of occupancy including flexible pro-active approaches to ensure Sasha did not feel isolated, anxious, or overwhelmed; there is clear evidence of personalised flexible support with considerate and compassionate approaches illustrated throughout.

13.92 Between 27th and 30th September 2021, the Turning The Spotlight support workers both had contact with Sasha and Brett.

13.93 On 6th October 2021, at the Child in Need Plan meeting, it was shared that on the days when Sasha was not staying at the temporary accommodation, she was staying with Brett. The Homelessness Accommodation Advice Officer met with Sasha the following day to work on budgeting, baby groups and employment aspects. No concerns were raised.

13.94 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.

13.95 Also on 8th October 2021, Brett was assessed by Recovery Steps Cumbria (RSC). He continued to describe use of alcohol and cocaine at weekends, where he described spending hundreds of pounds on his substance use. He disclosed a historical suicide attempt, where he took tablets to end his life. He identified the trigger of this event as an argument with his ex-partner. At the time of the assessment Brett stated he was working with Turning the Spotlight, however there is no further information recorded about history of violence or domestic abuse. Brett described having a good relationship with his baby and having contact at weekends. He stated he was actively co-parenting alongside Sasha and Children Social Care were involved in the family. Brett was placed on a waiting list for brief intervention via the HOPE team at RSC.

13.96 On 15th October 2021, the Turning The Spotlight support worker completed the initial assessment with Sasha over the phone. She was risk assessed as standard risk and offered a place on the next programme. She stated she felt safe and was in a relationship with Brett. They had both tested positive for Covid-19 and were self-isolating at Brett's home with the baby for one week. The Social Worker agreed with this plan. The temporary accommodation room was kept available for this week for Sasha.

13.97 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. Brett had kicked her out of his house without the baby and would not allow her to have access to the baby. The police attended and returned both Sasha and the baby to the temporary accommodation. Brett was interviewed at home, and Sasha did not wish to provide further evidence. A

Multi Agency Risk Assessment Conference referral was made following the incident.

13.98 There is a note on 20th October 2021, that Brett was unable to attend the Turning The Spotlight session due to Covid-19. There is no indication that Turning The Spotlight had been made aware of the incident on 18th October 2021. The Turning The Spotlight team were not made aware of Sasha being allocated an Independent Domestic Violence Advocate following the Multi Agency Risk Assessment Conference referral, therefore cases were open to both services without being linked.

13.99 The CCC Prevention and Crisis Officer offered Sasha support. She was unsure whether she wanted to end the relationship with Brett. The Turning The Spotlight support worker made a welfare call to Sasha the following day – no answer.

13.100 Children Social Care sent an update to Multi Agency Risk Assessment Conference regarding the incident. And on 25th October 2021, the Social Worker called Brett to discuss the incident. He stated she had slapped him first, and the relationship was over. He wanted to see the baby and co-parent.

13.101 The Turning The Spotlight support worker contacted Brett on 25th and 26th October 2021. There was no answer. On 27th October 2021, Brett called Turning The Spotlight Support Worker, to advise he did not feel comfortable attending the group session as the facilitator was Sasha's support worker.

13.102 On 28th October 2021, the couple were discussed at Multi Agency Risk Assessment Conference.

13.103 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, whether Sasha wanted support, and about the offer of a property.

13.104 During this time, Sasha spoke to the Turning The Spotlight support worker, stating she was very down on the days when Brett had the baby, and she was alone. The support worker offered to help her access a local women's group. Sasha advised she was speaking to her GP later that day. Sasha spoke with her GP, she stated she was struggling with her mood, and that she had been drinking, which had made her mood worse for a few days afterwards. The Turning The Spotlight support worker followed up with Sasha the following day.

13.105 Between 1st November 2021 and 10th January 2022 there were various attempts made by RSC to contact Brett. He engaged with two planned appointments during this time, including to complete a recovery plan, goal setting and a risk assessment. During these two appointments Brett disclosed a recovery goal of controlling his substance use.

13.106 The Social Worker also spoke with Brett on 2nd November 2021, he stated he had a job and was doing well. He was having contact with the baby and still did not want a relationship with Sasha. Also on 2nd November 2021, Brett spent time speaking to the Turning the Spotlight support worker. Brett is recorded as having a good understanding of what makes a healthy relationship.

13.107 Both parents were advised that if they restarted their relationship, this would lead to a Child Protection plan for the baby.

13.108 On 3rd November 2021, Brett attended the Turning The Spotlight group session and engaged well. Also on 3rd November 2021, the Social Worker spoke with Sasha, she reported ongoing low mental health, she had spoken to her GP earlier that day, and they were referring her to the CNTW Crisis Team. The Social Worker planned to see her the following day. The Social Worker updated the Health Visitor.

13.109 Sasha also spoke with the CCC Homeless Accommodation Officer, she was very tearful and disclosed feeling very low. Sasha was given emotional support and was advised to take her medication into the CCC offices, so they could be locked away from harm.

