Community Safety (Safer Merton)

Safer Merton

Working Together To Keep Merton Safe & Sound

Domestic Homicide Review

Annabel

Died March 2021

Author Margaret Tench

Chair and Independent Author

RMN, RGN, HV (DiP) MA

Revised final version May 2025

Contents:

Pen Portrait:

Below is a pen portrait of Annabel provided by her mother. The author has redacted some of the information to ensure it is relevant to this review and preserves the anonymity of this family and previous alleged perpetrators. The author is very grateful for this information and hopes it goes some way to allow the reader to have a picture of Annabel herself.

Annabel

Annabel was a happy child she made friends easily she enjoyed horse riding as a child and most school holidays she'd go to a relative's stud farm and help out or she'd go to 'own a pony day' at another farm

She was a brownie and a cub; she enjoyed cubs more than brownies as they went camping. She was a member of a local swimming club

Annabel was very close to her maternal grandparents and enjoyed staying at Nan and Grandad's house. She enjoyed cooking and playing cards board games etc at Nan's.

Annabel wanted to be a hairdresser and when she left school, she had a holiday job and weekend job in a hairdresser's and was doing well. She got into college to do hairdressing but became pregnant with her first child so didn't manage to go but she carried on working in the salon up until she had the baby. Over the next 4 years she had two more children. Domestic abuse was reported to be a feature in the relationship with the father. She managed to move to a lovely house, the children were very settled in their new home and school. Annabel met a new partner, and things started to go downhill again, the three children ended up living with Annabel's parents for three years before they moved back in with their mother. Annabel married this current partner and had a further child; the marital relationship was reported again to be abusive. After this relationship ended, she met another partner who was described as great with the children, he did a lot of activities with them and hoped to adopt them, unfortunately this one positive relationship in Annabel's life ended.

"Annabel had gone from a very outgoing person to a person scared of her own shadow. She was scared of water and wouldn't go swimming with the children, she became very secretive and closed off".

Annabel moved to another nice house where the children got settled and made new friends and went to a new school but then she had to move again, because an ex-partner found out where she was living.

At this point Annabel began to get her life together, she started university to do a degree in psychology and criminology. She passed her first year and was really enjoying the course. The children were slowly growing up, tending to be at maternal

grandmother's house more than they were at home, especially the older three. The eldest child started living with grandmother permanently as there were a few problems at home, with the child often clashing with Annabel, they were described as having very similar personalities. A further child moved in with grandmother full time mainly for the same reasons as well as not getting on well with a younger sibling.

The children carried on going to their schools and doing very well. At that point Annabel met the partner she was with during the scoping period of this review. Her parents noticed that she was suffering from anxiety and depression and also noticed changes her appearance. They found out that he was allegedly abusing her physically and mentally. He also was reported to have got her addicted to drugs which her parents found her help for. Annabel's parents at that point provided extensive support to Annabel and the children.

Annabel "had good days and bad days, but it was a terrible shock to us all when she took her life. We were planning a lovely weekend with the children. The children were really looking forward to it. We all spoke to her the night before she passed away making plans for the weekend. She would ring every night to say good night to the children and they would sit talking for about an hour telling her about their day and their plans for the weekend or evening".

Annabel's mother states "I still go to phone her at times to tell her about different things".

She says Annabel would have been so proud of all her children.

1. Introduction

1.1 This report of a domestic homicide review examines agency responses and support given to Annabel a former resident of Merton prior to the point of her death in March 2021.

1.2 In addition to agency involvement the review will also examine the past to identify any relevant background or trail of abuse before her suicide, whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.3 Summary of the circumstances that led to the review: Annabel who was 34 years old at the time was found in her car by a passer-by, the engine was still running. Emergency services pronounced her dead at the scene. There was evidence of empty medication packets in the car and the pathology results confirmed high doses of the medication in her bloodstream.

1.4 The review will consider agencies contact/involvement with Annabel and her ex-partner. This was clouded by the fact Annabel had not disclosed she had resumed her relationship with this man at the time of her death. He was the same age as Annabel.

1.5 The key purpose for undertaking DHRs is to enable lessons to be learned from homicides where a person is killed or has died by suicide as a result of domestic violence and abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.6 The multi-agency statutory guidance for the conduct of domestic homicide reviews requires that where a victim took their own life and it emerges that there was domestic abuse, a DHR should be undertaken. The guidance had not been updated to include death by suicide when Annabel died.

1.7 The guidance was updated June 2021 stating it is the responsibility of DHR Chairs to ensure the families have access to support. On commencing this review the author requested a referral be done to AAFDA (Advocacy After Fatal Abuse) with the family's agreement. Annabel's mother consented to this and subsequently received support throughout the review process.

1.8 Annabel was found dead in her car having taken an overdose. At the time of her death, she was in receipt of care and support needs and therefore the criteria for undertaking a Serious Adult Review (SAR) were met. This has concluded and is now published (appendix 1). At the time of her death, Annabel's children were subject to care proceedings and no longer lived with her. This also had a profound effect on her and the impact is covered within the parameters of the SAR.

1.9 There was no criminal case identified.

1.10 A referral was also made to the Home Office regarding the requirement to undertake a Domestic Homicide review as it was known Annabel had been a victim of domestic violence and abuse in recent and historical relationships.

2. Scope of the review:

2.1 A non-exhaustive list of factors were considered by the panel and author when developing the scope of the DHR. This included setting the time period under review given a SAR had already been undertaken, the Home Office advised a light touch, therefore it was decided the review would begin April 2020 concluding following Annabel's death in March 2021. The following key lines of enquiry were agreed during the scoping meeting held February 2023.

2.2 Annabel's death occurred during lockdown. How were agencies affected during this period and what was the impact on service provision? Has service provision returned to pre-lockdown or do some practices remain?

2.3 What training do agencies undertake regarding all aspects of domestic violence abuse?

2.4 Do agencies have access to appropriate line management oversight and clinical supervision for safeguarding cases and was it provided to staff working with Annabel and her children's?

2.5 Is there evidence of appropriate information sharing between the agencies involved, were there any barriers to this?

2.6 Annabel had a number of house moves, did this impact on service provision?

2.7 Did agencies, where appropriate have appropriate alerts / codes on the family's records to indicate risk of domestic abuse?

2.8 Annabel had previous self-harm attempts requiring hospital attendance, were appropriate risk assessments and on-going referrals undertaken?

2.9 Victims of domestic abuse are often asked whether they are safe. Were risk assessments of Annabel robust in considering her position as a victim of domestic abuse and also whether she was safe from herself? Was the known link to suicides where there is evidence of self-harm, substance misuse and mental health problems considered in risk assessments?

2.10 It appears the children experienced (and directly witnessed) abuse of their mother at the hands of male partners. Were the lived experiences of the children fully explored? Is the voice of the child 'heard' throughout, how is this evidenced? Was any focused support offered / available to the children?

2.11 How did Operation Encompass function during this timeframe? Were relevant schools made aware of any incidents and what action (if any) was taken?

2.12 During the child protection processes, how much focus was placed on the male partners involvement and co-operation? How was Annabel recognised as a victim (with little control) when described as making her own 'decisions' and 'choices'.

2.13 Annabel had experienced a number of ACEs – including loss of a sibling, parental relationship breakdown and abandonment by her father, raped aged 12 years and sexual abuse by peers in school. Were agencies aware of this and did they evidence a trauma-based approach when risk assessments were undertaken with Annabel?

2.14 Annabel suffered domestic violence and abuse in the majority of her relationships which featured physical and emotional violence. Reproductive violence and control is also a feature of abuse. Annabel required medical attention for a number of pregnancies / miscarriages, was this ever explored as being a possible feature of domestic abuse?

