Safer Lincolnshire Partnership

Domestic Abuse Related Death Review (DARDR)

Kamila/August 2023

Executive Summary

Author: Dr Liza Thompson

Commissioned by: Safer Lincolnshire Partnership

Review completed: October 2025

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1. The Review Process

1.1. This Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Kamila, a resident of Town A, prior to her death in August 2023.

1.2. Kamila died by suicide just over one week after her partner Sean had taken his own life. Both had died by hanging, in the home which they had shared since the commencement of their relationship in late 2019.

1.3. The key reasons for conducting a Domestic Abuse Related Death Review (DARDR) are to:

a) establish what lessons are to be learned from the death, 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; and
d) prevent domestic violence and abuse, and improve service responses for all domestic violence and abuse victims and their children, through improved intra and inter-organisation working;
e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

2. Review Panel Members

2.1. The panel for review consisted of:

Agency	**Name**	**Job Title**
ViMar Solutions	Liza Thompson	Independent Chair
Lincolnshire Partnership Foundation Trust	Tony Mansfield	Head of Safeguarding, Public Protection and Mental Capacity
United Lincolnshire Teaching Hospitals NHS Trust (ULTH)	Elaine Todd	Named Nurse Safeguarding Children and Young People
NHS Integrated Care Board	Claire Tozer	Head of Safeguarding Adults and Primary Care

EMAS	Charlotte Salt	Named Professional for Safeguarding Adults
Lincolnshire Police	Rachael Cox / Emma Coleman	DCI Safeguarding Hub and DA lead for the force
DA Specialist Services	Sharon Walker	IDVA Manager
Providers of Probation Services	Rachel Crook	Deputy Head East and West Lincolnshire PDU
Adult Social Care (ACCW)	Angela Copestick	Area Manager for Safeguarding
Children's Services	Paula Bexon	Head of Service
Children's Health	Dawn Waring	Locality Health Manager
Town Council A	Peter Hunn	Community Safety Manager
Public Health Suicide Prevention	Kate Cooper	Public Health Officer
Lincs Recovery Partnership	Lisa Brooks	Operations Manager
Lincolnshire Community Health Services NHS Trust	Jennifer Parker	Named Nurse for Safeguarding
Lincolnshire Education Support	Debbie Barkes	Pathfinder Education Lead

Panel Supported by:

Agency	**Name**	**Job Title**
Legal Services Lincolnshire	Toni Geraghty	Assistant Chief Legal Officer
Lincolnshire Domestic Abuse Partnership	Lara Iggulden	Domestic Abuse Operational Lead

3. Author of the Overview Report

3.1. The Independent Chair and Author of the DARDR was Dr Liza Thompson.

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

3.3. Dr Thompson is entirely independent of Lincolnshire County Council, and of all agencies and services within Lincolnshire.

4. Terms of Reference for the Review

4.1. Following a review of a collated chronology of agency contacts with Kamila and Sean, the Review Panel agreed the Terms of Reference at a meeting in October 2024.

4.2. The scoping period for the review was agreed as January 2019, to the date of Kamila's death in August 2023. The rationale for this period being that Kamila and Sean commenced their relationship in 2019.

4.3. Relevant issues for agencies to consider within their IMRs, and subsequently for the panel to consider throughout the process, are detailed in the Home Office Statutory Guidance.[1]

4.4. In addition, the following bespoke terms of reference were agreed by the panel:

a) Identification of coercive and controlling behaviour
b) How were the available disclosures schemes utilised?
c) What was known about Kamila prior to her relationship with Sean?
d) What was known about Sean prior to his relationship with Kamila?
e) What can agencies learn from this review, about children and young people as direct victims of domestic abuse?
f) Analysis of information sharing.
g) In what ways did agencies work together in responding to Kamila and/or Child A?
h) In what ways did housing provision have an impact on Kamila?

[1] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews | Page 13

5. DHR Methodology

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

5.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DARDR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Kamila or Sean during the period covered by the review.