13.110 Later that afternoon, the CNTW Crisis Team contacted Sasha by phone. She told the Community Practitioner about Brett and how the relationship had ended two weeks prior, due to an incident. She denied current suicidal ideation or self-harm thinking but wanted support to reduce the anxiety she was feeling due to Children Social Care involvement. She stated she had previously found First Steps unhelpful. Counselling was suggested, along with community support from some local specialist charity projects.

13.111 On 4th November 2021, Sasha spoke to the Turning The Spotlight support worker, stating she was very low when the baby was with Brett. She also saw the Social Worker and discussed how low she was feeling. She felt very anxious when the baby was with Brett. She stated that she was missing Brett and did not see many friends. She stated she had been out for a drink one weekend and had felt low ever since. She told the Social Worker that she had started the argument with Brett, and he had shoved her in response. The Social Worker stated that maybe Sasha was now minimising the risk of the incident, as Brett should not have been shoving her by the stairs. Sasha stated that her relationship with her mother was back on track.

13.112 Sasha engaged with the first Turning The Spotlight session on 8th November 2021. She was able to identify healthy and unhealthy relationship traits. Sasha shared with the group that she could not stand lying, and any dishonesty was unacceptable. The Turning The Spotlight support worker shared information from the session with the Social Worker.

13.113 On 9th November 2021, Sasha's mother contacted the Homeless Accommodation Officer stating she was concerned for Sasha and the baby, following an argument with Sasha. The Officer checked on Sasha who was ok, but tearful, feeling isolated with no support from her mum or Brett.

13.114 Brett attended the fourth Turning The Spotlight session. He spoke about arguing with Sasha as he wanted to go to a football match on a day when he was meant to be caring for his baby - and he also spoke about feeling jealous when he saw Sasha was dressed up.

13.115 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.

13.116 Brett cancelled the next Turning The Spotlight session and had to leave the following session early. Although it is recorded that he engaged well when he was there.

13.117 Sasha was unable to attend two of the next Turning The Spotlight sessions due to childcare and the baby being unwell.

13.118 On 1st December 2021, it is recorded that Brett had not stuck with the co-parenting plan, he was now in a new relationship and had not seen the baby for two weeks.

13.119 Sasha spoke with the Advanced Practitioner Nurse on 1st December 2021, complaining of a cough, however during the appointment she became tearful and stated she was struggling as she was living in a hostel with a 20-week-old baby with no support. A discussion took place between the GP practice staff and health visiting, and both services agreed to contact Sasha over the next two days independent of the other. The Nurse called back the following day, and Sasha felt better following medication to assist with her sleep, the GP also called, and Sasha advised she was feeling better.

13.120 The Social Worker visited Sasha on 13th December 2021, Sasha stated everything was going well, she had not found a property but was still looking for something suitable. Sasha was going out with friends when Brett had the baby and had been trying to enjoy herself.

13.121 The CCC Prevention and Crisis Support Officer, and the Homeless Accommodation Officer, both continued to support Sasha, speaking to her about steps to take when maternity allowance ended and also about a self-esteem course. Sasha returned to the hostel on 28th December 2021 with a bruise to her face, she stated this happened while in town, and a group of girls started a fight with her friends. This information was shared.

13.122 Brett did not attend Turning The Spotlight sessions 8,9, or 10.

13.123 The Turning The Spotlight support worker tried to contact Sasha on 30th December 2021, and 4th January 2022, they got no answer.

13.124 Sasha contacted the Health Visitor on 4th January 2022; she was upset and frustrated as she was trying to arrange a coil insertion but was advised her GP was unable to support her decision. Due to Covid-19 the local sexual health clinic was not completing routine appointments. The Health Visitor helped Sasha by contacting the clinic, and they agreed to contact Sasha to discuss alternatives. There was no professional curiosity employed by the Health Visitor, as Sasha was stating she was not in a relationship yet was requesting long term contraception.

13.125 On 11th January 2022, the RSC contacted the family's allocated Social Worker and updated about Brett engagement. The notes held by RSC about this interaction are fairly basic, and do not indicate the nature of this update, or indeed whether Brett was engaging and doing well. His substance misuse was self-reported only, he was not subject to any testing.

13.126 Brett attended the 11th Turning The Spotlight session on 6th January 2022. Sasha did not attend the Turning The Spotlight on 10th January 2022, and the support worker followed up with her.

13.127 On 10th January 2022, Sasha was offered a property. Sasha advised no mental health or physical health issues.

13.128 The following day the Social Worker checked in with both parents, both stated they were doing well. Contact and handovers were working well, and both had support from respective families, the plan was for the Child in Need Plan to be closed soon.

13.129 During the period between 18th January 2022, and 18th February 2022, Brett did not attend several planned reviews at RSC. Attempts were made during this time to contact him, and engage him in group work sessions, however he struggled to attend due to work commitments, during this time Brett disclosed being drug free.

13.130 In January 2022, Sasha was supported to move on positively into suitable long term independent accommodation with the baby. She was assisted to access furniture and set up the tenancy, utilities etc. and was provided with ongoing follow-on tenancy sustainment support until 20 April 2022. Sasha was very happy in the tenancy, she said she was settled and was taking pride in creating a home; she felt in a positive place and as she was getting a lot of support from her mum.