2.15 How were MARAC processes conducted throughout this period? Have there been any changes made since?

2.16 How are thresholds applied in decision making by the police / CPS when conducting evidence-based enquiries when the victim of domestic abuse declines to give evidence?

2.17 Were single and multi-agency policies and procedures adhered to during this process?

3. Timescales

3.1 There was a significant delay in commencing the DHR. This is described on more detail below.

3.2 Following Annabel's death in March 2021, the Community Safety Partnership gave consideration as to whether a DHR should be undertaken given a SAR had been agreed. Advice was sought from the Home Office but there was a delay in the reply

so a further email was sent March 2022 by the Community Safety Manager. A reply was received August 2022 requesting a form was completed for the Home Office's Quality and Assurance Panel to review. The Home Office subsequently advised a DHR should be undertaken. Further advice was sought regarding what the DHR should look like given the detailed SAR and its recommendations, the Home Office advised a brief report focussing only on domestic abuse would be necessary. The first scoping meeting was held February 2023.

3.3 The review period began April 2020 following the first known domestic incident with the partner she was with when she died in March 2021.

4. Methodology:

4.1 Community Safety Team and the Adult Safeguarding Board (Merton) met during the Safeguarding Adults review meetings to discuss the circumstances surrounding the death. It was decided advice should be sought from the Home Office. This was received August 3rd, 2022, but not commissioned until further advice had been sought regarding the nature of the review given a SAR had already been commissioned.

4.2 The Serious Incident Learning Process (SILP) model of review was commissioned to be used within the domestic homicide review process. This included a requirement for all agencies involved to provide reports. These were shared with all agencies and discussed during 2 Learning Events with practitioners, their supervisors and authors of the single agency reports present. The author spoke individually to practitioners if further clarity was required. Current policies and procedures were referred to as per the key lines of enquiry.

4.3 All single agencies where learning was identified and recommendations made, were required to implement an action plan to be monitored by Community Safety (Safer Merton).

4.4 Annabel's mother was informed about the review by the community safety manager and leaflet provided. This was a difficult time for the family as they were also aware of the on-going SAR. Support was provided throughout by AAFDA.

4.5 **Review Panel Members**:

Margaret Tench - Chair, Independent Author
Zoe Gallen - Violence Against Women and Girls Lead and MARAC Co-ordinator
Lorraine Henry - Adult Social Care &DOLS Manager
Claire Migale - Adult Social Care Manager
Rorie Evans - Children's Social Care Team manager
Teresa Hill - Children's Social Care Service Manager
Carole Bruce-Gordon - NHS South West London ICB Lead
Natalie Hutson Service - Manager, Victim Support
Alex Hatfield – Westminster Drug Project Service Manager (Now VIA)
Alun Goode – interim Head of Community Safety (Safer Merton)
Megan Hatton – Head of Community Safety (Safer Merton)
David Howard – MOAT Housing area Manager
Jennifer Lewis-Anthony – Associate Director of Social Work, St George's Mental Health Trust, South West London
Dr Hafsah Hussain – Named GP ICB
Lisa Brothwood – Metropolitan Police, Detective Inspector

5 Involvement of family, friends and wider community

5.1 Please see pen portrait provided by the family at the beginning of this report provided by Annabel's mother.

5.2 Annabel was 34 years old at the time of her death.

5.3 Annabel's mother was involved throughout this review and her older children were invited to participate. Although the eldest, an adult at the time, initially stated he wanted to become involved, he did not reply to attempts to contact him. His grandmother later explained this was due to the difficult nature of the process (remembering he had already contributed to the SAR) and his current personal circumstances, not relevant to this review. The author, through his grandmother offered to speak with him should he change his mind.

5.4 An AAFDA representative was present during all discussions which took place virtually by Teams meetings or via the telephone.

5.5 It must be noted that this family had also been subjects of a lengthy SAR and found the whole process quite difficult.

5.6 The author tried to make contact with Annabel's partner at the time of her death, but he did not respond to letters sent to him. Information regarding the DHR process (and leaflet) were supplied to him with an invitation to speak with the reviewer. The letter was sent by recorded delivery, signed for and returned. At the time of writing this report, his current whereabouts are unknown.

5.7 No other family or friends were identified by Annabel's mother.

5.8 Annabel was described by her mother as having previous abusive relationships. These were historical and not described in detail although there is some mention made in the SAR.

6. Contributors to the review

Metropolitan Police Service
Children's Social Care Merton
South West London St George's Mental Health Trust
Croydon Health Services – Named Midwife
Housing (MOAT)
Merton Council (DA & VAWG Lead & MARAC co-ordinator)
Merton Primary Care Recovery Service
VIA Team – Merton Drugs and Alcohol Team
Victim Support – Service Manager
Education/ Children's Schools
Primary Care – Named GP
Adult Social Care Merton (Reablement Team)
Greenwich Community Safety (MARAC)
Central London Community Healthcare NHS Trust (health visiting and school nursing service) – Safeguarding Nurse

Contributors providing single agency reports were independent of the case. Practitioners involved directly with the family were involved in providing information to agency authors as well as contributing to the process via the learning events. Everyone involved received all single agency reports.

7. Author of the review

7.1 The chair and author of this review has worked for the NHS for 43 years with 23 years in safeguarding before retiring December 2021. All previous work was undertaken in the North East of England. She now works as an independent consultant in safeguarding. The author has extensive involvement with case reviews of both children and adults with the majority involving domestic abuse. As chair of a strategic partnership's children safeguarding practice review group, she was a panel member for DHR's in the area. The author is completely independent to the area and case and has had no prior involvement.

7.2 A number of meetings were held for the purposes of the review, dates of circulation of draft reports is also included, please see below:

Scoping meeting (DHR Panel)	14th February 2023
Author's meeting	14th March 2023
Learning Event	17th May 2023
First draft report circulated	9th June 2023
Recall Event	14th June 2023
Second draft report circulated	6th July 2023
Second draft circulated to family	14th July 2023
Violence Against Women and Girls Strategic Board	24th January 2024
Draft report to Community Safety (Safer Merton) Partnership	7th February 2024
Submitted to the Home Office	30th May 2024

7.3 Although this review is commissioned on behalf of Community Safety (Safer Merton) where Annabel lived most of the time, her death occurred in another area and she also had a number of house moves outside the borough. Therefore there were agencies from those areas involved (see contributors).

7.4 Community Safety (Safer Merton) will agree how and where the review will be published and it is the partnership's responsibility to implement the action plan in response to the recommendations made. It is also the partnership's responsibility to have measures in place to seek assurance from partner agencies that individual action plans have been implemented, embedded and able to demonstrate impact.

8. Equality and diversity:

8.1 The reviewer gave due consideration to each of the protected characteristics under Section 149 of the Equality Act 2010.

8.2 Annabel was in a heterosexual relationship at the time of her death, her partner was the same age as her.

8.3 Annabel and her partner were from white British backgrounds.

8.4 Following a road traffic accident where she was initially paralysed requiring care and support needs, she was left with a functional neurological disorder (FND), insomnia, depression and anxiety which may have made her more vulnerable, the accident occurred just months before her death.

8.5 As a child Annabel suffered a number of traumas within her family such as the death of her sister and the impact of this caused a strained relationship with her own mother for a period of time. She lived with grandparents during this time. She was the victim of a rape and then further abuse by peers in school. Annabel left home aged 16 and then became involved in a sequence of abusive and controlling intimate relationships. All of this increased her vulnerabilities to abuse throughout her life and would have made it very difficult for her to access support.

8.6 Annabel was known to have had a number of pregnancies and miscarriages. Research shows that domestic abuse is more likely to start or escalate during pregnancy (see 13.5). This can include coercive and reproductive control.