5.3. In addition to IMRs, two organisations provided summary reports due to the small amount of information they held. Also, West Yorkshire based organisations who had limited contact with Kamila in January 2023 completed Summary of Involvement forms, which were sourced via the Leeds and Bradford Community Safety Partnerships.

5.4. The IMR and summary reports were also quality assured by the panel's legal advisor.

6. Summarised Chronology

6.1. During February and March 2019, Kamila was signed off work with back pain. During the same year, Sean's engagement with Probation was sporadic. In July 2019, he reported the end of his relationship with Ms Y. Although previous records recognised that risk to Sean and Ms Y increased at points of separation, Probation recorded no change Sean's risks of harming others.

6.2. Ms Y and Sean were discussed at MARAC on 18th July 2019, however there is no record of his Probation Practitioner following this up with Sean.

6.3. In August 2019, Sean was arrested for possession of an offensive weapon, and whilst in custody, he placed a ligature around his neck. CRHTT attempted contact with Sean after his release from custody, and when he could not be contacted, they closed his case. Sean missed further Probation appointments, and reported that he had moved address, although this was not explored with him.

6.4. Sean's involvement with Probation ended on 2nd November 2019, and there was no evidence of a final assessment being completed with him by his Probation Practitioner.

6.5. In December 2019, the NSPCC raised safeguarding concerns with Lincolnshire Children's Services, after Ms Y reported concerns about Child A being in contact with Sean. This led to the commencement of a Child and Family Assessment. Child A was seen by Social Workers with unexplained facial bruising, and a safety plan was completed, which included a recommendation for a Domestic Violence Disclosure Scheme (DVDS) application. Sean

declined to meet the Social Worker and described himself as being victimised by professionals.

6.6. By January 2020, Kamila was recorded as unwilling to engage with professionals and could not accept the concerns raised about Sean's offending history. At this point, the Social Worker reflected that Kamila appeared to be under Sean's influence. Leon reported to the Social Worker that Sean had assaulted him when he attended Kamila's address to collect Child A.

6.7. In March 2020, Kamila asked for the DVDS process to begin after Leon stopped Child A seeing her while she remained with Sean. During the DVDS process, a police officer spoke to Kamila by telephone. Within minutes Sean had called the officer. Sean was irate and abusive and was demanding what information the officer held about him. Kamila later denied giving Sean the officer's number, but she was told by the officer that she could not be trusted and the application was closed. This incident highlights Sean's influence over Kamila, and how he was able to gatekeep her access to services.

6.8. In August and September 2020, Kamila saw her GP; she was tearful and recorded as being low in mood. She was diagnosed with stress, and adjustment reaction. She was signed off work and prescribed Mirtazapine.

6.9. Between March and November 2021, Child A showed signs of distress at school. He had written in his notebook that he was feeling stressed. He was arriving at school hungry and told school staff that he had missed breakfast and had no lunch with him. Leon and Kamila were both spoken to, and assured school staff that there was food in the house but thought that Child A may have overslept and didn't leave enough time to prepare breakfast or lunch.

6.10. In September 2021, EDAN Lincs received information from Ms Y that Sean had sent her images of his injuries along with a message saying that he had injured Kamila. EDAN Lincs sent a referral to Children's Services, including details of Sean's offending history, however it was assessed that the threshold for intervention was not met, and it was considered that Ms Y may have been making malicious report.

6.11. In November 2021, Kamila experienced a miscarriage.

6.12. In September 2022, soon after joining secondary school B, Child A repeatedly wrote "help" in his notebook during a domestic abuse talk and later had a suspected panic attack.

6.13. In November 2022, Child A told school staff that he was worried about returning home because Kamila and Sean argued all night, he described Sean as paranoid and said that Sean had told his dog to bite Kamila. Kamila was spoken to by school staff and was recorded as minimising the situation.

6.14. Between November 2022 and January 2023, Kamila contacted GP Practice A reporting that Sean had been self-harming, cutting his arms with a knife, and that she did not want to

leave him alone. Sean was prescribed Citalopram and was signed off work, but he did not attend the follow-up appointment. There was no further contact documented by the GP.