13.131 The Health Visitor undertook a follow up visit to Sasha's new property, following the Child in Need involvement being closed. Sasha told the Health Visitor there was a co-parenting plan in place, which was unofficial but was being adhered to. Sasha stated she was mentally well. No concerns were raised regarding

safeguarding or Sasha's mental health. Sashas care was transferred to a different locality team, due to her change of address. She remained on the universal programme, although she would have been entitled to "listening visits".[57] Sasha was not advised of the change of Health Visitor, and as she had engaged well with the service, this could have been a missed opportunity to introduce the new Health Visitor to encourage her reaching out when needed.

13.132 On 31st January 2022, the Turning The Spotlight support worker confirmed with the Social Worker that Sasha had not attended the partner programme and was not responding to messages. Sasha was to be closed to Turning The Spotlight.

13.133 The Child in Need plan was closed on 3rd February 2022.

13.134 Brett did not complete the Heathy Relationship programme with Turning The Spotlight. The support worker advised Children Social Care on 17th February 2022.

13.135 On 11th March 2022, Sasha sent an e-consultation to her GP, concerned that she may have bi-polar disorder. She was seen by the GP face to face on 17th March 2022, disclosed no issues with illicit drug use, a referral was sent to the CMHT, stating that Sasha feels impulsive at times, pulls at her own hair, had issues with gambling which was often triggered by alcohol. She shared that Brett had contact with their baby and that the relationship was currently amicable. She felt she may have borderline personality disorder and requested medication for this. She did not want talking therapies or group work. There is no evidence in the case notes of the GP exercising any professional curiosity around her relationship with Brett. This was a missed opportunity to explore whether Brett's behaviours could have been trauma related. The information shared with the GP was not passed to Children's Social Care despite the Child in Need Plan only recently being closed. These disclosed behaviours should have triggered some curiosity around the welfare of the baby.

13.136 On 16th March 2022, RSC contacted Brett via phone. He informed the service that he no longer required RSC support. He stated he was engaged in employment and was hardly using any substances. Brett was offered a final review on 29th March 2023, which he did not attend, and he was discharged on 31st March 2022.

13.137 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.

[57]This is a term used to describe the therapeutic package of care that Health Visitors offer to mothers with mild to moderate mental health problems during pregnancy or during the perinatal period.

13.138 On 14th April 2022, the GP saw Sasha for a depression interim review - Sasha was also with her mother and the baby. Sasha had an assessment of her mood, and discussed the social situation, she stating she was tolerating the anti-depressant medication but would like an increase.

13.139 Sasha took a paracetamol overdose on 22nd May 2022. Her mum called 999, and Sasha was referred to the Cumbria Health on Call (CHOC), who advised her to take Sasha to ED. Once in ED Sasha declined support from the Mental Health Liaison Team within the hospital and was discharged home. Once home, Sasha's mother spoke with the GP, stating they had not felt supported at ED the previous evening. The Health Visitor contacted Sasha later that afternoon, Sasha stated she did not have any further suicidal thoughts.

13.140 Following this incident, the GP contacted the health visiting team to ask for a visit to Sasha. This was undertaken on 30th May 2022, Sasha reported her mood as stable, but she felt isolated due to family not living close by – this was not further explored. Sasha could have been offered referrals or signposting into support groups. Whooley questions[58] did not indicate low mood and the plan was to continue with medication supported by the GP. There was a lack of routine enquiry evident given the history of domestic abuse and clear link with Sasha's previous deterioration in her mental health. As per the healthy child programme[59] and family partnership model[60] Sasha could have been supported to set goals around her mental health and improved community networks. This could have been supported via a strategy plan under early help to enable professionals to work collaboratively.

13.141 Sasha was also seen at the GP Practice on 30th May 2022, this was for a review mental health appointment but also wanted to discuss losing weight, ongoing ear infections and hyperhidrosis.[61] She was given medication for the physical issues, and a referral to slimming world. She also stated living so far from her mother was not very good for her. She was provided with over half an hour appointment, and as all the issues had been dealt with, she did not require a follow up appointment.

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

13.143 On 9th August 2022, the Health Visitor completed a home visit to review progress and discuss Sasha's mental health as per NICE guidelines.[62] Sasha reported no altered mood and was engaging well with universal services.

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[58] Home | Whooley Questions – this is a tool used to screen for major depressive disorders
[59] Healthy child programme - GOV.UK
[60] An evidence based framework for goal orientated, partnership practice.
[61] Excessive sweating
[62] Quality statement 1: Identifying risk | Early years: promoting health and wellbeing in under 5s | Quality standards | NICE

13.144 On 10th August 2022, there was a discussion about Sasha and the baby at the monthly Health Visitor Safeguarding Concerns meeting. The Health Visitor had been liaising with the GP regarding a planned immunisation appointment; there were no further updates.

13.145 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. She did not want the information shared with Children Social Care through fear of repercussions as Brett had family working in Children Social Care.[63] There is no indication that this ever happened, however it is possible that Brett would have threatened Sasha with his connection to Children Social Care.

13.146 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. The information was shared with Children Social Care, health visiting and Victim Support.

