London Borough of Bexley Community Safety Partnership (BCSP)

Joint Domestic Abuse Related Death Review (DARDR) & Local Child Safeguarding Practice Review (LCSPR)

Summary of lessons learnt summary into the deaths of Mila, Audee & Pika

1. Introduction

Bexley Community Safety Partnership (BCSP) and Bexley S.H.I.E.L.D. commissioned a joint Domestic Abuse Related Death Review (DARDR) and Local Child Safeguarding Practice Review (LCSPR) following the deaths of Mila, Audee and Pika. The purpose of a DARDR is to identify lessons that can be learned where domestic abuse is known or suspected to have been a factor in a death. Similarly, the purpose of a LCSPR is to identify improvements that can be made to safeguarding practice and the ways in which organisations work together to safeguard and promote the welfare of children. The review examined how local agencies and professionals worked both independently and in partnership, with the aim of identifying learning that could strengthen future responses to domestic abuse, safeguarding concerns and vulnerability.

In line with safeguarding considerations, the full review will not be published. This decision has been endorsed to protect the privacy of surviving family members whilst ensuring that key learning from the review is shared across partner agencies.

2. Background

The review considered agency involvement with Mila and her family over an eight-year period. During this time, a range of agencies were involved in providing support, including health services, children's social care, education, specialist domestic abuse services, the police and family court services.

The review identified a complex family history which included parental conflict following separation, allegations of domestic abuse, safeguarding concerns, mental health difficulties, ongoing family court proceedings and financial disputes. Whilst a number of agencies had contact with the family, opportunities were missed to develop a shared understanding of risk, vulnerability and lived experience. The review identified significant learning regarding safeguarding practice, domestic abuse assessment, information sharing and multi-agency working.

3. Learning review

The review identified important learning for local agencies in relation to domestic abuse, safeguarding, information sharing and multi-agency working. Learning was identified regarding the importance of understanding the children’s lived experiences, recognising the cumulative impact of harm, embedding a Think Family approach and ensuring that domestic abuse is assessed and responded to effectively across the partnership.

The review found that opportunities were missed to develop a holistic understanding of risk, vulnerability and lived experience. Information was often held in isolation and assessments did not always take account of the cumulative impact of domestic abuse, emotional wellbeing, family conflict, financial pressures and wider family circumstances. The learning highlights the importance of professional curiosity, information sharing and coordinated multi-agency responses when supporting adults, children and families experiencing complex difficulties.

4 Key themes and learning identified

- ### Children's lived experience

A central finding of this review was that the lived experiences of children were not sufficiently understood by agencies. Whilst professionals were aware of parental conflict, allegations of domestic abuse and concerns regarding emotional wellbeing, no single agency developed a comprehensive understanding of how these experiences were impacting on the children.

The review found that opportunities to hear and understand the voices of children were missed and that the impact of parental conflict, domestic abuse allegations and prolonged family court proceedings was not fully assessed. Agencies should ensure that children's wishes, feelings and lived experiences are actively explored and that they meaningfully influence assessment, planning and intervention.

The learning identified within this theme informed recommendations 8, 9, 10, 11 and 12.

- ### Trauma, family history and think family

The review identified that greater consideration should have been given to parental histories, previous trauma and wider family experiences. Understanding the experiences of adults, including childhood adversity, relationship history, cultural influences and significant life events, can provide important context when assessing risk, resilience and vulnerability.

The review found that opportunities were missed to develop a holistic understanding of the family and the interaction between parental wellbeing, domestic abuse, family relationships and the experiences of children. Effective application of the Think Family approach remains essential in supporting improved outcomes for both adults and children.

The learning identified within this theme informed recommendations 1 and 9.

- ### Domestic abuse, coercive control and counter allegations

Domestic abuse featured throughout the period under review and was reported to several agencies. The review found that allegations and disclosures were not always explored through a robust analysis of power, control and coercive behaviour.

