A Combined Child Safeguarding Practice Review and Domestic Homicide Review concerning the deaths of

Bethany and Darren
in May 2021

Executive Summary

Dr Russell Wate QPM
(January 2024)

Glossary - Executive Summary

BBR – Building Better Relationships
CBT – Cognitive Behaviour Therapy
CIN – Child in Need
CRC – Community Rehabilitation Company
CSPR – Child Safeguarding Practice Review
DA – Domestic Abuse
DASH – Domestic Abuse Stalking and Honour Based Violence Risk Assessment
DHR – Domestic Homicide Review
DVDS – Domestic Violence Disclosure Scheme
DVPN – Domestic Violence Protection Notice
DVPO – Domestic Violence Protection Order
EDAN Lincs – Ending Domestic Abuse Now
IDVA – Independent Domestic Violence Advisor
IMR – Individual Management Review
LDAP – Lincolnshire Domestic Abuse Partnership
LSCP – Lincolnshire Safeguarding Children Partnership
MARAC – Multi -Agency Risk Assessment Conference
PPN – Police Protection Notice
SLP – Safer Lincolnshire Partnership

1. Introduction and participating agencies:

1.1 In this review, the actual names of the victims, Bethany (26 years) and her son Darren (9 years) are used. The use of their actual names is at the request of their family, expressing that no pseudonyms should be used for their loved ones to ensure that both Bethany and Darren (his family called him DJ and this is the name the report author uses for him) have a voice throughout this process and that this review is faithful to their legacy. No words can adequately describe their loss and as a panel, our motivation is to ensure that this review delivers an open and holistic picture of who they both were and how the learning identified can contribute to protecting other victims in the future.

1.2 At the end of May 2021, Officers from Lincolnshire police entered the scene of a reported stabbing incident at a residential address in a small Lincolnshire town. Prior to their arrival, a baby had been removed from the house by a passer-by. Tragically, officers discovered the bodies of Bethany and DJ in separate parts of the house. The infant, Child A, was unharmed.

1.3 The perpetrator and estranged partner of Bethany, was arrested the following day. He was subsequently charged and convicted of the murders. In February 2022, he was sentenced to life imprisonment. In passing sentence, the Perpetrator was said to have subjected Bethany and DJ to "*Abhorrent physical and psychological abuse*". The Judge described him as a *"very dangerous man*" who took pleasure in inflicting violence.

1.4 The Independent Chair and author of this review would like to thank the IMR authors and the practitioners from both statutory and voluntary agencies that have assisted in reviewing and compiling the information culminating in this report despite competing demands placed on resources from the effects of the Covid-19 pandemic.

1.5 The participating agencies are:

- Lincolnshire police
- Lincolnshire Safeguarding Children Partnership
- Lincolnshire County Council Adult Social care
- Lincolnshire County Council Children's services
- Lincolnshire Community Health Services
- EDAN Lincs (Ending Domestic Abuse Now)
- East Midlands Ambulance Service
- Lincolnshire Integrated Care Board on behalf of GP Practice
- Lincolnshire Partnership NHS Foundation Trust
- Probation Service
- Salvation Army
- United Lincolnshire Hospitals NHS Trust
- Darren's School
- Northern Lincolnshire and Goole NHS Trust
- Derbyshire MARAC services

2. Purpose and terms of reference for the review

2.1 The purpose of this Review is to ensure that it has been conducted with effective analysis and conclusions of the information related to the case in accordance with both statutory guidance, best practice and with due regard to the needs of the family. A key consideration was to ensure that the family of Bethany and DJ could seek answers to questions from all the participants to the review and to have the confidence that they would be professionally addressed throughout.

2.2 The generic questions as set out in the statutory guidance for both DHR and CSPR have been addressed in addition to the following specified terms of reference.

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

14) Did the agency have policies and procedures for domestic abuse and safeguarding, and were any assessments correctly used in the case of the subjects? Were these assessment tools, procedures and policies professionally accepted as being effective?
15) Were any issues of disability, diversity, culture, or identity relevant?
16) To consider whether there are training needs arising from this case.
17) To consider the management oversight and supervision provided to workers involved.
18) How has Covid-19 impacted on service delivery and interaction in this case?