8.7 One of Annabel's children is known to have a learning disability.

8.8 Annabel used to attend church every Sunday with her grandmother but this stopped when her grandmother died. She was in the process of having her children christened when she died.

9. Parallel Reviews

9.1 A coroner's inquest concluded Annabel's death was as a result of suicide.

9.2 This case has been reviewed in-depth as a Safeguarding Adult Review (SAR), published March 2023.

9.3 The author has therefore tried not to replicate the findings or recommendations from the SAR and tried to concentrate on the domestic abuse elements as originally agreed with the Home Office. The SAR is hyperlinked to this report and will be referenced throughout.

10. Confidentiality

10.1 The findings of this review are confidential. Information is available only to participating officers / professionals and their line managers. A pseudonym was agreed with the family for Annabel, this had also been used for the SAR.

11. Dissemination of the report

11.1 This report will be disseminated across the 3 partnerships in Merton, Community Safety (Safer Merton), Merton Safeguarding Children Partnership and Merton Adult Safeguarding Board. It will be published on Merton Councils web site. The family and AAFDA representative received a draft copy of the final draft and will receive the final version prior to publication.

12. Background information:

12.1 There is evidence in single agency reports that Annabel and subsequently her children were known to a variety of agencies over a number years prior to this review. These include police, victim support, children's services, housing, substance misuse, mental health services as well as universal services including GP, health visiting and school nursing. The main reasons were domestic abuse, chronic mental health and substance misuse issues. She was known to have self-harmed by taking overdoses. The following information is taken directly from the SAR:

12.2 Following an incident of domestic abuse in the home at the beginning of 2020, Annabel reported to the police that the physical altercation with her partner at the time (who had left the home by then) and his threats to kill had caused her to

have a panic attack, exacerbated by her existing and long-standing mental health issues of depression and anxiety. Annabel did not wish to provide a statement to the police.

12.3 In the following two weeks, Annabel attempted to seek temporary accommodation in Brighton on two occasions citing domestic violence. Once together with some of her children when Annabel was offered accommodation which she turned down as she felt it was too small. The second time, Annabel's partner at the time (who Annabel had reported to have made threats to kill her only a couple of weeks earlier) sought to be housed with Annabel as her carer but this request was refused. Annabel and her children returned to their home in Merton. During this time, Annabel was supported by an IDVA (Independent Domestic Violence Advisor) and whilst disclosing fear and threats by one of her ex-partners, she denied any domestic violence from her current partner.

12.4 Annabel was referred to Westminster Drug Project (WDP) in relation to substance use.

12.5 In a professionals meeting towards the end of April 2020, Merton Children's Services, who were involved with Annabel and her children under S17 Children Act ("children in need") at the time, as well as other professionals involved, shared their increasing concerns about the impact of Annabel's current relationship and recent experiences on the children. In a strategy discussion between Children's Services and police shortly after, it was decided that the threshold was met to proceed to an Initial Child Protection Conference due to concerns of the children suffering, or likely suffering significant harm as a consequence of the situation at home.

12.6 June 2020, an Initial Child Protection Conference decided that Annabel's children needed to be made subject to child protection plans under the category of emotional abuse. There was good representation from the multi-agency network, including support services for Annabel such as the IDVA and WDP. There was appropriate focus on the children's needs and their need for protection. However, the way Annabel's needs and decisions were articulated were problematic, raising questions about how her situation was actually understood by professionals. In particular, there was insufficient attention on the ongoing challenges around domestic abuse as well as Annabel's experience as a victim of domestic abuse in her own right. The Reviewers (SAR) would have expected others present in the conference to have challenged the presentation of and wording used about Annabel's 'decisions' and 'choices'. Too high a level of responsibility was placed on Annabel without equivalent consideration of the responsibility on the perpetrator.

12.7 Around this time, Annabel's allocated practitioner in the Westminster Drug Project (WDP) recognised the need for Annabel to receive a specialist assessment of, and treatment for, her multi-faceted mental health issues and therefore referred Annabel to Merton Mental Health Services (Primary Care Recovery Service). This was appropriate and in her best interest and what she needed at the time. Their response was timely and the initial assessment identified the need for trauma work. However, their strict criteria of being able to start working with an individual only once they are abstinent and sober can place real challenges on people who use substances to self-medicate, particularly in the absence of any other support.

12.8 Due to increased pressures on services by the pandemic at the time, in addition to existing challenges such as high staff turnover and insufficiently robust care pathway management, Annabel needed to be added to their waiting list to receive trauma-focused Cognitive Behavioural Therapy (CBT) and Eye Movement Desensitisation and Reprocessing (EMDR), both of which are recommended in NICE (national) guidance in treating Post-Traumatic Stress Disorder. Being placed on the waiting list started to create a delay for Annabel and meant that she was left without specialist mental health input when she needed it.

12.9 When Annabel then made disclosures to the IDVA about serious history domestic abuse against her by her partner at the time, including threats to her using a firearm and his involvement with a drug gang (September 2020), the IDVA shared this with police in a timely manner. It was taken seriously, and a thorough investigation of the different allegations was started, but the police did not take a statement from the IDVA which could have been helpful particularly in light of Annabel's unwillingness to provide a statement to police directly. Annabel repeated the disclosures to various professionals, shared her fear of possible repercussions from her partner and therefore requested to be re-housed outside of Merton.

12.10 Annabel's vulnerability at the time was heightened due to being pregnant with her partner's child that she unfortunately miscarried shortly after. The decision by police to delay the arrest of Annabel's partner therefore showed acknowledgement of her situation and took her fears seriously, although Annabel remained unhappy about the police's decision to pursue an evidence-led investigation.

12.11 The IDVA remained dedicated to and involved with Annabel around safety planning and her wish to be re-housed, also fuelled by her fear of being stalked by an ex-partner. This resulted in a couple of moves outside Merton in quick succession. Annabel had expressed a wish to move outside of Merton, however it was not in her desired area (Brighton) and professionals also grew concerned about the instability this was causing to the children, in addition to growing concerns about Annabel's mental health.

12.12 In September, Annabel was accepted as a "repeat referral" (first referral in May 2020) by Merton MARAC (Multi Agency Risk Assessment Conference) and was discussed in the meeting. This offered an opportunity for the multi-agency network to discuss their concerns about the most recent events and the risk that these posed to Annabel and her children. In their contributions to the SAR, practitioners shared that the logistics and timing posed real challenges at the time: partner agencies were still identifying the best possible way of conducting the meetings virtually in light of pandemic, including the sharing of information prior. The MARAC chair and coordinator both noted a good and mutually supportive working relationship which helped the running of the meeting, but they also both acknowledged that the high number of cases being referred impacted on the ability for thorough discussions. The absence of a dedicated minute taker at the time was evident in the minutes that were less comprehensive than desired, particularly in relation to the actions. This increased the potential that the risks to Annabel and the children, discussed in the meeting, were not accurately reflected and therefore possibly not understood in the same way by all partner agencies.

12.13 As Annabel was living outside Merton at the time of the discussion, it was good practice that a swift MARAC to MARAC referral into the other area was identified as necessary and made by the MARAC coordinator.

12.14 At that time, Annabel also started to experience physical health issues related to her recent pregnancy and miscarriage. When seeking medical attention in several hospitals outside Merton (there is no acute NHS hospital within Merton), she openly shared her experiences of domestic abuse and several miscarriages, and how this impacted on her overall.

12.15 28th September 2020 police were called to make a welfare check due to a GP not getting a telephone response following social worker concerns that Annabel was suicidal. This was later described by the social worker as miscommunication and no visit was made, police were able to speak with Annabel later the same day.