6.15. On 21st January 2023, Kamila attempted to hang herself in a hotel room in Leeds following an argument with Sean. Sean was initially arrested for attempted murder, but no further action was taken. There is no evidence that Kamila was asked domestic abuse by mental health services following this suicide attempt.

6.16. In January 2023, Ms Y contacted Children's Social Care with concerns that Sean had told her that he had assaulted Kamila and had left her because she had borrowed money from Leon. Ms Y also reported that Kamila had told her about serious domestic abuse, including an alleged hammer attack, being doused in petrol and Sean threatening to set her on fire. Ms Y also stated that Kamila had attributed the miscarriage to the domestic abuse. Ms Y also raised concerns about Sean's cocaine use, his paranoia, and Child A's exposure to the abuse and substance use. At this point, it was decided that the threshold for social care intervention was met.

6.17. Following discharge from hospital, after her suicide attempt, the LPFT Crisis Team struggled to contact Kamila. When she was seen, she said she did not have her own phone, and she later spoke to the Crisis Team on Sean's phone. She told the Crisis Team that she needed to be with Sean and was going to London with him; she declined further support from LPFT.

6.18. Leon sought help from his GP for Child A after Kamila's suicide attempt. Leon told the GP that Child A had written that "mum and Sean are fighting again, it is getting worse." Leon admitted to being scared of Sean due to the previous assault and uncertainty about what Sean might do. Child A had told Leon he was afraid, that there were frequent arguments in the house, and he spoke about four incidents of Sean being violent to Kamila.

6.19. At this time, Kamila described Sean to professionals as her "saviour," because he has saved her from suicide in Leeds. She denied any concerns and framed herself as the perpetrator, saying that often during arguments Sean had to restrain her.

6.20. During February and March 2023, Kamila's mental health deteriorated and her isolation increased. She was repeatedly signed off work for depression and said that she always needed someone with her. She was observed to have lost weight and appeared less groomed. When asked about the relationship, Kamila defended Sean and did not recognise the risks he posed. Child A's distress escalated during this time, and he started to self-harm; he would bang his head, make suicidal comments and show signs of anxiety and trauma. A MARAC referral was made, but the IDVA service could not contact Kamila because the referral had been submitted without consent.

6.21. When Kamila attempted to visit her family abroad, Sean intentionally drove into a wall. He reported low mood and voices, and disclosed substance use, and was detained under section 136.

6.22. Leon told the Social Worker that he believed that Sean was controlling Kamila. The Child and Family Assessment concluded that Kamila did not consider herself at risk from domestic abuse, that she was unwilling to engage with specialist services, that she relied on Sean for support and was very isolated, and that she was vulnerable due to this and significant concerns about her mental health.

6.23. On 11th April 2023, Sean called police from Norfolk saying Kamila was not answering her phone. Kamila was located by Police and was taken to hospital; she said she had been distressed after a 4am phone call with Sean, where he had accused her of infidelity. In hospital, LPFT assessed Kamila; however, there is no evidence that she was asked about domestic abuse.

6.24. Child A continued to self-harm and presented with suicidal thoughts. On 28th April 2023, a neighbour reported that Sean was banging and kicking at the front door, that he had climbed onto the roof and had entered the flat through a window. Kamila told police Sean believed another man was in the flat and had brought a hammer to kill the imagined male. She said that she could not live with his mood swings and feared that he would kill himself. She later approached the local authority housing team as homeless; however, she was not able to access a refuge space due to her serious mental health issues. The same evening, Sean had a psychotic episode and stabbed himself.

6.25. A Strategy Discussion was held, and it was agreed that progression to an Initial Child Protection Conference was necessary.

6.26. On 27th May 2023, emergency services were contacted twice: first because Sean threatened to hang himself, and later because Kamila was suicidal and had placed something around her neck. Kamila told ambulance crews and hospital staff that her mental health was deteriorating due to stress with her son, her partner, and her family, and that she was mostly confined to the home.

6.27. Child A was made subject to a Child Protection Plan in May 2023. Kamila had one appointment with the Crisis Team, however subsequent contacts with her failed, and she was discharged back to her GP.