2.3 The family asked that the agencies also explored, *'Why the perpetrator was not sent to prison, when he appeared at court (17/2/2021) for a further offence against Bethany and her mother.'*

2.4 The scope of the review runs to the date of Bethany and DJ's deaths and focussed on a period aligned with a significant domestic assault committed by the perpetrator on his previous partner in 2018. This timeframe also allowed for an understanding of DJ's life, pre-Covid-19, and therefore allows the panel to consider any potential impact of the lockdown and restrictions on him and his family.

3. Agency contact and information from the review process.

3.1 On November the 25th , 2018, the perpetrator committed an assault on his partner with whom he had been in a relationship with since late 2017. On the 12th of December 2018, he pleaded guilty to battery and received a community sentence and a restraining order until June 2020. A pre-sentence report identified that the perpetrator was at a medium risk of further offending and presented a medium risk of serious harm to intimate partners, particularly if they ended the relationship.

3.2 The perpetrator completed his community order, managed by the area Community Rehabilitation Company (CRC) who reported that he had complied *'relatively well'* until April 2019.

3.3 In mid-May, 2019, he informed his probation officer that he was now living out of the area with his '*new partner'*, Bethany. They had known each other when they were growing up and then connected again when he moved back into the area. During June 2019, a Senior Probation Officer noted that the management of the case needed to be transferred out of the area as the perpetrator was now resident in another County. By August 5th 2019, the perpetrators case management was in the process of being transferred to the new area with a 'caretaker' Probation Officer appointed to support this transitional process in the new area.

3.4 The perpetrator failed to make his initial two scheduled appointments with the new area Probation Service and a person identifying herself as 'Bethany', spoke on his behalf, stating that he was working and was unable to attend his appointments. When he did attend a meeting with the area Probation Officer on the 21st of August 2019, he confirmed that although he was living at Bethany's home, they were just good friends. He disclosed that he believed that he had Asperger's syndrome. The perpetrator failed to attend his next appointment with Probation on September 2nd 2019, and the former area's Probation Officer, who was maintaining the oversight and management of the case, attempted to contact him by phone, speaking on this occasion again to Bethany.

3.5 The perpetrator failed to attend his final probation appointment on 3rd of December 2019, and although action was considered for the breach, it was considered not be in the public interest to proceed with enforcement action. On the 11th of December 2019, on discharge of the community order, the perpetrator was assessed as presenting a medium risk of serious harm to the public, known adults and a low risk of serious harm to children.

3.6 On the 21st of December 2019, Bethany attended a pregnancy medical examination with an unidentified co-partner present throughout. Bethany commented that she had been with her partner for nine months, she presented as being anxious and concerned and had suicide ideations. She was signposted to mental health support services.

3.7 On the 29th of December 2019, Bethany contacted the police to report that the perpetrator was refusing to leave her home and Bethany had sought refuge at her parents address nearby. The perpetrator then arrived at Bethany's parents address arguing with Bethany's father but left prior to the police attending. A Police Protection Notice (PPN), which incorporates the Domestic Abuse Stalking and Honour Based Violence questions (DASH) and risk assessment was completed and identified that this was '*the first reported instance'* between Bethany and the perpetrator. The assessment noted Bethany was not aware of any previous domestic history involving the perpetrator, had no concerns over controlling and coercive behaviour, was not frightened of further violence and was aware of the Domestic Violence Disclosure Scheme (DVDS.) No action was taken against the perpetrator.

3.8 Bethany was ten weeks pregnant with the perpetrator's child. Referrals were made to Children's Services given that DJ was present at the time of the event. On the 30th of December 2019, Bethany attended an antenatal appointment, but no disclosure was made by Bethany of domestic abuse.

3.9 On the 17th of January 2020, the perpetrator consulted with a GP, he was concerned that he had Asperger's traits, felt angry and was not in contact with reality, the GP noted that he sounded and looked anxious. Medication was prescribed and he was referred to the local Community Mental Health Team. On the 21st of January 2020, Bethany saw her GP as she was concerned with her mental health. She was referred to local mental health services.