12.16 Annabel's emotional and psychological wellbeing deteriorated further towards the end of September, she grew increasingly concerned about the police investigation into her earlier disclosure against her partner and the possible repercussions to her from him.

12.17 Annabel informed professionals that she was pregnant again from this partner and she had decided to move back to her home in Merton to be close to the hospitals that she knew as she was deemed a high-risk pregnancy. This should have

triggered an automatic MARAC to MARAC referral back to Merton which did not happen and unfortunately none of the professionals involved with Annabel in Merton alerted MARAC either.

12.18 Annabel also withdrew her allegations in one of the core group meetings that were held regularly in respect of her children who continued to be subject to child protection plans. The IDVA said that Annabel was angry with her for having shared information in the recent MARAC meeting and felt her trust had been breached. Annabel's contact with the IDVA became sporadic from this point onwards and it meant that Annabel had lost an important source of support. The IDVA remained involved indirectly however and continued to offer advice to the Social Worker of Annabel's children when this was needed which was a necessary means of keeping the issue of Annabel's experience of domestic abuse part of the discussions by professionals.

12.19 The situation escalated and on several occasions, Annabel shared with police as well as with her children's Social Worker threats to kill herself if the partner was arrested, the GP was alerted. Her threats seemed to have been understood differently by different professionals without any formal risk assessment being conducted or specific tools being used to support this process. Annabel's threats was also known to the Adult Safeguarding Team. (See SAR findings).

12.20 When Annabel experienced the second miscarriage during the time under review in early October, she shared further details about the circumstances around previous miscarriages as well as the trauma of rape when she was much younger.

12.21 The police, after investigation and intelligence gathering into Annabel's different disclosures against the partner, finally arrested him in October, during interview he denied all offences. Annabel's continuous refusal to engage with the police investigation meant that they relied on evidence only and the Evidential Reviewing Officer concluded that the threshold set by the Crown Prosecution Service (CPS) could not be met.

12.22 Following Annabel's second miscarriage, she required further medical attention for physical health needs and she continued to struggle with her mental health. The Primary Care Recovery Service (PCRS, Merton Mental Health) was alerted and referral was made by the GP, but Annabel was assessed as not meeting the threshold for an assessment. This is discussed in the SAR findings.

12.23 10th December 2020 Annabel was involved in a road traffic accident that left her temporarily paralysed and with care and support needs. She was given the diagnosis of Functional Neurological Disorder. Annabel's mother shared with the SAR

reviewers that the period which followed on from there was the most difficult time for Annabel. Her mother emphasised that Annabel had asked repeatedly for help for her mental health but did not feel listened to or taken seriously by professionals. Annabel therefore took the decision to self-discharge herself from hospital and the family stepped in to help out with the care arrangements of the children whilst Annabel was recovering. Although Children's Services were not involved in making those arrangements for the children who were still supported through child protection plans, they were aware of them and did not object.

12.24 Children's Services made a referral to Merton Adult Social Care to request a Care Act Assessment for Annabel, particularly in the absence of a referral having been made by the hospital following Annabel's self-discharge. The response to the referral by the relevant teams (First Response, Hospital Discharge and Reablement) was swift, especially in light of the time of the year (close to Christmas) and another national lockdown due to the COVID 19 pandemic. The focus of the assessment was on the task in hand, without consideration for Annabel's wider circumstances and vulnerabilities, and she was assessed as requiring a package of care of two daily visits to help her with personal care whilst being in her home and a referral to Occupational Health was made to assess the need for additional aids within the home.

12.25 31st December 2020, Annabel moved to Brighton into council accommodation. Annabel's mother was concerned how Annabel would be able to manage and look after herself whilst recovering from her injuries and she was also worried about her emotional wellbeing, being at a distance from her and her children. But nevertheless, Annabel moved to the area which had been her long-standing wish and she was preparing the home for her children to join her long-term.

12.26 Children's Services grew increasingly concerned about the situation and how the children's long-term needs could be met sufficiently and safely long-term by Annabel. At that point, a review of the family's history was undertaken, including seeking information and chronologies from local authorities where the family had lived before. The focus seemed to have been on the cumulative impact of Annabel's long-standing mental health issues, historic substance abuse, impact of domestic abuse, frequent moves and relocations, previous involvement by Children's Social Care and the decision to remove the children from a stable arrangement to Brighton in an area that was close to her partner and his family where there were significant concerns of domestic abuse including disclosures of weapons.

12.27 Children's Services arranged a Legal Planning Meeting on 6th January 2021. It was decided to initiate care proceedings in respect of Annabel's younger children. When Annabel was informed about this decision, she was understandably shocked. The lack of support for Annabel is addressed by the SAR.

12.28 A few days later after being told about the plan by Children's Services, on 10th January 2021, paramedics attended Annabel's home in Brighton following her attempt to take her life. She did not require any further medical attention and was advised of local mental health services. She did not contact them and the agencies in Merton, who were still involved with her, such as GP, Merton Uplift (albeit on the waiting list), WDP, IDVA, and Children's Services, were not made aware of this significant event. This meant Annabel's significant mental health crisis at the time was not flagged and did not allow them to review their level of involvement and support in line with the newly escalated risk. This is discussed in more detail in the SAR.

12.29 The initial contact with Annabel by the manager of the children's social worker, in preparation for the court hearing in relation to Annabel's children, was around one month after Annabel's attempt to take her life and this was a telephone conversation with Annabel two weeks before the actual hearing. The national lockdown (pandemic) was still in place which most likely impacted on the ability to have a face-to-face meeting with Annabel, in addition to the distance between Merton and Annabel's new home in Brighton.

12.30 18th February 2021, nine months after the first referral to Merton Mental Health, Annabel was assessed and had her first treatment session with a therapist. This was a video call rather than a telephone call, considering the ongoing lockdown, this was usual practice and would have allowed the therapist to also use some observation to inform their assessment of Annabel's state of mind.

12.31 In the session, Annabel was described as tearful, particularly when talking about her children and the care proceedings, with the hearing scheduled for less than a week later on 24th February. She also shared with the therapist that she had written a goodbye letter to her children earlier in the year. The focus of the session was on managing risks and completing a safety plan of what to do if she was in crisis. It was agreed for the first of 16 sessions of EMDR intervention to start on 25th February. During the review period health visitor and school nurses were aware of issues regarding domestic abuse and children's behavioural problems and were trying to engage with Annabel. She was reporting mistrust issues with children's social care. Records were flagged and tagged appropriately due to MARAC.

12.32 The school who provided information for the DHR stated there were no Operation Encompass (see Appendix 4) referrals received at any point.

12.33 Annabel was known to her GP at this time because of increased anxiety, panic attacks and insomnia, she was on the waiting list for counselling. The GP practice was not included in the MARAC process and therefore no alerts were placed on her records.

12.34 The court hearing on 24th February 2021 ordered for Annabel's younger children to continue living with other family members on Child Arrangement Orders with an Interim Supervision Order granted to the local authority. Annabel did not attend her first appointment with the therapist but she did attend her next session on 4th March and spoke openly about recent self-harm. The therapist appropriately focused on the risks and protective factors together with Annabel and they agreed on practical steps for Annabel to follow in a situation of crisis. This was the last contact made with Annabel before her death.

13. Good practice:

13.1 Annabel was provided with home safety measures through police and MARAC processes.
13.2 Merton Children's Services retained responsibility for the children despite Annabel's frequent moves.
13.3 The IDVA worked over and beyond to engage and support Annabel and continued providing practical help to professionals even when Annabel disengaged with her.
13.4 Following a core group meeting when Annabel appeared highly emotional, the school representative contacted her afterwards to check on her well-being.