13.147 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. It is positive that the Health Visitor reached out to support Sasha. This would have been a good opportunity to explore her relationship with Brett further and a DASH could have been utilised to identify any additional risk factors with consideration for a Multi-Agency Risk Assessment Conference referral to be completed.

13.148 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).

13.149 Sasha passed away five days later.

13.150 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[64] 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

[63] Cumberland Council have policies in place around codes of conduct where there may be possible conflicts of interests and issues linked to confidentiality.

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

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."

14. Analysis

14.1. 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.

14.2. 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.

14.3. The lack of expectation placed on Brett, is linked to a widespread issue, where social care professionals sideline fathers,[65] instead focusing their expectations on mothers.[66] This is significantly evidenced by Sasha being required to sign a safety agreement with Brett in July 2021. 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.

14.4. 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[67] and

[65] The Myth of Invisible Men

[66] 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

[67] Depression in pregnancy

psychosis[68] – Children Social Care could have managed this more sensitively and proportionately, by visiting at home with the Health Visitor.

14.5. 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 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.

14.6. 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.

14.7. 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.

14.8. Identification and Management of Risk

14.8.1. There was a lack of robust risk assessment by professionals linked to both Sasha and Brett.

14.8.2. Risk is fluid and should be continuously assessed. Risk assessments should have been completed at various points throughout the period of health and social care agencies' involvement. This should have been at each point where the dynamics and the situations of the relationship changed.

14.8.3. Assessments of risk also need to be consistent, using similar tools such as DASH/Homicide Timeline/Power and Control Wheel. To assist with assessment of risk, and also safety planning, the IDVA service can be contacted to engage in joint work wherever appropriate.

14.8.4. Throughout September 2021, Brett started socialising more with friends, and it became clear that Sasha and Brett wanted different things from the relationship.

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

At this point, the safety plan should have been reviewed with the changing dynamics in the relationship. On one occasion Sasha contacted the Social Worker to say that Brett had shouted at her in town, and due to his drinking, she wanted contact between the baby and Brett to be supervised by his family. Although the Social Worker was proactive in contacting agencies regarding support for both Sasha and Brett, the risk from Brett should have been reassessed at this point.

14.8.5. When Sasha moved out of her mother's home and into temporary accommodation, a new Child and Family assessment should have been completed due to her change of living arrangements. At this point, a new assessment of risk should also have been completed, along with a new safety plan. Especially considering Sasha's parents had been identified as protective factors in the previous assessment.

14.8.6. Risk assessments should consider all factors, of all parties involved - and are therefore best completed within a multiagency context. There should have been more exploration of Brett's behaviours, individually with Sasha but also amongst the various services engaging with Sasha and Brett. For example, Turning The Spotlight were working directly with Brett and should have been brought into discussions, going beyond asking about Brett's attendance at the sessions. For example, did he appear to be understanding the content of the sessions, was he obstructive or engaging, and did he discuss anything of any concern linked to risk of harm to Sasha or the baby.

14.8.7. Aside from the Multi Agency Risk Assessment Conference, there were very little multiagency discussions regarding the couple. Children Social Care are perfectly placed to organise meetings with the variety of services involved, even when there is not a Child Protection plan in place. A strategy meeting should have been held at the point(s) when the couple returned to the relationship.

14.8.8. There was limited engagement between Recovery Steps Cumbria and other agencies. There was communication with the family's allocated Social Worker, however the content of these discussions does not appear to be fully recorded. In addition, historical information relating to risks - including domestic abuse - do not appear to have been communicated within discussions. If these discussions had been held between relevant agencies, this would have supported co-ordination of information and more robust risk assessments.

14.8.9. It is evident from the initial contact that North Cumbria Integrated Care staff identified concerns in the relationship between Sasha and Brett. Risk factors were recorded, and information shared with external partners in order to create a risk mitigation and management plan. This was evidenced throughout her maternity and child and family care plans.

14.8.10. The Individual Management Report author for Cumberland Police reviewed all DASH risk assessments completed by police in respect of Sasha. All

of these were poorly completed, they had not been reviewed in the safeguarding hub effectively, and there was no feedback recorded for the officers who completed them. This not expected practice.

14.8.11. It is also important that all professionals understand the nuances and risks associated with coercive and controlling behaviour, which goes beyond obvious physical violence. During the process of the Domestic Abuse Related Death Review, the police IMR author spoke with the officer who had reviewed and declined the Multi Agency Risk Assessment Conference referral. It was considered that the lack of violence or threats of violence towards Sasha by Brett led to the decision to decline the referral to Multi Agency Risk Assessment Conference. However, since the period of the review, processes have been adapted which have seen pregnancy and separation being recognised as high-risk indicators. Also, since September 2022, around 1000 NCIC staff have been trained on routine enquiry of domestic abuse.

14.8.12. Information was shared by midwives with the North Cumbria Integrated Care safeguarding hub regarding concerns over Brett, the Hub advised that as Sasha was not living with Brett there would be no further action at that time. In hindsight this appears to have been a poor decision and learning from this review will be shared to assist all agencies in understanding coercive and controlling behaviour, and particularly how it continues regardless of where people reside.

