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The following document contains material of a highly sensitive nature (including references to death, violence, and abuse) and may be upsetting for some individuals.

Reigate & Banstead Community Safety Partnership

DOMESTIC HOMICIDE / SAFEGUARDING ADULTS REVIEW

Into the death of Jane (Pseudonym)

In October 2021

OVERVIEW REPORT

Independent Review Chair & Report Author: Michelle Baird MBA, BA.
Review Completed: 11 September 2023

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PREFACE

The Independent Chair and Domestic Homicide Panel Members wish to express their deepest sympathy to Jane's[1] family and all who have been affected by Jane's death.

The Review Chair thanks the Panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review.

1. INTRODUCTION

1.1 Domestic Homicide Reviews (DHRs) came into force on the 13th April 2011, established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a Domestic Homicide Review should be a Review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

(a) A person to whom he was related or with whom he was or had been in an intimate personal relationship or

(b) A member of the same household as himself; held with a view to identifying the lessons to be learnt from the death.

Throughout the report the term 'domestic abuse' is used interchangeably with 'domestic violence'.

1.2 The purpose of a Domestic Homicide Review:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims.

- Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result.

- Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate.

- Prevent domestic violence and homicide and improve service responses for all domestic violence to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity to try to prevent future incidents.

[1] Pseudonym used for the deceased.

1.3 The purpose of a Safeguarding Adults Review:

- Section 44 of the Care Act 2014 sets out that Safeguarding Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked more effectively to protect the adult.

- Determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death.

- What lessons can be learned and applied to future cases to prevent similar harm occurring.

1.4 Domestic Homicide Reviews (DHRs) and Safeguarding Adults Reviews (SARs) are not disciplinary inquiries, nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.5 This Review was held in compliance with legislation and followed Statutory Guidance. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Jane and John[2] entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Jane's death in a meaningful way and address with candour the issues that it has raised.

1.6 This Domestic Homicide Review (DHR) and Safeguarding Adults Review (SAR) examines agency responses and support given to Jane, John, Alex, Pat and Sam, all residents in the county of Surrey prior to the point of Jane's death in October 2021.

1.7 In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Jane's death, 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.[3]

Summary of the incident

1.8 Jane lived on her own and died at her home address in October 2021.

1.9 On the day of Jane's death, she phoned her ex-partner John telling him that she was going to kill herself and wanted him to hear her die. John then called the Police, and when the Police attended Jane's home address, they found Jane suspended by the neck from the stair banister.

[2] Pseudonym used for the deceased's ex-partner who is now deceased.
[3] Home Office Guidance for Domestic Homicide Reviews December 2016. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206.pdf

2. TIMESCALES

- Surrey Police notified the Reigate & Banstead Community Safety Partnership of the death on the 29th December 2021.

- A decision to undertake a combined Domestic Homicide Review/Safeguarding Adults Review was taken by the Chair of the Reigate & Banstead Community Safety Partnership on 23rd February 2022. The Home Office were informed of this decision on the 24th February 2022.

- The Independent Review Chair was appointed on the 12th October 2022 and a further update was provided to the Home Office on the 18th October 2022 regarding timescales. The first meeting of the DHR Panel was held on the 17th November 2022 to agree Terms of Reference.

- The Review considered the contact and involvement that agencies had with Jane and John from 1st January 2019 and Jane's date of death in October 2021. These dates were chosen, as it was during this time that John was staying at Jane's address on a regular basis.

2.1 The Review was concluded on the 14th August 2023. Normally such reviews, in accordance with National Guidance, would be completed within six months of the commencement of the Review. However, the Review was delayed initially due to local restructuring which was protracted due to staff changes within the Community Safety Partnership and later by the death of the alleged perpetrator.

2.2 The Review Panel had 3 formal 'Teams' Meetings:

17th November 2022
29th March 2023
20th June 2023
June 2023 - August 2023, individual meetings were held with the Review Chair, Panel/IMR Authors to finalise their reports.

3. CONFIDENTIALITY

3.1 In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel Members and Individual Management Review (IMR) Authors.

3.2 To protect the identity of the deceased and her family, pseudonyms have been used throughout this report. The Review Chair chose the pseudonym 'Jane' for the deceased, 'John' for the deceased's ex-partner, 'Alex', 'Pat' and 'Sam' for Jane's children.

3.3 Until this report has been approved for publication by the Home Office Quality Assurance Panel, the findings of this Review have been restricted to only participating Officers/Professionals, their Line Managers, and with the agreement of the Home Office, a copy of the Overview Report has been provided to the Surrey Police Crime Commissioner and the Coroner.

4. TERMS OF REFERENCE

4.1 This combined Domestic Homicide Review / Safeguarding Adults Review which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant Statutory Guidance for the Conduct for Domestic Homicide Reviews (DHRs) and Safeguarding Adults Reviews (SARs).