6.28. On 19th June 2023, a member of the public reported that Kamila was screaming for help from an upstairs window while Sean was trying to pull her back inside.

6.29. On 23rd June 2023, Sean attempted suicide by hanging after using cocaine use. He had not slept for days and was experiencing paranoia and hallucinations. The Crisis Team were unable to make contact with him following his discharge from hospital, and he was discharged back to his GP.

6.30. On 1st July 2023, a member of the public reported to Police that they had witnessed Sean hit Kamila, while she was walking down the street with a suitcase, and screaming that

she was leaving him. Police arrested Sean and Kamila was assessed as being high risk. Police found cameras set up in the lounge and bedroom, which had enabled Sean to monitor Kamila's movements. Referrals were made to MARAC and the IDVA included details of assaults. Kamila later attended the police station to retract her statement, but an evidence-led prosecution continued. Sean pled guilty to common assault and received a 24-month community order and a requirement to attend Building Better Relationships. He was allocated a Probation Practitioner.

6.31. The IDVA spoke with Kamila and found that she was unable to recognise the abuse and blamed Sean's behaviour on alcohol and substances.

6.32. By 20th July 2023, Kamila and Sean were living back together. The MARAC was heard and Probation were given an action to consider MAPPA level 2, and to work with the IDVA to ensure safe contact with Kamila. There is no indication that these actions were completed before Sean died ten days later.

6.33. On 29th July 2023, Kamila drank bleach and was taken to hospital. She described this as a cry for help, which she connected to strained family and relationship pressures. She was referred to the Crisis Team. The following day, Kamila found Sean hanging. He was taken to intensive care with hypoxic brain injury and died the next day.

6.34. Following Sean's death, Kamila blamed herself, saying she could have saved him. She reported Sean's family messaging her and calling her a "murderer," and she told the IDVA about a large amount of rent arrears linked to the flat.

6.35. Kamila was supported by the IDVA, Crisis Team and the Social Worker with immediate practical issues, including access to housing and rehoming of the dogs. Kamila spoke of moving to Poland after the funeral and continued to describe Sean as having saved her life in Leeds.

6.36. One week later, Kamila was found deceased by Leon at her home. A note was left stating that she could not continue to live because she had not saved Sean, and that when he died, she had died with him.

7. Conclusions

7.1. The review identified Sean's coercive and controlling behaviour, which was the central context for understanding the risks faced by Kamila, Sean, and Child A. However coercive control was not consistently recognised as a pattern of behaviour, particularly where it presented through Kamila's isolation, his surveillance of Kamila, the enforced dependency upon Sean, his threats of self-harm, the changes to Kamila's physical presentation, and both parties' mental health deterioration. For practice, this means professionals should look beyond individual incidents and consider cumulative patterns, changes in the behaviour of victims, and the wider impact of abuse on a victims' autonomy, and overall wellbeing.

7.2. A further area of learning relates to professional curiosity and timely enquiry. There were repeated opportunities across health, mental health, education, ambulance service, police, probation, domestic abuse, and children's services to explore what was happening within the relationship. This was particularly relevant, when Kamila presented to professionals with low mood, self-harming behaviours, seemingly "choosing" Sean over Child A leading to loss of contact with Child A, having no access to her own phone, feeling fearful of being away from Sean, and comments made which should have pointed to coercive control. The implication of this for practice is that practitioners should be confident and supported to ask direct, sensitive questions about domestic abuse and coercive control, especially when mental health concerns and suicide attempts, of both parties, are evident.

7.3. The application of the homicide and suicide timelines highlights the importance of recognising escalation, perceived loss of control, threats of suicide from the abuser, and rapid changes in thinking or behaviour as significant risk indicators. In practice, agencies should ensure that suicide risk is assessed in the context of domestic abuse where relevant, and that threats or acts of self-harm by a perpetrator are considered as potential tools of coercion as well as indicators of risk to self and others.