14.8.13. Recovery Steps Cumbria could have explored the dynamics within the relationship between Sasha and Brett during his comprehensive substance use assessment and subsequent risk assessment. This may have prompted additional communication with other professionals involved with the family and more informed decision making in respect of the care and treatment provided.

14.8.14. Recovery Steps Cumbria's risk assessment could have been more comprehensive, specifically in relation to exploring issues relating to violent behaviour, historical suicidal ideation, childcare responsibilities, and relationships that were referenced. There was very limited focus upon Sasha within Brett's files. There are arguments documented between Brett and Sasha, and Brett had identified that these arguments had been a trigger to his suicide attempts. Further exploration and identification of the dynamics in the relationship may have enabled the service to gain a deeper understanding of the risk relating to domestic abuse, leading to a more effective risk management plan that understood this links between substance use and domestic abuse.

14.8.15. Professionals working with Sasha could have been proactive in challenging her perception of the relationship, to raise her awareness about healthy relationships, coercive control and the risk she was facing from Brett – especially how it was affecting her mental health.

14.8.16. Following an incident in October 2021, there was a further Multi Agency Risk Assessment Conference meeting, where it was shared that Sasha was not

engaging with Victim Support. A co-parenting plan had been agreed, based on the couple not being together. Contact between Brett and the baby appeared to continue without concern into November 2021. During this period of calm, and separation between the couple, the Social Worker could have readdressed the issues of Brett's behaviour – both with him, and with Sasha. With a view to solidify Sasha's resolve not to return to the relationship.

14.8.17. Sasha's friends told the Chair that during the periods where the relationship was off, Sasha was in a much better place. Often professionals only address the issues as they arise, however in relationships which are unstable – with the cycle likely to happen again – the calm period is the best time to make safety plans; ahead of the cycle beginning again.

14.8.18. Sasha saw the Specialist Mental Health Midwife on 1st April 2021. Sasha had declined a phone call and requested a face-to-face meeting, stating she had nowhere safe to speak on the phone. The Specialist Mental Health Midwife followed up the Safeguarding Hub referral on 27th April 2021, and to find out the progress of the Domestic Violence Disclosure Scheme request. On 2nd May 2021, Sasha attended the maternity department at Hospital A reporting reduced foetal movements. She was noted as attending alone and no concerns were raised – however there is no evidence of routine enquiry during this contact. Safelives[69] state that many victim/survivors will access health services seeking support in relation to domestic abuse. As Sasha had attended alone, this would have been a good opportunity to explore her home circumstances.

14.8.19. The Safeguarding Hub contacted the Specialist Mental Health Midwife on 17th May 2021, and advised no further action would be taken, as it was not deemed that the case had met the threshold for Children Social Care involvement. The same day Sasha contacted the Midwife and disclosed further issues with Brett. The Midwife visited two days later and completed a DASH, which came out as medium risk. However, the NCIC Safeguarding Team advised the Midwife to refer into Multi Agency Risk Assessment Conference, due to the exacerbating factors that Sasha was 30 weeks pregnant, there was a recent separation, and Brett had a history of violence, along with a current substance misuse issue. This recognition of the factors exacerbating Sasha's risk was very good practice. However, following the Multi Agency Risk Assessment Conference referral being declined, the Midwife did not challenge the decision, or seek assistance from the NCIC Safeguarding Team with challenge the decision, despite the rationale for this decision being inconsistent with the circumstances.

14.8.20. Children Social Care involvement with the baby ended on 1st February 2022. The couple were reported as separated with contact being supported by Brett's sister two days per week. Brett's contact with Turning The Spotlight was reported as positive, and he was reported as engaging with Recovery Steps. Both parents verbalised that their relationship was "toxic"" this was not challenged and was therefore accepted as the narrative – rather than naming Brett's behaviour

[69] Cry for Health (2016)

as coercively controlling. The Children Social Care involvement ended prematurely. The period leading up to the Children Social Care ending was a period of uncertainty for Sasha. She was struggling with her mental health, she was still within the perinatal period, and there was no evidence that the cycle of Sasha and Brett being on and off had ended.

14.8.21. Following the report of a stalking crime, a safeguarding Detective Constable contacted Sasha, however she was too upset to speak to the officer over the phone and for a variety of reasons, the crime was allocated to a series of three different Constables to visit Sasha in person. The visit took place around one month after the crime was reported, this is an un-acceptable amount of time to lapse between the incident and the opportunity to make the report.

14.8.22. During the scoping period, the Midwife made a request for a Right to Know[70] disclosure under the Domestic Violence Disclosure Scheme. This was processed by police and was sent to the Domestic Violence Disclosure Scheme panel and allocated to a safeguarding officer share the information about Brett, with Sasha. Cumbria police followed the National Domestic Violence Disclosure Scheme guidance, and their own policy. Since the period of this review, the Domestic Violence Disclosure Scheme procedures have been adapted, with the safeguarding hub now reviewing all safeguarding reports and proactively considering if there should be a Right to Know disclosure made to the victim.