14. Emerging themes and analysis:

14.1 **The Links between mental health issues and domestic abuse.**
14.2 "In the realm of mental health and personal safety, few issues cast as long and baleful a shadow as domestic violence. This nefarious problem, which affects millions of individuals around the globe, knows no boundaries of geography, culture or socioeconomic status. It is a scourge that can infiltrate the life of anyone, often leaving behind a trail of profound psychological trauma." *The Link Between Domestic Abuse and Mental Health Issues*. NADA Foundation March 2024. The article discusses anxiety and depression as being most prevalent with victims describing feelings of hopelessness, isolation, loss of self-esteem, relentless worry, flashbacks and nightmares from associated post-traumatic stress.

14.3 The SAR refers to longstanding mental health issues regarding Annabel including anxiety, depression and self-harm. She was seen in primary care, maternity services, drug and mental health services. Each of these services were aware of the

longstanding abuse Annabel had suffered from previous and current partners. There is no evidence of relating her presenting symptoms to her being a victim of abuse despite risk assessments being used in all services.

14.4 Much emphasis was placed on safeguarding the children with Annabel experiencing multiple child protection meetings (as a lone parent) and ultimately court proceedings and subsequent restricted contact with her children afterwards. Little attention was paid to recognising the links between domestic abuse and mental health issues from an early point in Annabel's life. Early support and intervention may have empowered Annabel to identify and overcome her own vulnerabilities and the mental health challenges she faced. The SAR makes reference to ensuring parents going through care proceedings are better supported, this report will make a recommendation to support changes in practice when identifying the links between domestic abuse and mental health issues. **Recommendation 3.**

14.5 **The links between suicide and domestic abuse.**

14.6 Annabel frequently, especially towards the end of her life self-harmed and voiced suicidal thoughts. Although agencies knew about this, because of her long history, no-one believed how imminently serious this was. There is a wealth of current research information which suggests a history of domestic abuse can be a factor in many cases of suicide and I believe this should be considered in Annabel's case. I have highlighted some of this research below.

14.7 'Intimate partner violence, suicidality, and self-harm: a probability sample survey of the general population in England' McManus et al, Lancet Psychiatry July 2022 – this research supports that 50% of people with recent suicide attempts had experienced Intimate partner violence.

14.8 Suicide prevention transformation proposal 2018/19 (nspa.org.uk) Medway Council and Kent County Council found that no one knows how many people die by suicide after having their lives impacted by domestic abuse so they have undertaken a series of mini research projects to try and understand the scale of the issue, with the ultimate goal of trying to find ways to reduce the risk of unnecessary deaths

14.9 In an annual survey (2016) Women's Aid found that 36% of women in the 'extensive physical and sexual violence' group had attempted suicide. In 2020 the Domestic Homicides Project was established by police and government in England and Wales as part of the 'Vulnerability Knowledge and Practice Programme' to collect, review and share learning from domestic homicides including suspected suicides of individuals where domestic abuse was a feature in the wake of the Covid-19 pandemic. It was noted that during lockdown restriction, victims were less able to access help and support as well as being

more likely to be at home with the perpetrator. The data showed 90% of suicide deaths were female, many had been assessed as high risk and history of coercive control was a common feature. The report concludes "there is new evidence of a sizeable number of suspected suicide victims with a known history of domestic abuse. This is still likely to be an underestimate of all victim suicides with a history of domestic abuse , as it will inherently exclude those suicides where a prior history of domestic abuse was not known to the police". The report concludes that "domestic abuse can have an extremely significant impact on victims' mental health". The report also highlights that recent separation was present in a "sizeable number of cases". Existing mental health conditions, alcohol and drug misuse were found to be exacerbating factors.

14.10 In an article discussing a project report 'Building a temporal sequence for developing prevention strategies, risk assessment, and perpetrator interventions in domestic abuse related suicide, honour killing, and intimate partner homicide' Monkton-Smith et al, University of Gloucestershire, Cheltenham, Gloucestershire 2022, Sarah Dangar, a domestic abuse consultant states "We rightly risk assess perpetrators, but for some women suffering horrendous abuse we should also be considering the risk they might pose to themselves. That's a responsibility not just of the police, but for GPs and drug, alcohol and mental health services too. That rarely happens". Dangar is currently working alongside AAFDA and Prof Vanessa Munro on a project for the Home Office, examining the domestic homicide reviews (DHRs) of thirty domestic abuse related suicides. **Recommendation 4.**

14.11 **Risk Assessments**

14.12 There does not appear to be evidence of robust risk assessment in the context of the whole family or of the risk Annabel posed to herself despite a number of agencies having concerns for her well-being. She had long term mental health issues and was known to be a victim of domestic abuse yet this doesn't appear to have been considered when assessing her behaviours.

14.13 School described Annabel's mental health issues as a barrier at times and stated she would often shout in meetings thus making her less likely to appreciate or accept any support. She was known to mistrust children's social care. In cases such as this, it is important to try to overcome these perceived barriers and understand the root causes behind them. Many professionals experience fear when someone is adjudged to be hostile for example by shouting. This can lead to an inability to see past the presenting problem, it was possibly because Annabel was frustrated and afraid herself. Developing strategies to cope with these behaviours is important to help build trusting professional relationships.

14.14 When she was discharged from adult social care, the author of the single agency report stated the team dealing with her at the time did not fully consider the safeguarding issues and how vulnerable she was. There should have been an onward referral to the neighbouring team when she moved.

14.15 **Sexual and reproductive coercion as a feature of domestic abuse:**

14.16 Annabel had multiple pregnancies and miscarriages but none of the agencies involved (including MARAC) considered this may be a feature of domestic abuse. Rape is a type of outright violence that's often easy to define, it's sexual contact without consent. But within the context of sexual assault is a more misunderstood but just as sinister tactic of power and control: Sexual coercion and its counterpart, reproductive coercion. These are two ways in which perpetrators and abusive partners alike force a victim to have sex or become pregnant without consent, but with manipulation instead of direct force.

14.17 The Home Office's statutory guidance framework C*ontrolling or Coercive behaviour* April 2023 states "Reproductive coercion, including restricting a victim's access to birth control; refusing to use a birth control method; forced pregnancy; forcing a victim to get an abortion, to undergo in vitro fertilisation (IVF) or other procedure; denying access to such a procedure." Intimate partner violence in pregnancy also increases the likelihood of miscarriage, stillbirth, pre-term delivery and low birth weight babies. The same 2013 study showed that women who experienced intimate partner violence were 16% more likely to suffer a miscarriage and 41% more likely to have a pre-term birth. *Violence Against Women* WHO March 2021.

14.18 **The impact of Adverse Childhood Experiences (ACE's) and how these should be included within assessments.**

14.19 When the author spoke with Annabel's mother, she gave a history relating to her daughter's early life which included abandonment through parental separation, bereavement, sexual abuse and substance misuse. Adverse Childhood Experiences (ACEs) are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. They can be a single event, or prolonged threats to, and breaches of, the young person's safety, security, trust or bodily integrity." (Young Minds, 2018). Examples of ACEs include; physical abuse, sexual abuse, emotional abuse, living with someone who abused drugs, living with someone who abused alcohol, exposure to domestic violence, living with someone who has gone to prison, living with someone with serious mental illness and bereavement. The presence of ACEs can lead to an increase in the risk of certain health problems in adulthood, such as cancer and heart disease, as well as increasing the risk of mental health difficulties, violence and becoming a victim of violence. There is an increase in the risk of mental health problems, such as anxiety, depression, and post-traumatic stress. One in three diagnosed mental health conditions in adulthood directly relate to ACEs. I am of the view that assessments such as those used in adult and children's social care, substance misuse teams and mental health services should include a trauma informed approach for children and young people as well as adults in order to recognise and predict vulnerabilities and ensure appropriate and timely intervention.