7.4. The review also reinforces the need for a Think Family approach. Sean's behaviour affected not only Kamila, but also Child A and Leon, who experienced fear, distress, family disrupted contact and feeling a responsibility for managing risks they could not control. Children should be recognised as direct victims of domestic abuse, and risk assessment and safety planning should include all affected family members, including those living outside of the household. Cultural context, language, and isolation from family networks should also be considered when assessing need and planning support.

7.5. Overall, the implications for practice are that agencies should improve recognition of coercive control, strengthen information sharing, robustly record and connect concerns over time, and ensure that domestic abuse expertise informs assessments involving mental health, substance use and suicide risk. Effective practice requires professionals to create safe opportunities for disclosure, whilst understanding the impact of coercion on decision making. Subsequently, interventions should be planned, which increase space for action for victims and their children.

8. Lessons to be Learnt

8.1. The review highlighted various barriers victims face when attempting to end a relationship with an abuser, and also barriers they face in accessing services. Practitioners must be aware that ultimately, the abusive behaviour of the perpetrator forms a barrier for victims accessing support and also attempting to end a relationship. There are often other barriers, which intersect and strengthen one another, however it must be highlighted that all victims of abuse face the universal barrier to support, which is the abusive, coercive and controlling behaviour.

8.2. In Sean's case, he used his mental health to control Kamila. She was afraid to leave him, or even leave the home, because she feared that Sean would self-harm or attempt

to take his own life. Sean isolated Kamila in this way, and in other ways; for example, his violent and aggressive behaviour led her to be isolated from Child A, as it was unsafe for Child A to be near Sean.

8.3. A further barrier to engagement for Kamila may have been her Polish culture. It is not clear from the information gathered for the review that this was the case, however this was not explored with her by any practitioners. It is important that professionals do not assume that because an individual speaks fluent English and has been living in the UK for some years, that their native culture doesn't continue to shape their views and understanding of the world. Practitioners should be mindful of cultural competency and seek to access information and training to support them with this.

8.4. A Culture and Faith learning bulletin, which was created following learning from a previous statutory review,[2] has recently been shared across the multiagency by the Safer Lincolnshire Partnership. The panel recommend that this bulletin be reshared across the partnership, alongside Kamila's story.

8.5. Consideration by all professionals, across all agencies, should be given to working creatively in order to engage victims of domestic abuse in a range of ways, which will allow the breaking down of barriers, and the building of trust over time.

8.6. Since the review's scoping period, Op Komoran has been introduced by Lincolnshire Police. This is a pathway for professionals to report non-urgent crimes for cases that are heard, or due to be heard at MARAC. This allows professionals to share information, which builds a picture of the circumstances, without making a formal report which may lead to a breakdown of trust between the professional and the victim.

8.7. Learning was also identified in this review regarding the identification and assessment of risks, across and between whole family systems. In Kamila's case, she was at risk from herself, and from Sean; Sean was at risk from himself; and Child A and Leon were at risk from Sean. These risks intersected and exacerbated one another in certain circumstances, for example when Child A was spending time with Kamila when Sean was present, or when Sean was intoxicated and self-harming due to Kamila leaving the property.

8.8. Agencies have been developing their approaches to a Think Family model. For example, the LPFT Safeguarding Hub contains details in relation to the concept of Think Family, as does the LPFT Safeguarding Policy 11. All LPFT Children and Young People/Domestic Abuse training packages reiterate the need for children and young people to be given due consideration in any situation where safeguarding concerns are present or have arisen.

8.9. In June 2024, the Lincolnshire Family Justice Board Conference was held. The conference had the focus of domestic abuse, and with permission of the family, a local

[2] DHR Natalia

statutory review[3] was included as a case study example of the importance of agency checks for adult family members during CSC interventions, to form whole family assessments.

8.10. A further area of learning linked to the identification of suicide risks, is the need for practitioners to take a contextual view of identifying risks of suicide. Any type of risk is fluid, and this includes suicide risk. The National Suicide Prevention Strategy[4] indicates that previous attempts, self-harming incidents, and bereavement from suicide are indicators of current suicide risk. Kamila's risk of suicide undoubtedly increased following Sean's suicide, and indeed in hindsight the LDASS panel members reflected that Kamila's presentation and outlook rapidly shifted following Sean's death; however there appeared to be little to no recognition of the time being a period of high suicide risk.