14.9. Prevention of Suicide

14.9.1. Suicide is a leading cause of death during the perinatal period, and accounts for up to 20% of maternal deaths.[71] In 2016, the Government announced a commitment to fund specialist perinatal mental health services. This is detailed in the NHS Long Term Plan.[72]

14.9.2. In early November 2021, Sasha stated that her mental health was poor. She disclosed to the Social Worker that she felt low and questioned whether she was suffering with perinatal depression. She stated she was lonely, had been out one night and had felt low for three days afterwards. There is no indication that a link between Sasha's recent birth, her poor mental health, and Brett's ongoing behaviour were made, or that Sasha's concern about perinatal depression had been followed up – apart from medication being prescribed. As detailed in section 13 above, the perinatal period is a period of high suicide risk, and this does not seem to have been considered throughout the Children Social Care involvement.

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[70] Domestic Violence Disclosure Scheme factsheet - GOV.UK (www.gov.uk)

[71] Palladino, C et al "Homicide and Suicide During Perinatal Period: Findings from National Violent Deaths Reporting System" *Obstetric Gynaecology* (2011) 118 pp.1056-63

[72] NHS Long Term Plan » The NHS Long Term Plan

14.9.3. There was no consideration by police of the risks linked to mental health and suicide in perinatal women, and this is an area of learning for the Multi Agency Risk Assessment Conference systems within Cumbria.

14.9.4. The only recorded discussion by police officers with Sasha about her mental health was at the point when the Domestic Violence Disclosure Scheme was shared with her.

14.9.5. North Cumbria Integrated Care staff demonstrated a therapeutic relationship with Sasha from early on, her mental health was explored, and referrals made to specialist services providing targeted support. A link between Sasha's mental health and the domestic abuse was recorded with Sasha continuing to be open and honest regarding her lived experiences. However, the work with Sasha was mostly undertaken in silo, and apart from liaising with the Social Worker, there was a lack of multi-agency working between the Midwifery Team and other agencies.

14.9.6. Sasha engaged well with the Midwifery team. The specialist mental health Midwife contacted Sasha on 19th January 2019, and Sasha stated that her anxiety was well managed, and she was subsequently closed to the specialist mental health Midwife. However, ten days later Sasha contacted the community Midwife stating that she was feeling very low and struggling with her anxiety. Sasha noted that Brett was experiencing mental health issues and was also very low in mood, and she stated she "was struggling to manage him." She requested a referral back to the Specialist Mental Health Midwife. There does not appear to have been curiosity or challenge regarding this statement, especially within the context of Brett's history of offending behaviours.

14.9.7. The Midwife demonstrated good consideration and support for Sasha's mental health with appropriate referrals made to specialist services, which indicated good knowledge around risks associated with mental health during the perinatal period. However, when Sasha told her Midwife that she had been prescribed anti-depressant medication until July 2020, and had recently stopped taking them, there was no professional curiosity as to why. The Midwife also did not link in with Sasha's GP at this point or invite the GP to be part of multi-agency discussions.

14.9.8. This review has identified the need to raise awareness of specialist services available for women during and after maternity; criteria, thresholds and referral pathways into these services should be shared to assist professionals in accessing appropriate help, at the appropriate time, to reduce incidents of peri-natal suicide.

14.9.9. Research shows that the risk of suicide is higher for people who had previously attempted, and higher still for those who also have a mood disorder.[73]

[73] Massimiliano, B and Rosenbaun, J "Risk Factors for Fatal and Non-Fatal Repetition of Suicide Attempts: A Critical Appraisal" *Current Opinion in Psychiatry* July 2010 23 (4) pp.349-355

Both of these factors were present for Sasha, alongside the other high-risk indicator of her being within the perinatal period following the birth of her baby.

14.9.10. This review also highlights the need for all professionals to take disclosures of suicidal intent seriously. It is vital that the "whole person" be considered when identifying the risk of suicide, and therefore risk assessment tools should not be wholly relied upon, especially not as a tick box exercise. If risk assessments are used, they should be used as a starting point, with personalised risk management tools utilised to ensure the specific circumstances of an individual are considered.[74]

14.9.11. In August 2022, Sasha reported Brett for making threats to share explicit footage of her. Crimes were recorded for Stalking, and for Malicious Communication. A safeguarding report was submitted, and a DASH completed. The risk was assessed as medium, although it is not known if Sasha's risk of harm from herself was assessed as well as her risk of harm from Brett. Had the full context of Sasha's situation - as described at various points throughout this report - been considered, Sasha would have been identified as being at high risk of harm from herself following this disclosure.

14.9.12. Completion of suicide prevention training is the most effective way of ensuring that professionals are able to safely identify and support people at risk of suicide.

14.9.13. It was acknowledged during primary care's involvement that there were several situational factors impacting on Sasha's mental wellbeing, however there were limited connections made between the domestic abuse she was experiencing and the impact this would have had on her mental wellbeing. Domestic abuse was discussed by the GP, with Sasha during the 6-week postnatal appointment; however, it was recorded that there were no concerns raised, as Sasha denied any issues with domestic abuse.