14.20 **The impact of domestic abuse on children. Think Family approach.**

14.21 "Domestic abuse always has an impact on children. Being exposed to domestic abuse in childhood is child abuse. Children and young people may experience domestic abuse both directly and indirectly". Protecting children from domestic abuse. NSPCC October 2024. Domestic abuse undermines a child's basic need for safety and security. It can have a serious effect on their behaviour, brain development, education outcomes and overall wellbeing. Psychological effects of experiencing domestic abuse can include: aggression and challenging behaviour, depression, anxiety, mood changes, withdrawal, fear and may lead to suicidal thoughts.

14.22 Annabel was the victim of domestic violence during most of her relationships and therefore as author I can conclude all of her children have witnessed this throughout their lives and would link this back to previous discussions regarding ACE's. Annabel experienced physical violence, emotional abuse, stalking, coercive control and there were threats to kill. This led to multiple house moves. The impact on her as a woman and mother is incalculable. Although widely reported that she was a good and loving mother, how she functioned when under such extreme duress and distress is difficult to imagine given the abuse occurred throughout most of her relationships. Her children were born during these times and therefore the impact of their health and well-being must have been and still probably is enormous. They too must have lived in fear for either their own safety, their mother's or both. The short term and long term impact of domestic abuse on children can be huge.

14.23 Apart from Children's Services who were actively working with the children, there is little emphasis placed on considering what life was like for them during their young lives whilst witnessing their mother's abuse. There should be no 'wrong door' for services (especially adults) when children are involved. Currently in Merton, there is no daily input into the children's MASH (see Appendix 4) by adult social care.

14.24 School did offer the children support but this was refused and it was felt the children were generally quite guarded and protective towards their mother.

14.25 It is the responsibility of all agencies working with families to have a good understanding of the short and long term impact of domestic abuse on children. **Recommendation 5.**

14.26 **Operation Encompass.**

14.27 The author does not feel the use of Operation Encompass was visible through this review and queried this at the recall event and was informed when the police are called to a domestic incident and there are children in the household, a 'merlin' is submitted to the MASH. As part of Operation Encompass this is then forwarded to the designated safeguarding leads (DSL's) for all schools involved. The school involved with two of the children stated they'd received no notifications relating to Operation Encompass.

14.28 It is not clear how robust this process is in terms of DSL's accessing this information on a daily basis and school nurses are not informed. This is concerning that should a child not attend school following an incident, there may be no follow-up to ensure they're safe and supported appropriately. Information shared by the school was that attendance at times was very poor.

14.29 The Care Act 2014 states that a whole system, whole council, whole-family approach must be taken which organises services and support around the adult and their family. It also means that everyone working with the adult and their family must think about the impact of the care needs of each member of the family, including any children. The Supporting Families national programme "has championed whole family and multi-agency working to support vulnerable families, that is those experiencing multiple disadvantages such as worklessness, domestic abuse, and poor mental health. It proved through a robust impact study, that this approach prevents children in vulnerable families from ending up in the care system, reduces the likelihood of involvement in crime and supports families back towards work and more fulfilling lives" Supporting Families 2021-22 qnd Beyond, HM Government, March 2021.

14.30 The SAR (Serious Adult Review) published March 2023 has also identified learning regarding this issue so hopefully all strategic partnerships will continue to work together on this important issue. **Recommendation 6.**

14.31 **The function of MARAC. Collaborative multi-agency working and information sharing.**

14.32 Annabel moved around, often as she was fleeing domestic abuse. The cross boundary MARAC processes did not always ensure appropriate information was shared.

14.33 There was nothing in place in Merton for the flagging and tagging of GP records. There will not be a recommendation regarding this as work has already begun (see 9.1)

14.34 I queried the use of the DASH risk assessment (see Appendix 4) at the Learning Event as I was concerned risk assessments don't currently explore the risk a victim might fully pose to themselves or identify sexual and reproduction coercion and control. I was informed by the police a new risk assessment DARA (Domestic Abuse Risk Assessment) has been piloted by the Metropolitan Police and will be rolled out nationally. This allows fuller answers and better risk assessment of wider issues.

14.35 **Cross boundary working.**

14.36 It is essential in such high risk and complex cases that frequent house moves should not diminish the support and protection families should receive. The purpose is to ensure that an adult and their family at risk in one local authority area will be provided with the same level of support and protection until the circumstances of any move are assessed, shared and reviewed and can indicate whether the risks are reduced or eliminated in the new setting. This is made more complicated when those moves are short lived, often in an emergency when fleeing domestic violence.

14.37 MARAC see 8.19.

14.38 When Annabel was subject to care and support needs, her case was closed by adult social care when she fled domestic violence and moved to Brighton and no onward referral was made.

14.39 At the learning event the representative from mental health services expressed concerns regarding how to ensure that vulnerable, at risk people are identified when they move out of area.

14.40 Annabel's frequent (and necessary) house moves made her more vulnerable and at risk and there is evidence this was not shared with neighbouring boroughs.

14.41 The children remained the responsibility of Merton throughout this which was positive.

15. Developments since the review:

15.1 Following discussions at the Learning Event it was agreed secure email addresses for GP practices would be shared for the purposes of MARAC. This will ensure patients records will be flagged and tagged as per MARAC requirements. This was confirmed at the recall event and is a significant development.

15.2 Annabel had previous abusive relationships. At the time there was no perpetrator programme in Merton. This has now changed. PAC is a domestic abuse perpetrator intervention programme running across Merton and six South London boroughs, delivered in partnership with specialist providers. Home Office grant funding received for delivery spanning April 2023 March 2025 (two year project). The project aims to increase the safety and wellbeing of victims and survivors and associated children and prevent new and / or further victimisation and harm. Outcomes achieved by delivering multi-agency panels, system change and targeted partnership intervention, direct and integrated support.

15.3 At the time of hearing Annabel's case it was the COVID pandemic and MARAC was dealing with 50% more cases than normal using a secure telephone line at first and then Microsoft Teams. Following Annabel's case, there is now a part time administrative officer in post which has improved the resources to the MARAC. The system has also been changed to ensure research is received ahead of the case so that all agencies can see the draft minutes rather than waiting until the meeting to hear what agencies know. All agencies now flag and tag a case on their system so it highlights the person has been heard at MARAC. Meetings are on-line and this has improved the partnership working.

15.4 Regarding Operation Encompass, the author has been assured that improved training for school designated safeguarding leads (DSL's) is in progress to ensure they are signed up to and receiving information from the police.

15.5 A number of services including midwifery and domestic abuse have recognised the need to improve training to include issues surrounding sexual and reproductive coercion and control.

15.6 It was confirmed at the recall event that since the SAR and this DHR, work has been undertaken to ensure closer working relationships and collaboration between adult and children's social care.

16. Conclusion:

16.1 As the author of this review and with the ability to look at Annabel's life, she suffered trauma from early childhood and throughout adulthood as a mother and victim not only from multiple perpetrators but from the systems themselves in place to protect her and her children. Annabel must have been overwhelmed by everything that happened or was 'done' to her and ultimately could not see a way out. The impact of the care proceedings on her with regards her children is discussed in the SAR.

16.2 The period covered by this review was during the pandemic, Covid-19. It is without doubt that services were impacted during this time with meetings and conversations held via telephone or electronically. MARAC referrals increased by 50% making it more difficult to hear individual cases in-depth.

16.3 Annabel was well known to multiple agencies but not, in the sense that most agencies appeared to look at the here and now of her life and lifestyle as opposed to try and understand how and why she'd got in to that position in the first place.

16.4 Annabel had known long standing mental health issues and domestic abuse but no-one made a link early on or throughout her life as an adult and a parent.

16.5 The children had witnessed domestic abuse throughout their lives and the enormity of this does not appear to have been understood.