Professionals were presented with differing accounts and counter allegations, yet there was limited exploration of coercive control, resistance violence and the wider dynamics of abuse. The review highlights the importance of professional curiosity and ensuring that domestic abuse assessments move beyond individual incidents to understand patterns of behaviour and the wider context of family life.

The learning identified within this theme informed recommendations 3, 13, 14, 17 and 18.

- ### Information sharing, DASH risk assessments and multi-agency working

The review identified that agencies frequently worked with only part of the information available to them. Risk assessments, safeguarding concerns and professional judgements were not consistently shared across the system, resulting in fragmented assessment and decision making.

Particular learning was identified regarding the sharing of DASH risk assessments and communication between agencies, including Children's Social Care, Cafcass and specialist domestic abuse services. Improved information sharing and coordinated multi-agency analysis are essential to ensure that cumulative risk is identified and responded to effectively.

The learning identified within this theme informed recommendations 6, 7 and 13.

- **Family Court proceedings and safeguarding responsibilities**

The review found that the existence of private family court proceedings can create a perception that risks to children and families are being assessed elsewhere. Whilst agencies were aware of ongoing court involvement, opportunities to undertake statutory safeguarding assessments and explore concerns independently were missed.

Professionals must remain vigilant in assessing risk and need regardless of court involvement and ensure that responsibilities relating to safeguarding, assessment and intervention are not inadvertently diminished by the presence of parallel legal proceedings.

The learning identified within this theme informed recommendations 7 and 8.

- **Economic abuse and financial pressures**

Financial circumstances featured prominently throughout this review. Ongoing financial disputes, changing financial circumstances and allegations of economic abuse formed part of the wider context within which agencies were working.

The review found limited evidence that financial pressures and economic abuse were routinely considered within safeguarding assessments. Economic abuse is recognised as a significant form of domestic abuse which can continue after separation and can have a profound impact on wellbeing, vulnerability and decision making. Professionals should ensure that financial circumstances and indicators of economic abuse are explored within risk and needs assessments.

The learning identified within this theme informed recommendations 2 and 17.

- **Professional curiosity, bias and routine safe enquiry**

The review identified opportunities for agencies to demonstrate greater professional curiosity and to challenge assumptions when assessing risk and vulnerability. The presentation of families, their circumstances or their engagement with services should not diminish professional scrutiny or influence safeguarding decision making.

The review also reinforces the importance of Routine Safe Enquiry as a tool to support the identification of domestic abuse and vulnerability. Agencies should ensure that Routine Safe Enquiry is embedded within practice and that professionals are confident in recognising and responding to disclosures of abuse.

The learning identified within this theme informed recommendations 4, 16 and 19.

5. Summary of recommendations

The review panel developed 20 multi-agency recommendations arising from Individual Management Reviews (IMRs). The recommendations focus on strengthening safeguarding practice, improving responses to domestic abuse, enhancing information sharing, embedding the Think Family approach and ensuring that the voices and lived experiences of children remain central to assessment and decision making.

The recommendations have been incorporated into a structured action plan to support implementation, monitoring and ongoing evaluation. In line with statutory guidance, the Bexley Community Safety Partnership and Bexley S.H.I.E.L.D. will maintain strategic oversight of the action plan and ensure that learning from this review is shared, embedded and translated into improved practice across partner agencies.