3.10 On the 28th of January 2020, Bethany attended for a pregnancy ultrasound appointment. On this occasion she was accompanied by the perpetrator which prevented routine domestic abuse enquires being made.

3.11 On the 17th of February 2020, the perpetrator was assessed by the Community Mental Health Team. He was allocated a Community Psychiatric Nurse and referred for an Autism assessment from the Autism Diagnostic and Liaison Service.

3.12 On the 25th of February 2020, a telephone call was made to the perpetrator at his request by the Community Mental Health Team. The record indicates "*He was noted to be incoherent & would go off on tangents, reported experiencing some paranoia.*" He also stated that he was *currently* living with his girlfriend who was pregnant and was guarded not wanting her address to be widely shared.

3.13 On the 4th of March 2020, in a telephone call with the perinatal team, Bethany reported that she'd recently separated from the perpetrator and her mood had deteriorated. There was no obvious risk for the unborn child which she seemed excited about. She was seen by the perinatal team on the 6th of March and was deemed to not meet criteria for perinatal support and was advised to self-refer for CBT support.

3.14 On the 18th of March 2020, the Community Mental Health Team contacted the perpetrator by phone where he stated he would not be attending his appointment scheduled the next day. He accused staff of not providing him with a crisis service and that if he'd become unwell he would have "*been hung out to dry*". The service reinforced that support was being offered and to keep him engaged to be able to identify the most appropriate support for him. He did not attend an appointment with them on the 19th of March, nor respond to contact from the service on the 23rd of March.

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

3.16 By the 15th of May 2020, Bethany had received Cognitive Behaviour Therapy on two occasions from mental health services. Her antenatal appointments were all attended. There was no reference to the perpetrator or her relationship with him, although Bethany was asked on 12 separate occasions in relation to DA.

3.17 In August 2020, Bethany gave birth to Child A. On a home visit on the 8th of August 2020, by Midwifery, the perpetrator was present, so on this occasion no domestic abuse questions were asked of Bethany, no concerns were raised by the midwife. Bethany was discharged from Midwifery Services on August the 12th 2020.

3.18 On the 23rd of September 2020, Bethany attended a child development assessment where the professional asked her directly about domestic abuse. Bethany raised no issues. Bethany was asked about her partner, she stated that she had been in a relationship with him for a year and he was supportive.

3.19 On the 30th of October 2020, in a telephone call to the Crisis Resolution and Home Treatment Team, the perpetrator stated that he "*was a violent and aggressive person and needed the writer to log him on the system and get him a sedative"*. Staff noted he was, "*challenging", "terse" & "needed to speak to a superior*". He was advised to seek support from his GP, but he declined, stating that he was not physically or mentally unwell and he terminated the call.

3.20 On the 6th November 2020, Bethany moved to another area of Lincolnshire and on the 10th of November, DJ disclosed at school that the perpetrator "*pushed mum over, said swear words*". Staff asked DJ what happened and he responded, "*Mum fell down. Mum is upset* [the perpetrator] *was shouting loud and made [Child A] upset*". This disclosure was not shared by the school at that time.

3.21 On the 23rd of November, an anonymous call was made to DJ's school about the perpetrator that he "*wants to get rid of Darren and calls him freaky".* The school shared the information with Children's Services alongside the information dated the 10th of November. Following a review of this information by Children's Services, they had also received an anonymous call, on the 23rd of November 2020, a Child in Need (CIN) process was opened which was focused on safeguarding the children from experiencing domestic abuse.

3.22 On the 24th of November 2020, Bethany was assaulted by the perpetrator and he was arrested, admitting the assault. He claimed that Bethany just viewed him as a part time dad to Child A and only wanted him at weekends which upset him and concerned him in terms of the bond he is building with his child. He cited that he felt 'bullied' by DJ. Within her witness statement following this assault on her Bethany stated, "*We moved into a private rented house on 6th of November 2020 and [the perpetrator] comes to stay with us now and then. He chooses to come just at weekends when my elder son is with his dad. Things were initially better between us but then things have deteriorated and we have been arguing a lot recently about Darren and his autism".*

3.23 The perpetrator was not charged and bail conditions were imposed to prevent him having contact with Bethany. He was referred to the Criminal Justice Liaison and Diversion Team and was assessed as having mental health and accommodation needs and having "*erratic"* thought processes and pressured speech and "*went in-between moods throughout*". He stated that his "*negative thoughts are too easily triggered".*

3.24 The Police Protection Notice (PPN) containing the DASH risk assessment acknowledged that Bethany was aware that the perpetrator had been violent to a previous partner, as she commented, "*I know that he strangled a previous partner because he told me".* There is no indication that she was signposted to the DVDS at this time.