4.2 The Review will identify agencies that had or should have had contact with Jane, her ex-partner John (who is now deceased), Alex, Pat or Sam between the 1st January 2019 and Jane's date of death in October 2021 or any relevant contact prior to that period.

4.3 Agencies that have had contact with Jane, John, Alex, Pat or Sam should:

- Secure all relevant documentation relating to those contacts
- Produce detailed chronologies of all referrals and contacts
- Commission an Individual Management Review in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews and Safeguarding Adults Reviews.

The Review Panel will consider:

- Each agency's involvement with the following from the 1st January 2019 until October 2021, as well as all contact prior to that period which may be relevant to safeguarding, domestic abuse, violence, controlling behaviour, self-harm, mental health issues or substance abuse.

- Jane who was 51 years of age at date of her death.
- John was 55 years of age at the time of Jane's death.
- Alex was 30 year of age at the time of Jane's death.
- Pat was 23 years of age at the time of Jane's death.
- Sam was 18 years of age at the time of Jane's death.

- Whether the agencies or inter-agency responses were appropriate leading up to and at the time of Jane's death.

- Whether there was any history of mental health problems or self-harm and if so whether they were known to any agency or multi-agency forum.

- Whether there was any history of substance misuse and if so whether it was known to any agency or multi agency forum.

- Whether there were any other known safeguarding issues relating to Jane.

- Whether there was any history of abusive behaviour towards Jane and whether this was known to any agencies.

- Whether there are any lessons to be learned from the case about the way in which professionals and agencies worked individually or together to safeguard Jane.

- Whether agencies have appropriate policy and procedure to respond to needs of a vulnerable adult and to recommend and change as a result of the Review process.

- Whether practices by agencies were sensitive to the ethnic, cultural, religious, identity, gender and ages of the respective individuals and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

- Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any safeguarding concerns or abusive behaviour to Jane prior to her death.

- Whether in relation to the family members, were there any barriers experienced in reporting the vulnerabilities of Jane or the abuse she was subjected to.

- The Review must be satisfied that all relevant lessons have been identified within and between agencies and will set out action plans to apply those lessons to service responses, including changes to inform national and local policies and procedures as appropriate.

- The Review will consider any other information that is found to be relevant, and which may contribute to a better understanding of the nature of domestic abuse and adult safeguarding.

- The Review will also highlight good practice.

5. METHODOLOGY

5.1 The method for conducting this Domestic Homicide Review (DHR) / Safeguarding Adults Review (SAR) is prescribed by Legislation and Home Office Guidance. Upon notification of Jane's death from Surrey Police, a decision to undertake the Review was taken by the Chair of Reigate & Banstead Community Safety Partnership.

5.2 Agencies were instructed to search for any contact they may have had with Jane, John or their children. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Jane, John or their children's circumstances in the future.

5.3 The Review Panel considered information and facts gathered from:

- The Individual Management Reviews and other reports of participating agencies and multi-agency forums
- Pathologist Report
- Coroner's Report
- Discussions during Review Panel meetings

6. INVOLVEMENT OF FAMILY AND FRIENDS

6.1 Jane's three children were contacted at the commencement of the Review by formal letter via the Review Chair on the 19th October 2022. They were provided with a copy of the draft Terms of Reference and the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA) leaflets explaining DHRs and available support. During the first of the telephone conversations, on the 2nd November 2022, the Review Chair explained the purpose of the Review and why it was being held. The three children took the decision not to participate in the Review and did not wish to receive a copy of the Reports as it would be too harrowing for them to read.

7. CONTRIBUTORS TO THE REVIEW

7.1 Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation, Trusts and Health Bodies to engage in both a Domestic Homicide Review/Safeguarding Adults Review, other organisations can voluntarily participate; in this case the following twelve organisations/Trusts were contacted by the Review:

- **Adult Social Care Surrey County Council (ASC):** This organisation had contact with Jane and John, and an IMR was completed. A senior member of this organisation is a panel member.

- **Children Social Care Surrey County Council:** This service had contact with Jane, John, Alex, Pat and Sam and an IMR was completed. A senior member of this organisation is a panel member.

- **East Surrey Domestic Abuse Services (ESDAS):** This service had previous involvement with Jane and an IMR was completed. A senior member of the organisation is a panel member.

- **Multi Agency Risk Assessment Conference:** The Chair of the MARAC provided a Report for the Review. The MARAC Chair is not a panel member.

- **Raven Housing Trust:** This Trust had contact with Jane and an IMR was completed. A senior member of this Trust is a panel member.

- **Reigate & Banstead Borough Council Housing Team:** This service had previous involvement with Jane and John and an IMR was completed. A senior member of this service is a panel member.