16.6 There does not seem to be a process whereby adult and children's services come together to identify and discuss the risks for complex families such as this by exploring and sharing knowledge and identifying gaps in order to provide holistic support and reduce risk.

16.7 Operation Encompass does not appear to be embedded.

16.8 There are multiple times when she threatened to take her own life. Whilst many agencies were aware of the risk she and her children were at, no-one truly saw the risk she posed to herself due to her life experiences.

Recommendations:

1 **All agencies to implement the recommendations made within their own reports and share action plans and progress with Community Safety (Safer Merton) and other strategic partnerships where appropriate.**

2 **Community Safety (Safer Merton) to implement a process to provide assurance to Annabel's family demonstrating learning has taken place as a result of this review:** This should be on a six-monthly basis once the Home Office has agreed the report and it has been published. It should continue until the action plan is complete and has demonstrated evidence of impact.

3 **The 3 strategic partnerships (Community Safety (Safer Merton), Safeguarding Adults Board and Safeguarding Children Partnerships) to work jointly to promote a wider understanding and awareness of the link between adult mental health issues and domestic abuse.**

4 **The 3 strategic partnerships to promote a wider understanding of the links between domestic abuse and suicide.**

5 **The 3 strategic partnerships to promote a wider understanding of domestic abuse and the impact on children:** This should be evidenced through case file audits to ensure the child's lived experience is appropriately understood.

6 **The 3 strategic partnerships to promote a wider understanding of the use and interpretation of risk assessing victims of domestic abuse.** All training and learning events must include how risk assessments identify domestic abuse victims when they are a risk to themselves as well as identifying factors such as sexual and reproductive control.

7 **Operation Encompass:**

- A review should be undertaken to ensure Operation Encompass is embedded in to all schools.
- Consideration should be given as to whether school nurses could be informed as part of an extension of the process.

8 **Think Family approach:**

- Note the learning from SAR published March 2023.
- Adult social care should consider how to work more closely with the children's MASH to ensure all relevant information is shared.
- A multi-agency, cross partnership audit of cases known to either children's or adult services should be undertaken to provide assurance that assessments of all family members and lived experiences of children are included.

9 **The 3 strategic partnerships:**

- To develop a joint action plan to ensure the learning from both reviews (DHR and SAR) is disseminated widely and agree continued joint working following all case reviews regarding families. This will include seeking assurances from single agency recommendations and action plans.
- To consider how to identify complex families and implement a multi-agency approach to review them in order to share all known information and develop risk management plans of intervention and support in order to reduce risk.

10 **Cross Boundary working:**

- A process should be put in place to ensure when a person is in crisis, timely notification is undertaken to appropriate services in and out of hours when the subject's whereabouts is known. This could be through revision of the newly introduced Multi-Agency Risk Framework.

11. Marac processes should be reviewed to ensure victims are protected when moving to different areas:

- Merton VAWG lead to liaise directly with SafeLives as part of learning from this DHR.

Appendix 1

Annabel -Safeguarding Adults Review Statement- March 2023

Firstly, on behalf of the Merton Safeguarding Adults Board (MSAB), our condolences are offered to the family and friends of Annabel.

Following Annabel's death, the MSAB commissioned an independent review to understand her experience of services prior to her taking her life and to consider the support she received and how agencies worked in partnership to protect her.
The purpose of a Safeguarding Adults Review is to identify what happened and to establish what needs to change to ensure there is system learning to ensure our services in Merton make a difference to the lives of those in need of care and support and their families.

Since the review there has been system change to improve how services work with adults and children. The MSAB and Merton Safeguarding Children Partnership (MSCP) have incorporated a 'Think Family' approach to the delivery of our services so adults at risk and their children are supported at the earliest opportunity to maintain their health, wellbeing, and autonomy.

In March 2023 we are delivering the second annual MSAB and MSCP Safeguarding Conference, which is entitled 'Domestic Abuse-Learning from the Lived Experience of Trauma from Child to Adult'. We will be including learning from Safeguarding Adult Reviews and Child Safeguarding Practice Reviews.

In addition, the Annabel SAR has recommended:
• Agencies consider the need for therapeutic support for women whose children are the subject of court proceedings and where there is the likelihood their children may be removed from their care on either a temporary or permanent basis and in particular for women who have known long-standing mental health issues, and a known history of self-harm and attempts to take their own life.
• There is assurance children's services 'think family' when working with families and when initiating court proceedings.
A Task and Finish Group of relevant partners has been set up to deliver and oversee this work. The Merton Safeguarding Adults Board will continue to work with the agencies involved and the wider partnership to monitor the actions arising from this review and ensure that practice changes as a result.
The full report can be read here:

https://www.mertonsab.org.uk/wp-content/uploads/2023/03/ANNABEL-SAR-Full-Report..pdf

https://www.mertonsab.org.uk/what-we-do/safeguarding-adults-reviews/

Appendix 2

The SILP process:

The principles of a SILP review includes the engagement of frontline staff and first line managers. It is a collaborative and analytical process. All of the information is shared with all of the participant. The focus is on WHY someone acted in a certain way. It is aimed at reducing the scope for blame and is systems focussed. The subject of the review should remain at the centre at all times. There should be active and meaningful involvement with the family throughout.

Appendix 4

Glossary

1. **MARAC** – Multi-agency Risk Assessment Conference led by the police and involving agencies from both adult and children services, health, housing and domestic abuse services. Discusses high risk victims of abuse using specific risk assessments in order to formulate a protection plan. The perpetrator of the abuse is not usually aware of the plan. All agencies involved should 'flag and tag' records to identify victims, perpetrators and any vulnerable linked people such as children.
2. **DASH** – Domestic abuse risk assessment checklist used for the purposes of MARAC to identify the risk to a victim. Usually completed with the victim themselves and used by all agencies as means of referral in to MARAC.
3. **CPVA** – Child to Parent Violence and Abuse. Abuse perpetrated by a child to a parent within a household. The most common form is abuse perpetrated by son to mother.
4. **Operation Encompass** - Police led operation to ensure schools are notified of a domestic abuse incident where children are in the home. This ensures schools can monitor and provide appropriate support to pupils in their care.
5. **MASH** – Multi-agency Safeguarding Hub where referrals for possible child abuse are discussed and a plan of action take. The agencies involved are the police and children's social care along with representatives from health. Police notifications regarding domestic abuse where there are children in the household are also discussed within the MASH.
6. **SAR** – Serious Adult Review. Independent review undertaken when an adult has suffered serious abuse or died and there are multi-agency lessons to learn.
7. **ACE's** – Adverse childhood experiences which impact on the child and subsequent adult. This may include abuse as a child, grief, parental mental health issues amongst others. These may lead to vulnerabilities in adulthood and increased risk of criminality, mental health issues and suicide, substance misuse, reduced life span and other issues.
8. **IDVA** – Independent Domestic Violence Advisor / Advocate. An expert in domestic abuse appointed to provide emotional and practical support to victims.
9. **Children Act 1989 & 2004**. Legislation in place to safeguard children for all agencies working with them.
10. **Care Act 2014**. Legislation setting out local authorities duties in relation to assessing people's needs and their eligibility for care and support.