3.25 On the 30th of November 2020, a social worker visited Bethany. No concerns were noted regarding the home environment or care of the children. Bethany stated that her relationship with the perpetrator had ended but she was unsure if she wanted to pursue any charges against him. Bethany accepted a referral to EDAN Lincs and a safety plan that she would not allow the perpetrator into the property and would call the police should he come to the house. Bethany said she had adequate support from her mother.

3.26 On the 5th of December 2020, the perpetrator arrived unannounced at Bethany's home accompanied by his stepmother wanting to see Child A. Bethany later told the police that she felt coerced to allow him to enter her home.

3.27 On the 9th of December 2020, Bethany reported that the perpetrator had assaulted her, and her mother. Bethany's witness statement also identifies his making threats towards her. The perpetrator was arrested, he denied the allegations of assault with the resulting PPN DASH risk assessment to Bethany graded as medium. The perpetrator stated that he felt "*like my emotions are setting fire to my chest*" and that he believed "*his partner's family have reconditioned me to feel a certain way*". Health professionals recommended that the perpetrator should be seen urgently by mental health services due to his "*presentation being consistent over a period of time, possible paranoia and*

possible risk to his ex-partner". The decision taken by the police was that the perpetrator would be released on bail without charge, with the same bail conditions as were imposed on the 24th of November. Charging advice was sought from the Crown Prosecution Service.

3.28 On the 11th of December 2020, the perpetrator had several contacts with, and face to face appointments at his GP practice. During the GP's examination, he became abusive and aggressive and left, returning later where he was referred to a psychiatrist.

3.29 On the 12th of December 2020, Bethany reported that the perpetrator was outside her address in breach of police bail conditions. Police officers attended and found the perpetrator in the rear garden of Bethany's property. He stated he could not take the impact on his mental health of not seeing his child anymore and had gone to ask Bethany to let him see the child and that he had done the same the previous week and Bethany had let him stay the night on that occasion, so he thought she would do the same again. Officers found that he had a large holdall packed with personal belongings and told the perpetrator he was breaching his police bail. He was not arrested but taken to his stepmother's (she was the perpetrator's fathers partner from when he was one year old and is known as stepmother) address where he had been temporarily residing. Bethany confirmed that she had let him stay for a night during the previous week as she felt sorry for him, but that afterwards she realised this was a mistake as he tried to "*worm his way back in".* No statement was taken from Bethany and she declined to answer the PPN DASH risk assessment questions as she said there was '*no change from those that she had provided 3 days previously*.'

3.30 On the 14th of December in a telephone call between the perpetrator and the Criminal Justice Liaison and Diversion Team, the perpetrator was distressed stating he *"spends hours getting lost in his thoughts"* and it was *"breaking me"*. His focus was that Bethany would not allow him contact with his child and he was concerned about the impact of DJ's behaviour on his child.

3.31 On the 20th of December 2020, a Child in Need plan was agreed and a review date set for a six-week period. Bethany spoke to the EDAN Lincs caseworker on the 21st of December, 2020, for pre-assessment, and during this process it was graded as tier 3 (Medium Risk Cases, with indicators of potential high risk). The worker recorded that there was an element of disguised compliance by Bethany due to the conflicting information provided on the referral from the police and what Bethany was saying. Bethany recognised that DJ had witnessed some of the domestic abuse incidents and the arguments had increased recently with the perpetrator, due to him wanting DJ to go to his father to live there temporarily, which she disagreed with. Safety advice was given, and the worker noted that bail was in place and the risk to Bethany was thereby reduced. Bethany was signposted to mental health services and the case was closed to EDAN Lincs on the 11th of January 2021.