- **Sanctuary Supported Living:** This service had previous involvement with Jane and John and a report was completed for the Review. A member of this service is not a panel member.

- **Surrey and Borders Partnership NHS Foundation Trust (SaBP):** This Trust had contact with both Jane and John and an IMR was completed which included contact with i-access which is part of the Trust. A senior member of this Trust is a panel member.

- **Surrey and Sussex Healthcare NHS Trust (SaSH):** This Trust had contact with Jane and John and an IMR was completed. A senior member of this Trust is a panel member.

- **Surrey and Sussex Probation Service:** This service had no contact with Jane or John during the timeframe of the Review. However, they did have prior contact with John and information has been provided to the Review. A senior member of this service is a panel member.

- **Surrey Heartlands Integrated Care Board (ICB) for GPs:** This organisation had contact with Jane and John and an IMR was completed. A senior member of this organisation is a panel member.

- **Surrey Police:** This Police Force had relevant contacts with Jane and John and an IMR was completed. A senior member of this organisation is a panel member.

7.2 All IMR Authors have confirmed that they are independent of any direct or indirect contact with any of the relevant parties subject to this Review.

8. REVIEW PANEL

8.1 The Review Panel consists of experienced Senior Members from relevant statutory and non-statutory agencies, none of which had any prior contact with Jane, John, Alex, Pat or Sam. Members of the Panel:

8.2 Panel Members:

Michelle Baird	Independent Chair / Author - Know More Limited
Georgia Tame	Domestic Homicide Review Co-Ordinator, Surrey County Council
Trevor Ford	Community Safety Officer - Reigate & Banstead Borough Council
Sarah McDermott	Safeguarding Manager - Surrey Adults Safeguarding Board
Andy Pope	Statutory Reviews Lead - Surrey Police
Helen Milton	Designated Nurse, Safeguarding Adults - Surrey Heartlands Integrated Care Board (ICB) for GPs
Ludmila Ibesaine	Safeguarding Adults & Domestic Abuse Lead - Surrey and Borders Partnership NHS Foundation Trust (SaBP)
Trevor Woolvet	Housing Needs Manager - Reigate & Banstead Borough

	Council
Vicky Abbott	Head of Safeguarding - Surrey & Sussex Healthcare NHS Trust
Clement Guerin	Head of Adult Safeguarding - Surrey County Council
Tom Stevenson	Assistant Director Quality Practice and Performance Children Social Care - Surrey County Council
Michelle Blunsom	CEO - East Surrey Domestic Abuse Services (ESDAS)
Richard Williamson	Tenancy Enforcement Team - Raven Housing Trust
Alison Hopkins	Deputy Head - Surrey and Sussex Probation Service

9. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

9.1 The Chair and Author of this combined Domestic Homicide and Safeguarding Adults Review is legally qualified and is an Independent Chair of Statutory Reviews.

9.2 She has no connection with the Reigate & Banstead Community Safety Partnership or the Surrey Safeguarding Adults Board and is independent of all the agencies involved in the Review. She has had no previous dealings with Jane, John or their children.

9.3 Her qualifications include three degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers and staff within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Emotional Freedom Techniques (EFT).

9.4 She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.

9.5 In June 2022, she attended a two day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. This offence came into force on the 7th June 2022.

10. PARALLEL REVIEWS

10.1 The Inquest concluded on the 28th March 2022. It was concluded that the cause of death was suicide by hanging.

11. EQUALITY & DIVERSITY

11.1 The panel and the agencies taking part in this Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness, and transparency. All nine protected characteristics in the

Equality Act were considered and the panel was satisfied that services provided were generally appropriate.

11.2 Section 4 of the Quality Act 2020 defined 'protected characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3 There is no information within organisations records to indicate that any incident mentioned within this report was motivated or aggravated by age, disability, gender reassignment, marriage/civil partnership, pregnancy / maternity, race, religion/belief or sexual orientation.

11.4 Sex was a protected characteristic in this Review. Statistically women are at greater risk from domestic violence and abuse than men (Walby and Towers, 2017[4]). It is important to highlight the level and extent of domestic violence and abuse against women, but at the same time it is equally important that men are not discriminated against as a result of the focus on women as victims.

11.5 Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if -
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on a P's ability to carry out normal day-to-day activities[5]

Mental Health

11.6 There was recorded mental health problems relating to Jane, who was diagnosed with borderline personality disorder, and agoraphobia[6], which lead to panic attacks and anxiety. She had also disclosed financial difficulties which would have had an impact on her mental wellbeing.

[4] Walby, S. and Towers, J. (May 2017) 'Measuring violence to end violence: mainstreaming gender', Journal of Gender-Based Violence, vol. 1, no. 1, p11-31.
[5] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability. Mental Capacity Act 2005.
[6] Agoraphobia is a fear of being in situations where escape might be difficult or that help wouldn't be available if things go wrong.