8.11. A recently published report[5] highlighted that in 2023 more victims of domestic abuse died by suicide than were murdered by their intimate partner and hypothesised that around 1800 domestic abuse related suicides were happening each year.

8.12. In April 2025, NHS England published guidance entitled "Staying Safe from Suicide"[6] which introduces a shift from traditional risk prediction tools to a more holistic, person-centred approach. The guidance encourages professionals to gain an understanding of everyone's situation and manage their safety through therapeutic engagement.

8.13. Since June 2025, the DASH assessment tool has been updated to include an enhanced question about suicide risk. This has been shared across all agencies, alongside guidance on its use. All DASH documents are available to professionals[7].

8.14. Lincolnshire County Council have also developed a Suicide Toolkit. This is a multifaceted toolkit to support professionals in identifying and responding to suicidal ideation. It includes contextual guidance, which is aligned to NHS England guidance, along with helplines and best practice for sensitive engagement. The toolkit will become a live document by the end of 2025. Upon publication, the Suicide Prevention Toolkit will be available on the professionals' resources link and will also be linked to the guidance for the updated DASH.

8.15. Early learning from the review has been shared with GP Practice A staff. Following this review, GP Practice A identified a need for additional training and guidance on professional curiosity, particularly for patients who had recently attempted suicide and were requesting multiple repeat medical certificates. The Practice have highlighted

[3] A Combined Local Child Safeguarding Practice and Domestic Homicide Review
[4] Suicide Prevention Strategy
[5] The person most likely to kill a victim of domestic abuse is themselves
[6] NHS England » Staying safe from suicide
[7] DASH Resources - Professional Resources

that patients who present in this way should be seen face to face, and practice staff should be empowered to ask for reasons for repeat medical certificates.

8.16. Since the scoping period of the review, all MARAC updates received by GP Practice A are discussed at practice safeguarding meetings.

8.17. Following learning from this review, UHLT identified the need for their domestic abuse policy to include the links between domestic abuse and mental ill health. This was updated in May 2025.

8.18. LPFT have identified learning for the Mental Health Liaison Service and CRHT around the completion of DASH assessments when they see patients in Accident and Emergency Departments. There were no DASH assessments completed when Kamila was seen by these services in the hospital. LPFT identified the need for more professional curiosity, to gain further knowledge around domestic abuse, and the need for safety planning with potential victims of domestic abuse.

8.19. The LPFT safeguarding team will be delivering DASH workshops with CRHT staff to help develop their knowledge and encourage the use of professional curiosity. LPFT's safeguarding training has been developed to include a greater focus on domestic abuse and completing DASH's.

8.20. LDASS have recently funded external training which enhances the identification of suicide warning signs to inform risk management strategies to support domestic abuse victims who have suicidal ideation. All LDASS staff have attended this training. LDASS have also introduced a suicide policy to ensure staff are aware of how to manage both practical and emotional wellbeing of the victims they are supporting.

8.21. The review has highlighted learning regarding the DVDS process; however, the process has substantially changed since the scoping period of the review which includes an online platform. This process has been rolled out nationally across all police forces.

8.22. Since the scoping period of the review, LDASS have been contracted to deliver a refuge provision with additional units, and through a model that improves the response to victims who may not be suited to residing in a multiple occupancy space. The model includes a specialist refuge IDVA to support victims with additional complexities, which may usually act as a barrier to accessing a general needs refuge.

8.23. When reviewed for this DARDR, some of the ASC records should have given further clarity regarding which organisations and agencies had been liaised with, and the information that had been received, or sent. This learning has led to recording guidance being reviewed, updated and embedded into practice.

8.24. The Town Council A Housing Team continues to have a Domestic Abuse Lead within the team; however, this funding has only been extended for a further year, and the role is therefore unstable. The panel considered that longer term funding and the development of the position into a caseload holding role, would enhance the offer

available to victims who present at Town Council A as homeless and fleeing domestic abuse.