3.32 On the 3rd of January 2021, Bethany contacted Lincolnshire Police to report that the perpetrator had been outside her address confronting DJ's father, who was returning him home. She admitted she had let the perpetrator into the house to see Child A, there had been an argument between the two men before the perpetrator left. Shortly after this the perpetrator had attended an urgent treatment centre asking to see "*the cleverest person*" available because of his mental health. The perpetrator was asking to be '*put on the screen to show he has been to department'* but he left

without assessment. The perpetrator was arrested later that day and appeared before the next available court, on January 4th 2021 for breach of bail. The PPN DASH in respect of Bethany was shared with Children's Services and in her statement Bethany spoke of her fear of the perpetrator coercing her into allowing him to see his child.

3.33 On the 4th of January 2021, the perpetrator was dealt with at the Magistrates' Court for the assault that occurred on the 24th of November 2020, entering a guilty plea. He was granted bail by the court to re-appear on the 12th of January 2021, for sentencing, with conditions not to contact Bethany or go to her address. He was homeless and sought temporary accommodation at the Salvation Army refuge. On January the 6th , he was granted residential support for up to six-months.

3.34 On the 11th of January 2021, the Probation Service carried out safeguarding checks for a pre-sentence report. It was ascertained that Bethany's children had an appointed Social Worker. The probation assessment identified that the perpetrator was in a high percentage category of reoffending and breaches of his bail meant those risks were elevated. It was apparent that the perpetrator was not willing to accept that the relationship with Bethany was over and he expressed negative attitudes towards DJ, blaming the child for the problems in his relationship with Bethany. The probation officer shared those safeguarding concerns with the children's social worker.

3.35 On the 12th of January 2021, the perpetrator was sentenced to a 24-month Community Order with an accredited programme requirement, 20-day Rehabilitation Activity and a Restraining Order, active until 11th of July 2021 prohibiting him from contacting Bethany. This sentencing was in respect of the assault of November the 24th 2020, not the more recent incidents which remained pending charging advice from the CPS.

3.36 In a Probation Service meeting held with the perpetrator on 19th of January 2021, it was clarified that he was living in temporary supported accommodation and was actively seeking employment. His relationship with Bethany had ended and there was a restraining order in place, and he was under the support of the Community Mental Health Team.

3.37 On the 25th of January 2021, Bethany stated to a health visitor, that she no longer had any contact with the perpetrator and a restraining order was in place. She had good support from her mother and was working with a children's social worker.

3.38 On the 28th of January 2021, the perpetrator informed a social worker that he had broken his bail conditions six times, once going to Bethany's house and the rest of the time Bethany collected or met him. He said he asked for the restraining order as he needed to be in a better place but commented that he did not know why she has not talked to him since the restraining order. He blamed Bethany for starting arguments, that Bethany's mother was possessive, "*she started all of this*". When asked about DJ he responded, "*No comment, I need to be in positive place to discuss him".* On the 29th of January 2021, the perpetrator was charged and bailed to appear at the Magistrates Court on the 17th of February following CPS charging advice.

3.39 On the 2nd of February 2021, in contact with the community mental health services, the perpetrator reported that he felt that he had got a positive outcome from court, although he was

concerned that his ex-partner and her mother were going to try to stop him from seeing his child and had accused him of "*other silly things which were thrown out'.* He stated that he has not been in contact with Bethany and "*has not fallen into the trap of her making out she needs him",* so she can then report him.

3.40 On the 10th of February 2021, Probation completed the risk assessment, risk management plan and initial sentence plan for the perpetrator for his next court appearance on the 17th of February.

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

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

3.43 On the 17th of February 2021, the perpetrator appeared at magistrates court for the assaults committed on 9th December 2020, on Bethany and her mother. He was sentenced to a further 24-month Community Order with the same 'Building Better Relationships' requirements that he had been sentenced to on the 12th of January 2021. The pre-existing Community Order was fully revoked and replaced with an identical Order, to expire on 16th of February 2021. The court also imposed a further Restraining Order prohibiting any contact whatsoever with Bethany but allowed child contact via a 3rd party to Child A.