14.9.14. There have been many links found between living with domestic abuse, and coercive control, and completion of suicide. This may be due to the victim thinking there is no other way out of the situation,[75] they may be exercising the only form of control they felt they still had due to the abuse.[76]

14.9.15. Recent research shows that many domestic abuse victims who have died by suicide, have done so by hanging. The same research found that survivors are more likely to complete suicide if they experience hopelessness and despair, if they feel trapped, and are most likely to complete suicide if they also feel panic,

[74] https://sites.manchester.ac.uk/ncish

[75] Aitken, R and Munro, V "Domestic Abuse and Suicide" *Refuge* (2008) New-Suicide-Report2c-Refuge-and-University-of-Warwick.pdf (nspa.org.uk)

[76] Pavulans, K et al "Being in Want of Control: Experiences of being on the road to, and making, a suicide attempt" *International Journal of Qualitative Studies in Health and Well Being* (2012)

or terror.[77] The threats to release explicit images of Sasha, may have caused her both hopelessness, with a lack of control over the situation – but also panic and terror of what would happen when the images were released.

14.9.16. There is no indication that any professionals linked Sasha's previous suicide attempts, current mental health state, ongoing coercive control from Brett, and the threats he made to release the images and the distress that this would cause; and identified all of these factors as exacerbating her risk of a further suicide attempt.

14.9.17. Learning from this review will be used to raise awareness across all agencies, of suicide risk indicators.

14.9.18. Following years of research, Professor Jane Monckton Smith developed a pilot tool for professionals to use to identify risk of domestic abuse related suicide, this is now used by Victim Support in Cumbria, however this was not being used during the scoping period of this review.[78] Had this tool been in place during the scoping period, Sasha's and Brett's behaviours and characteristics may have evidenced movement up the suicide timeline, and allowed a greater degree of understanding around the risks that were present.

14.9.19. Victim Support had good opportunities to explore Sasha's suicide risk, however these opportunities were not utilised. Those working with Sasha and Brett could have triangulated the information they held and unpicked some of the comments made by both parties. It is considered that since the suicide timeline has been introduced across Victim Support, the practice would now include more professional curiosity around suicide risk.

14.9.20. The suicide timeline and merged risk assessment tool has been shared locally with partners and invited them to webinar sessions hosted by Professor Monckton Smith, in order to encourage the use of the tool across multi agencies.

14.9.21. The Cumbria Multi-Agency Suicide Prevention Strategy 2024-2029 was signed off in August 2024. The strategy commits to widespread training, including an expectation for all professionals working with pregnant women to be trained to a level which is classed as Orange Button Training.

14.9.22. Orange Button training is specialist suicide prevention training to enable people to be able to explore myths, facts and stigma around suicide. Understanding when someone is at risk and how to support them whilst gaining knowledge of what help is available both locally and nationally. In Cumbria this is a half day, 3 hours, online or face to face session which is delivered by Every Life Matters.

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[77] Christie, C et al "Domestic Abuse Links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report" *Home Office* (2023) OSF Preprints | Domestic Abuse links to Suicide: Rapid Review, Fieldwork, and Quantitative Analysis Report.

[78] 10579_Monckton-Smith_(2022)_Home_Office_Report.pdf (glos.ac.uk)

14.9.23. In February 2024, NCIC introduced new clinical guidelines for perinatal mental health and wellbeing, which included the creation of Perinatal Mental health/Wellbeing Midwives, who attend the weekly perinatal mental health multidisciplinary ream meeting to discuss cases of concern.

14.10. Involving Fathers

14.10.1. Learning from case reviews have identified that fathers, male caregivers, and male partners can often go "unseen" by services.[79] And research has identified that despite some men being very dangerous, they are often "out of sight" of service design and professional practice.[80]

14.10.2. In early July 2021, the Social Worker met with Sasha and Brett at Sasha's family home and spoke to them both about the impact of domestic abuse on children, and on victims. The couple stated that they "argued and needed support." There was no challenge of this perception recorded, either with the couple, or with Brett himself. As highlighted in section 12 above, non-abusive mothers are often held responsible for the abuse they are subjected to and are tasked within Children Social Care plans to both protect the child and end the abuse. Although it is positive that the Social Worker spoke to Brett about domestic abuse; by speaking to both Sasha and Brett together about domestic abuse, the Social Worker was placing Sasha in a difficult, maybe even dangerous position. Sasha may not have recognised Brett's behaviour as abusive, and both parties may have recognised the behaviour as "mutual arguments". However, Sasha may have recognised it as abuse, but was not able to discuss it as such while sitting with Brett. By telling Sasha about the effects of Brett's behaviour on the baby, the Social Worker is placing responsibility on Sasha to stop Brett's behaviour – something which Sasha had no control over.

14.10.3. As mentioned above, the Midwife had handed Sasha a letter from Children Social Care whilst Sasha was in labour, and the Social Worker had visited Sasha on the ward before she was discharged with the baby. When Sasha raised this with the Social Worker, she was told that this was because information at the Multi Agency Risk Assessment Conference was shared about the relationship continuing; however, visiting the hospital whilst Sasha was in labour was not only heavy handed, but it also placed the onus of the Children Social Care involvement upon Sasha, despite the issue being Brett's behaviour.

14.10.4. In mid-August 2021, the Social Worker visits to Sasha's family home included Sasha and her mother. Brett was not present; the women told the Social Worker that he had not been prioritising the baby and had started drinking again. Sasha stated she was doing "everything". This did not appear to have been addressed with Brett.