Appendix 5 - Annabel DHR ACTION PLAN

No	Recommendation	Action to take	Purpose and intended outcome	Lead Agency	Target/ Review Date	Date of completion and outcome
1	All agencies to implement the recommendations made within their own reports and share action plans and progress with Safer Merton and other strategic partnerships where appropriate	To ensure on-going progress is monitored through relevant partnership meeting with minutes demonstrating this	Learning from the review is implemented	Community Safety, Children's & Adults Safeguarding	September 2025	
2	Safer Merton to implement a process to provide assurance to Annabel's family demonstrating learning has taken place as a result of this review: This should be on a six-monthly basis once the Home Office has agreed the report and it has been published. It should continue until the action plan is complete and has demonstrated evidence of impact.	Update Annabel's mum every six month until recommendations are completed. This will be done via email.	The family will receive assurance learning has taken place and practice changed where relevant to help preventing a similar death	Community Safety	Ongoing until actions complete.	May 2025 – spoken to Annabel's mum to update her on progress and discuss about publishing the report.
3	The 3 strategic partnerships (Community Safety (Safer Merton), Safeguarding Adults Board and Safeguarding Children Partnerships) to work jointly to promote a wider understanding and awareness of the link between adult mental health issues and domestic abuse.	Risk assessments identifying domestic abuse & mental health to be completed by agencies when there is a disclosure of domestic abuse. MSCP and SAB to add this training to their programmes. All agencies to review their training offers. Lunch and learn sessions to be arranged	Partner agencies will be better equipped to use risk assessments and identify risks / vulnerabilities	Community Safety, Children's & Adults Safeguarding	Ongoing	

4	The 3 strategic partnerships to promote a wider understanding of the links between domestic abuse and suicide.	Ensure that this is included in any training with staff	Partner agencies will be better equipped to understand the links with domestic abuse and suicide	Community Safety, Children's & Adults Safeguarding	Ongoing	
5	The 3 strategic partnerships to promote a wider understanding of domestic abuse and the impact on children: This should be evidenced through case file audits to ensure the child's lived experience is appropriately understood.	Case audits to be carried out to ensure partners are ensuring they understand domestic abuse, ensure the voice of the child is present.	We provide better support to our families that are experiencing domestic abuse	Community Safety, Children's & Adults Safeguarding	Ongoing	Children's safeguarding has already started case audits.
6	The 3 strategic partnerships to promote a wider understanding of the use and interpretation of risk assessing victims of domestic abuse. All training and learning events must include how risk assessments identify domestic abuse victims when they are a risk to themselves as well as identifying factors such as sexual and reproductive control.	Risk assessments identifying domestic abuse & sexual and reproductive control to be completed by agencies when there is a disclosure of domestic abuse. MSCP and SAB to add this training to their programmes. All agencies to review their training offers.	Partner agencies will be better equipped to use risk assessments and identify risks / vulnerabilities	Community Safety, Children's & Adults Safeguarding	Ongoing	

No	Recommendation	Action to take	Purpose and intended outcome	Lead Agency	Target/ Review Date	Date of completion and outcome
7	Operation Encompass: • A review should be undertaken to ensure Operation Encompass is embedded in to all schools. • Consideration should be given as to whether school nurses could be informed as part of an extension of the process.	Police will review who has accounts, Training to designated safeguarding leads DSL's to have training.	To provide evidence Operation Encompass is fully embedded in all schools	Police, Children's and Community Safety	July 2025	Work has already started and Designated Safe Guarding Leads in schools have had more information about accessing information
8	Think Family approach: • Note the learning from SAR published March 2023. • Adult social care should consider how to work more closely with the children's MASH to ensure all relevant information is shared. • A multi-agency, cross partnership audit of cases known to either children's or adult services should be undertaken to provide assurance that assessments of all family members and lived experiences of children are included.	Multi-agency strategic partnerships to implement a process to ensure learning from both reviews is embedded MSCB and SAB to host a cross-department case audit Adult Safeguarding to work closer with children's safeguarding, this could be via cases where there is two social workers, adults ensuring children are referred to children's hub and the yearly joint conference.	Multi-agency partnerships working assurance the Think Family approach is embedded across both adult and children's services All family members are part of on-going assessments (including risk) whether the focus of the agency is from adult or children's services	Adult and children's safeguarding boards	Ongoing	Children's safeguarding has already started case audits. Children and Adult safeguarding have a joint conference every year

No	Recommendation	Action to take	Purpose and intended outcome	Lead Agency	Target/ Review Date	Date of completion and outcome
9	The 3 strategic partnerships: • To develop a joint action plan to ensure the learning from both reviews (DHR and SAR) is disseminated widely and agree continued joint working following all case reviews regarding families. This will include seeking assurances from single agency recommendations and action plans. • To consider how to identify complex families and implement a multi-agency approach to review them in order to share all known information and develop risk management plans of intervention and support in order to reduce risk.	Adult Safeguarding and Community Safety to work together to ensure both recommendations are completed Ensure assessments are carried out thoroughly to ensure risk and need is identified	Shared Learning from the DHR and SAR Shared Learning sessions This will be discussed at the Children and adult safeguarding boards	Adult Safeguarding board and Community Safety Adult and Children Safeguarding	September 2025	Discussions have started between Community Safety and Safeguarding Adults board to plan joint learning.
10	Cross Boundary working: • A process should be put in place to ensure when a person is in crisis, timely notification is undertaken to appropriate services in and out of hours when the subject's whereabouts is known. This could be through revision of the newly introduced Multi-Agency Risk Framework.	Adult and Children's safeguarding boards to review their processes	To ensure when someone moves off borough they receive the appropriate support in the new area.	Adult and Children Safeguarding	September 2025	
11	Marac processes should be reviewed to ensure victims are protected when moving to different areas:	MARAC continue to follow SafeLives guidance on MARAC to MARAC transfers.	To ensure MARAC is following the SafeLives guidance	Community Safety	Ongoing	MOPAC has recently carried out a consultation on high-risk domestic abuse cases and MARAC, we are reading the report and

	• Merton VAWG lead to liaise directly with SafeLives as part of learning from this DHR.	MARAC to feedback back the DHR Learning				reviewing how we implement any new guidance.

Appendix 6 – Home Office Letter

Interpersonal Abuse Unit

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Zoe Gallen

Violence Against Women and Girls Lead and MARAC Coordinator

Safer Merton, London Borough of Merton, Civic Centre, London Road, Morden, SM4 5DX

28th May 2025

Dear Zoe,

Thank you for resubmitting the report (Annabel) for Merton Community Safety Partnership to the Home Office Quality Assurance (QA) Panel. The report was reassessed in April 2025.

The QA Panel noted the heartfelt tribute to Annabel provided by her mother, which gave a good sense of who she was and the adversities she experienced throughout her life. The recommendations were also clearly listed and there was good use of research on domestic abuse related suicide.

The QA Panel noted that most of the issues raised in the previous feedback letter have now been addressed. The view of the Home Office is that the DHR may now be published.

Areas of final development:

• Annabel's experience of domestic abuse is only referred to in general terms. The Panel therefore recommends providing more detail on the impact and severity of the domestic abuse experienced by Annabel and her children.

• The report would benefit from using spaces between paragraphs to assist with easy reading.

Once completed the Home Office would be grateful if you could provide us with a copy of the revised final version of the report with all finalised attachments and appendices and the weblink to the site where the learning report will be published.

Please ensure this letter is published alongside the report.

Please send the digital copy and weblink to DHREnquiries@homeoffice.gov.uk. This is for our own records for future analysis to go towards highlighting best practice and to inform public policy.

The DHR report including the executive summary and action plan should be converted to a PDF document and be smaller than 20 MB in size; this final Home Office QA Panel feedback letter should be attached to the end of the report as an annex; and the DHR Action Plan should be added to the report as an annex. This should include all implementation updates and note that the action plan is a live document and subject to change as outcomes are delivered.

Please also send a digital copy to the Domestic Abuse Commissioner at DHR@domesticabusecommissioner.independent.gov.uk

On behalf of the QA Panel, I would like to thank you, the report chair and author, and other colleagues for the considerable work that you have put into this review.

Yours sincerely,

Home Office DHR Quality Assurance Panel