3.44 On the 17th of February 2021, DJ's paternal grandfather reported that the perpetrator had approached him, had been verbally abusive towards him and had stated, "*you do something or I'll do it,"* in relation to DJ allegedly waking the perpetrator early in the morning. The police visited Bethany and the children and were satisfied that Bethany had not seen or heard from the perpetrator.

3.45 On the 18th of February 2021, a Child in Need Review meeting was held via 'Microsoft -Teams' attended by Bethany, her mother, and the children's social worker. DJ was reported to be happy and no disclosures were made concerning domestic abuse.

3.46 On the 25th of February 2021, an induction meeting with the perpetrator post-sentence was held by phone with a Probation Officer who noted concerns over the perpetrators use of language during the conversation. The perpetrator stated he was not in a current relationship, had fully admitted the offence on Bethany and was open to probation supporting him and wanted the restraining order. Also on the 25th of February, the Salvation Army night concierge had raised that on a recent number of occasions, the perpetrator was returning to the shelter under the influence of alcohol and his mood was also very low. In an email to the Local Authority housing team on the same date, the perpetrator commented, "*I have a child here' I've fought tooth and nail already to*

stay in their life your system and your opinion will not change the course of my future in my child's life'.

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

3.48 On the 5th of March, the perpetrator had telephone contact with the Probation Service and no issues were raised and in further contact with his probation officer on March 10th, the perpetrator indicated that he had had no contact with Child A but had spoken to the social worker.

3.49 On the 11th of March, staff at the Salvation Army hostel raised a concern from the Chaplains concerning the 'very real threats' the perpetrator was making regarding both Bethany's and DJ's family. He stated they were *'all wicked'*, and there *'wasn't a good one among them'*. He said that *he has things to sort out and "line up" in his mind, then, if they are still the same, he will kill the 'whole blood line*'. Staff consulted with a police officer, who was at the premises on a separate matter. The officer advised that people made threats all the time and it did not mean they would carry them out. Staff seemed re-assured by that response and no referrals were made. The police, after searching their records have no record of an officer visiting the centre at that time.

3.50 On the 24th of March 2021, a CIN meeting was held via Microsoft 'Teams' with Bethany, and children's social worker. The school contributed through information shared with the social worker. In a discussion concerning contact between the perpetrator and his child, Bethany stated she would not initiate contact, but she agreed that it needed to be supervised, not by family members. On the 29th of March the issue of whom could facilitate and supervise visits was discussed between the Children's Social worker and the Probation Service who confirmed they would send a representative to the next CIN meeting.

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

3.52 On the 12th of April 2021, in a telephone assessment with mental health services, the perpetrator reported he wasn't good at communicating with others on emotional levels. He stated, "*happiness scares me"* he felt, 'frustrated, angry, anxious, down, low, depression and numb', feeling this way all his life. Although a child safeguarding screening tool was completed based on what the perpetrator disclosed, there was no evidence of a child protection enquiry or a record that the child was open to children's services. The following day, in a risk assessment completed with the Community Mental Health Team by an advanced practitioner, the perpetrator denied being any risk

to himself or to others and was summarised as being of no homicidal or suicidal risk, showing self-evidence of presenting better than previously.

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

3.54 On the 5th of May, the Probation Officer spoke to the perpetrator who was sounding *'very flat and tired'* but confirmed that he had heard from the social worker and he was awaiting further contact.

3.55 A CIN meeting took place on 7th May 2021, but at this point the perpetrator was not aware of that fact as contact did not appear to have been made with him in the interim by the social worker. The Probation record indicated *"The attempts to contact him by the Social Worker have been fraught with difficulty"* as there were issues with the perpetrator's 'phone.

3.56 On the 7th of May 2021, the BBR manager's assessment was that the perpetrator was possibly not suitable for the programme as he did not have the ability to cope in a group environment. The integrity of the programme's design meant that it could not be delivered on a one to one basis.

3.57 By the 11th of May 2021, it was apparent the perpetrator has become increasingly frustrated with not seeing his child and the Probation Service noted he had demonstrated his frustration in contact with the children's social worker the previous day, although there is no corresponding record within the Children's Services records concerning communication.