8.25. In July 2024, CSC signed up to be part of the launch of locality based Multi-Agency Child Protection Teams (MACPT) through the Families First for Children Pathfinder Programme. A key element of this development was the establishment of a standalone Independent Child Protection Chair post in each locality. This change enables Independent Child Protection Chair's to focus solely on child protection.

8.26. CSC have identified that children living in homes where domestic abuse is a regular occurrence are significantly underrepresented in the number of children being heard at Child Protection Conferences, because they are captured within the category of neglect. Lincolnshire CSC have raised the need for a standalone domestic abuse category, with the DfE, as this would reflect more accurate reporting of risk, and reason for the child protection plan. In the meantime, Independent Child Protection Chair's will support and facilitate discussions in each conference regarding the categories as part of the multi-agency decision making forum.

8.27. GP Practice A identified the need for their staff to reflect children as victims of domestic abuse in their own right. The Practice's Lead Safeguarding GP will undertake additional training to this end and will be attending safeguarding forums which occur three times per year.

8.28. Secondary School B have developed their policies and general understanding across their staff teams regarding the identification of domestic abuse, and of children as victims of domestic abuse. The Designated Safeguarding Leads, and their Deputies have attended training on the voice of the child when considering safeguarding concerns, and the use of consultations offered by Lincolnshire CSC.

8.29. Since July 2024, Primary School A have included a mandatory requirement for all staff to undertake LSCP "Children Who Experience Domestic Abuse" training on a bi-annual basis. All members of the safeguarding team must also complete the Key Adult Briefing Trainings from Operation Encompass.

8.30. The availability, and criteria of the Children and Young Person IDVA service, delivered by LDASS, should be reshared across multiagency services.

8.31. The EMAS safeguarding brochure for frontline crews has been updated to include guidance on recording details of perpetrators wherever possible. The updated brochure is scheduled for launch in April 2026 and will be made available to all frontline crews.

8.32. As part of the EMAS three-year blended education programme, the forthcoming safeguarding brochure for frontline crews will incorporate guidance on recording perpetrator details wherever feasible. The updated brochure is scheduled for dissemination on 1st April 2026 and will be made available to all frontline crews.

9. Recommendations

The Review Panel makes the following recommendations from this DARDR:

9.1. East and West Lincolnshire Probation Service should link in with regional and national quality development units, and their Quality Assurance exercises to ensure that Probation Practitioners are completing high quality and timely reviews of OASys. Senior Probation Officer should have oversight of this.

9.2. East and West Lincolnshire Probation Service hold accountability meetings with the local team managers, and the regional case assurance tool should contain a specific focus on enforcement activity and responses to missed appointments, in line with policy.

9.3. Specific activities should continue to be rolled out in East and West Lincolnshire Probation Service team "protected learning days" on professional curiosity and domestic abuse, with the completion of these being monitored by head of service/deputy head of service. The impact of these should be monitored through continued completion of the case assurance exercises.

9.4. This DARDR will be discussed with clinical and non-clinical staff at GP Practice A. Non-clinical staff will be asked to access some additional training. GP receptionist and admin staff who don't have the same level of safeguarding training as clinicians but are often the first contact point, need to complete the controlling and coercive behaviours online training through LSAB. This will be rolled out and completed within the coming 6 months.

9.5. To discuss with GP partners regarding putting a reminder on system to advise the number of sick notes issued and prompt for face-to-face review with the patient. Having discussed with partners initially, it was decided if a patient has requested multiple sick notes, it should raise professional curiosity to review the number of sick notes, if the person has not been seen, invite them in for a face-to-face review. This will be reviewed via Audit in 6 months' time.

9.6. ASC will circulate a short briefing to the Safeguarding Team which focuses on the updates of the recording guidance with particular focus on the recording of referrals and multiagency involvement.

9.7. A recently published DHR in Lincolnshire, which pertained to the death of a local Polish woman, highlighted learning cultural expectations and the cultural competency of professionals. The panel recommend that the learning briefing from DHR Natalia be shared alongside learning from DHR Kamila, in order to highlight the need for professionals to understand how culture impacts decision making and engagement with services.