No	Recommendation
1	Bexley S.H.I.E.L.D, and Bexley Children's Social Care should seek assurance through practice review and learning that practitioners are using the Think Family approach in fully assessing parental history in practice, including histories of mental ill health. The outcome of which should assure relevant safeguarding agencies that holistic assessments capture significantly relevant information which may influence parental behaviour.
2	Bexley S.H.I.E.L.D. and Bexley Community Safety Partnership should work together to develop practice guidance on assessing economic abuse. This practice guidance should be communicated across the partnerships for use by practitioners
3	Bexley S.H.I.E.L.D. and Bexley Community Safety Partnership should work to implement the Safe Lives Practice Guidance to support practitioners in managing counter allegations of domestic abuse.
4	Bexley S.H.I.E.L.D. and Bexley Community Safety Partnership working alongside the Bexley Integrated Care Board, should assure themselves through practice review that 'Routine Safe Enquiry' by health professionals is embedded across the health system.
5	Cafcass should evaluate the impact of domestic abuse policy and practice changes made in 2023. Cafcass should assure itself that those policy and practice changes have made an impact on assessment and private family court processes. They should assure themselves that parents have available literature regarding local services and are referred to appropriate support services locally if needed.
6	Bexley S.H.I.E.L.D. and Bexley Community Safety Partnership should revise practice guidance in how DASH risk assessments are shared appropriately in the safeguarding system to ensure that appropriate risk evaluation takes place.
7	Cafcass should ensure that information sharing protocols are effective and that private family law cases where domestic abuse allegations are made are referred appropriately to
8	Bexley Children's Social Care should undertake a practice review of children's cases over the last 12 months where it is known that private law applications are ongoing, and the children have been/are known to children's social care. Children's social care need to assure themselves that risks are appropriately assessed and intervention appropriate regardless of the private family law process

No	Recommendation
9	Bexley S.H.I.E.L.D. should assure itself through practice evaluation and feedback across the safeguarding system that the Think Family Protocol is embedded and that it is improving outcomes for children and young people
10	Bexley S.H.I.E.L.D and Bexley Children's Social Care should reinforce expectations regarding how the voices of children and young people are influencing assessment and interventions. There should be a specific reference to how children and young people's voices are being heard where domestic abuse is being alleged. The partnership should assure itself that virtual meetings with children and young people are not the norm and face to face meetings are taking place
11	The Cafcass 'Seeing and Engaging with children policy' has been effective since 2021 and stipulates that children should be seen in person. Cafcass should assure itself that this policy is effective and that any virtual engagement with children is effectively managed.
12	Bexley S.H.I.E.L.D. should ensure that the Rapid Review actions are incorporated into any future Action Plan following this review.
13	SOLACE Women's Aid and Cafcass should work together to ensure that information sharing arrangements are in place and are effective, particularly in private family law cases involve allegations of domestic abuse.
14	Bexley S.H.I.E.L.D. and the Bexley Community Safety Partnership should assess the effectiveness of support services to men who may be experiencing domestic abuse and assure themselves that support services are well communicated, and practitioners are aware of those arrangements
15	The Metropolitan Police should develop an action plan following the review of Operation Encompass and ensure that the current and future arrangements are effective in keeping children safe.
16	Bexley S.H.I.E.L.D, Bexley Community Safety Partnership and Bexley Children's Social Care should assure themselves through practice review that the ethnic and cultural background of parents and children is considered in assessment practice and the information evaluated using an intersectional lens.
17	The Department for Work and Pensions should evaluate the effectiveness of the domestic abuse policy and guidance and assure itself that staff are fully appraised of how to manage cases where domestic abuse is alleged.
18	Bexley S.H.I.E.L.D and Bexley Community Safety Partnership should evaluate the effectiveness of the current training for family court judges and magistrates regarding cases of domestic abuse and where counter allegations are made and use the Safe Lives Practice Guidance as a tool to share with judges and magistrates.
19	Bexley ICB should assure themselves that all GP surgeries in the Borough have a stand-alone domestic abuse policy including 'Routine Safe Enquiry'.
20	The Metropolitan Police should explore with safeguarding partners in Bexley whether practice guidance is needed for safeguarding partners to share third party information with the police.

6. Joint review follow up

An action plan has been developed in response to this joint Domestic Homicide Review and Local Child Safeguarding Practice Review. Delivery of the action plan will be overseen by S.H.I.E.L.D. and the Bexley Community Safety Partnership (BCSP) to ensure that the learning from the reviews is implemented across the borough.

For further information about the DHR process or the associated action plan email DHR@bexley.gov.uk

For further information about the LCSPR email: shield@bexley.gov.uk