3.58 On the 14th of May 2021, the perpetrator contacted Steps2change and expressed that he needed "*urgent support*". The record notes he was unhappy and he "*started speaking various different words without purpose*". The call handler had no previous knowledge of him but signposted him to urgent services and the call detail was immediately passed to a clinician. Contact with the perpetrator was attempted on a few occasions by a clinician without response. A letter was then sent to him inviting contact.

3.59 On the 18th of May 2021, a further CIN meeting was held virtually. Bethany, her mother, the Children's Social worker and school representative attended. Bethany reported that she had not had any contact from the perpetrator but was aware that he did want to see Child A. No plans were put in place to address the contact.

3.60 On the 27th of May 2021, in a visit with the Probation Service, the perpetrator was reported as being frustrated about his accommodation as he wanted somewhere where he was able see his child. He wanted to impress that *he* was a good father, whereas he inferred Bethany was not attentive to his child, he was not bothered about her, the relationship was not good. He expressed unhappiness about the social worker having stated that he was a risk to his child and was against him having contact. The Probation Officer was concerned about how the perpetrator had presented

during his residence and contacted the Salvation Army. The response was that there were no problems in relation to his residency, he was quiet and there had been no issues.

3.61 At the end of May 2021, Bethany and DJ were attacked and murdered at their home by the perpetrator. Child A was unharmed. The perpetrator was subsequently arrested, charged, and convicted of their murders after a trial.

4. Key issues arising from the review.

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

5. Learning themes

5.1 The review has identified five key themes which in summary are:

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

6. Conclusions

6.1 The perpetrator was a man with numerous previous convictions of violence and a history of a domestic abuse related offence before he started a relationship with Bethany. The level of his risk to Bethany, DJ and the wider family was underestimated throughout. What is unequivocal is that the lines of communication between agencies was not sufficient to fully understand the risks involved.

6.2 Opportunities to have addressed a more thorough understanding of the perpetrator's risk towards Bethany and DJ became secondary to the perceptions of the needs of the mental health of the perpetrator and he manipulated this to his advantage. The panel agrees that they were intrinsic to the overall picture, but those needs became the primary driver and not the numerous warning signs for safeguarding.

6.3 There was an early opportunity to ensure that Bethany was advised and made aware of the Domestic Violence Disclosure Scheme by the Probation Service, and the police following the DA incidents. This did not happen, and although Bethany may have been aware of his previous violent relationship, she was probably unaware of his violent past. Planned amendments to the scheme in line with the Domestic Abuse Act 2021, should place greater emphasis on the scheme across agencies with statutory responsibilities for domestic abuse and reduce the timeline in response to applications.

6.4 The controlling element of the perpetrator's behaviour towards Bethany raises a further question of whether the perpetrator was stalking and harassing her. Coupled with coercion and control, it does become apparent that other solutions and action could have been taken against the perpetrator in both mid, and then late December 2020, but also in January 2021. The exercise of coercion and control was not identified even though there were indicators of such behaviours. Those signs were missed, even though they were part of the evidence from Bethany in her witness statements. It can be reasonably argued that the charges the perpetrator faced did not actually address the offending profile towards Bethany between November 2020 and January 2021.

6.5 The fact that the perpetrator was repeatedly returning to Bethany's home was an obvious indicator of the escalation of the risk of harm. This escalation should have been identified and the associated level of PPN DASH risks could have been raised to high. This would have brought Bethany's case into MARAC arrangements and given the domestic abuse incidents the managed support required, importantly placing the children in an integrated arena of safeguarding running in parallel.

6.6 The decision taken to conduct a CIN in November 2020 was well judged, however, it is appreciated that the timing of the CIN was within the period where 'normal' activities were affected by emergency legislation and Governmental advice concerning the COVID-19 pandemic. There is evidence that the school were collaborative partners in the Child in Need plan and supported the social worker to capture DJ's voice and explore his world. However, the Child in Need process was in this particular case not robust, nor was it multi-agency and it should have sought the views of the perpetrator and DJ's father from the outset. Agencies that should have attended, in person or otherwise, did not, or were not considered as part of the process, and this prevented accurate current information and risks being shared.