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[79] Unseen men: learning from case reviews | NSPCC Learning

[80] The myth of invisible men safeguarding children under 1 from non-accidental injury caused by male carers.pdf (publishing.service.gov.uk)

14.10.5. In early September 2021, the Social Worker visited Sasha and Brett at his home, where Sasha and the baby had been staying. They told the Social Worker that at a recent christening, Brett had become intoxicated and was angry at Sasha for going into a "mood" about this. The Social Worker challenged Brett blaming Sasha and questioned if his behaviour may have been the problem. This was good practice.

14.10.6. The Social Worker undertook checks with Unity, First Steps and Turning The Spotlight – who all confirmed that Brett was attending sessions – although upon review of the information his engagement was sporadic at best and does the raise the question of how information is presented to, and received by, Social Workers when undertaking assessments.

14.10.7. During the gathering of research for the DARDR, the Social Worker reflected that in hindsight they may have been too optimistic about Brett's behaviour and placed more emphasis on Sasha due to what was seen as her emotional dysregulation.

14.10.8. Practice A did not ask, or record, Brett's name in Sasha's notes. He was referenced, as was his behaviour and the links of this behaviour to Children Social Care involvement, and to Sasha's mental health – however he was rendered invisible in the GP records.

14.10.9. Learning from this review will be shared with multi-agency partners, alongside current available research regarding the problem of sidelining male family members and caregivers, to remind professionals to consider men in assessments and planning, challenge their behaviours in practice, and to balance the level of expectations placed on both parties – instead of placing all expectations upon mothers.

15. Lessons to be Learnt.

15.1. Children Social Care

15.1.1. Social workers must assess both parents, when it is safe to do so, following receipt of referrals. Both parents' current and historic information should be included in assessments and when it is safe to do so, both parents should be involved in planning throughout a family's involvement with Children Social Care.

15.1.2. Genograms should be used, to explore maternal and paternal family. Brett's sister appeared to be a support to him yet there is little information about her or indeed his family. Within the information gathered for this review there was a lot of detail around Brett's early life history, criminality, and patterns of alcohol/drug use/violence, which did not appear in case notes from the scoping period. It is therefore not clear what elements of Brett's history were considered in the assessments and planning.

15.1.3. Since the scoping period for the review, training has been rolled out around genograms and there is an expectation that genograms include maternal and paternal family and key information.

15.1.4. A strategy meeting should have been convened following the first Multi Agency Risk Assessment Conference, due to the risk of harm to Sasha, and in turn the baby, being considered high risk. This would have enabled key agencies to share critical information which would have informed how Children Social Care could manage the risks.

15.1.5. When circumstances change, for example when parents separate or rekindle their relationship, or where a parent moves out of their family home and into temporary accommodation, a re-assessment should be undertaken or at least considered.

15.1.6. All children subject to child in need plans are now reviewed by both Team Managers, and Service Managers. The purpose of this is to ensure that the key aims of the plan and key areas of work are being progressed. At the review, the Social Worker must share the genogram and talk through the work that is being completed to address the key areas of concern, risk and signs of safety are reviewed and clear actions are put into place.

15.1.7. In this case, supervision was held at the point of allocation, and then monthly – aside from one month where supervision did not happen. This is expected practice. During supervision, reflective discussions could have taken place around the key aims of the plan and the direct work that could have been undertaken with both parents together, and separately. Cumbria County Council have introduced Signs of Safety, and it is expected practice for supervision sessions to be undertaken using the Signs of Safety format and actions are set within the sessions.

15.1.8. In Cumbria, an internal review was completed regarding evaluating and improving responses to domestic abuse in children's services. Several recommendations were made with a view to strengthening practice, partnership working and training. Leading on from these recommendations, a domestic abuse model was developed. This involved having two specialist teams across the two Cumbrian local authorities. Each team consisted of a Team Manager, and three domestic abuse advisors, who worked alongside social work practitioners. The aim of the model was to encourage practitioners to focus specifically on the root cause of domestic abuse. Unfortunately, due to funding implications Cumberland Council were unable to continue the service.

15.2. Cumbria Constabulary

15.2.1. 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.

15.2.2. 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.[81]

15.2.3. 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.

15.2.4. New DA Matters[82] 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.

15.2.5. 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.

15.2.6. 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.

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

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

15.3.2. 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.

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

[82] Provided by Safe Lives

15.3.3. 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.

15.3.4. 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.

15.4. North Cumbria Integrated Care

15.4.1. 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.

15.4.2. 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.

15.4.3. 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.

15.4.4. 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.

15.4.5. 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.

15.4.6. 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.

15.5. Victim Support

15.5.1. 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.

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

15.5.3. 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.

15.6. Recovery Steps Cumbria

15.6.1. 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.

15.6.2. 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.

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

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

16. Recommendations

<u>Multi Agency Recommendations</u>

16.1. 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.

16.2. 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.

16.3. A learning tool will be developed for multiagency training and awareness, which will share Sasha's 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.

<u>North Cumbria Integrated Care</u>

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

<u>Children Social Care</u>

16.5. 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.

16.6. 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.