6.7 It is apparent that a considerable amount of time and effort went towards the perpetrators support and mental health needs and consequently Bethany's safeguarding needs became secondary. There was little work by agencies to 'target harden' her, her children, or her home. Overall, there was a distinct lack of joined-up working in this case and when considering the wider issues MARAC would have been the most suitable forum, but risks were not raised high enough by any agency.

6.8 Despite the CIN process, a most concerning aspect is that no agency acted to address the perpetrators abject dislike of DJ and raise the threshold of that specific concern. It was frequently narrated that the perpetrator considered DJ as the wedge in his relationship and when Child A was born, that view was omnipresent. Although some key individuals, such as the social worker, were

not aware of the extent of this until after the murders, numerous threats and comments made by the perpetrator to different practitioners throughout, were effectively disregarded.

7. Recommendations

7.1 There are a number of agency specific recommendations in addition to the following key practice recommendations:

Recommendation 1

The Safer Lincolnshire Partnership (SLP), Lincolnshire Domestic Abuse Partnership (LDAP) and the Lincolnshire Safeguarding Children Partnership (LSCP) need to coordinate the raising of professionals' awareness, knowledge and understanding of:

i) the Domestic Violence Disclosure Scheme, Domestic Violence Protection Notices and Domestic Violence Protection Orders (to be led by Lincolnshire Police).

ii) The risks following separation of harassment and stalking.

iii) Coercive and controlling behaviours

iv) The fact that domestic abuse is always harmful to children.

(Utilising the lives of Bethany and Darren would help understanding as a case study and for each agency to support the learning by also delivering agency specific guidance.)

Recommendation 2

The Lincolnshire Domestic Abuse Partnership and the Local Safeguarding Children Partnership should seek assurance from partners that when they work with victims of domestic abuse who are unable to, or reluctant to engage, that they consider the best individual, or agency, who could facilitate this engagement, in order to ensure that any risk posed to the victims and their children in these families is properly assessed and the victim can be suitably supported. (As an example this may be through Lincolnshire Children Social Care tool, 'Family Seeing' as it may be a family member best placed as it was in this case to make more use of Bethany's mother or through the MARAC process and an IDVA.)

Recommendation 3

i) The Lincolnshire Safeguarding Children Partnership must seek assurance from Children Social Care that they have made changes to the local Child in Need processes which makes them more inclusive and that all relevant agencies, including those providing services to adults, are included more consistently in the process and meetings. This also includes the consideration for the meetings to have records taken.

ii) The Safer Lincolnshire Partnership and the Lincolnshire Domestic Abuse Partnership should seek assurance from all agencies that their staff are aware of the impact that Domestic Abuse has on Safeguarding Children. That the agencies also ensure that any perpetrator risk assessments feed into the safety planning around any children in the family.

Recommendation 4

I) The Lincolnshire Domestic Abuse Partnership must seek assurance from those agencies who are working with perpetrators of domestic abuse, that they are able to co-commission with them services that will provide a robust response with perpetrators to try and alter their abusive behaviours and prevent future domestic abuse

ii) The Lincolnshire Domestic Abuse Partnership must also seek assurance that those supporting and working with perpetrators of domestic abuse are fully trained to ensure that interventions target and manage their abusive behaviours.

Recommendation 5

i)The Lincolnshire Domestic Abuse Partnership and Lincolnshire Safeguarding Children Partnership should engage with the Local Criminal Justice Board, to promote that they use the learning from the deaths of Bethany and Darren as a case study to raise awareness and understanding of the domestic abuse risks involved in these cases.

ii) Lincolnshire Safeguarding Children Partnership & Lincolnshire Domestic Abuse Partnership to explore with the Local Family Justice Board, provision of the multi-disciplinary training recommended by the Harm Panel, with a particular focus on coercive and controlling behaviour, including the ways that perpetrators utilise private law children proceedings as part of this behaviour.

Recommendation 6

The Safer Lincolnshire Partnership and Lincolnshire Safeguarding Children Partnership should seek assurance from partners that their information sharing systems ensure that in cases of domestic abuse, information is being shared in a timely and appropriate manner, and that the voluntary sector are included as an integral part of information sharing for safeguarding adults and children. This should include the agencies reminding individuals of their duty to share information and ensure these individuals have an opportunity to be fully trained in information sharing.