11.7 John was diagnosed with dissocial personality disorder (DPD)[7], he had intermittent contact with secondary care mental health services over the timeframe of this Review.

Disability

11.8 Jane was reported to have suffered from osteoarthritis which restricted her mobility. She was also diagnosed with deep vein thrombosis.

11.9 John had suffered a brain injury after a significant assault in 2012, and subsequent to this he experienced depression, anxiety and hearing voices.

12. DISSEMINATION

12.1 Each of the Panel Members, the Chair and Members of the Reigate and Banstead Community Safety Partnership and Surrey Safeguarding Adults Board have received copies of this report. A copy has also been sent to the Surrey Police Crime Commissioner and the Coroner.

12.2 In accordance with Statutory Guidance[8], the findings of this Review are restricted to only participating Officers/Professionals and their Line Managers, until after this report has been approved for publication by the Home Office Quality Assurance Panel.

13. BACKGROUND INFORMATION (THE FACTS)[9]

13.1 Jane and John had been in a relationship for close on 20 years. However, they separated a number of times during this period, the longest break being for eight years.

13.2 Jane and John had two children, Alex and Pat. Sam was Jane's child from a previous relationship.

13.3 At the time of Jane's death, she lived on her own and died at her home address in October 2021. She had a long history of mental health problems and substance misuse issues and had been subjected to domestic abuse over a long period of time.

13.4 On the day of her death, Jane phoned her ex-partner John, (who is now deceased) telling him that she was going to kill herself and wanted him to hear her die. John then called the Police and when the Police attended Jane's home address, they found Jane suspended by the neck from the stair banister.

[7] DPD is a particularly challenging type of personality disorder characterised by impulsive, irresponsible and often criminal behaviour.
[8] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. paragraph 72 (Home Office December 2016).
[9] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016).

13.5 A suicide note revealed her pain at getting back on to methadone again and letting her family down. She blamed John for getting her back on methadone and stated that he was playing with her head. Jane gave instructions on what to do with her money and instructions for her cremation.

13.6 Jane was found wearing methadone patches with the following noted on them:

- "NO METH WK4"
- "TOO MUCH PAIN WK4 TAKEN WK EARLY AS IN TOO MUCH PAIN"
- "NO METHODONE WK3"

13.7 The Pathologist report confirmed cause of death - 'Suspension'.

14. CHRONOLOGY

14.1 The events described in this section explain the background history of Jane and John, prior to the key timelines under review as stated in the Terms of Reference. They have been collated from the chronologies of agencies that had contact with Jane, John, Alex, Pat and Sam.

14.2 Jane's medical records show a very long and complex history of substance misuse and overdoses. Her first overdose (of paracetamol) was recorded in 1987 when she was 16. She was recorded as struggling with drug and alcohol misuse from 2001, undergoing detoxification programmes on several occasions.

14.3 John had a history of significant drug use dating back to him being 9 years old. He reported using Class A drugs from 1987 to 2004 when he began misusing alcohol. He had a history of hepatitis C (resolved) and alcoholic liver disease, and the risks of his ongoing alcohol consumption were discussed with him on numerous occasions. He was under the care of the gastroenterology team at a named hospital.

14.4 John was receiving a methadone prescription, he also disclosed taking non-prescribed medication to "*calm him down*". John reported having issues with his temper and felt angry about his childhood, experiencing a period in the care system when he was 15. He spent a number of years in foster homes, secure units, Young Offender Institutes and then adult prisons (total of 32 years due to a variety of convictions). John was also the victim of a significant assault in 2012 that resulted in a brain injury. Since this time, John reported experiencing depression and anxiety and hearing voices.

14.5 In January 1994, Children Social Services received Child Protection referrals concerning Alex and Pat (Jane's two children with John). They were made subject to a Child Protection Plan from March 1994 to September 1994.

14.6 In April 2013, Police were contacted by a Support Worker from a Drug and Alcohol Service, advising that John had stated he was going to kill himself. A

welfare check was completed by Police and a referral was made to Mental Health Services, as John was already known to them.

14.7 From October 2016, Jane was in contact with a Community Mental Health Recovery Service (CMHRS) Support Worker and Care Coordinator. The CMHRS Support Worker saw her regularly at home and supported her with a range of tasks, including rebooking hospital appointments, attending dental appointments, completing housing forms and support with Department for Work and Pensions (DWP) and her Personal Independence Payment (PIP).

14.8 In January 2017, Sam was noted to be off school due to issues at school. Jane's Care Coordinator was in contact with a Children Social Care Social Worker, and noted concerns that Jane was potentially in contact with her ex-partner John who had just been released from prison. Jane's stress and anxiety regarding Sam was documented in records made by her Care Coordinator and CMHRS Support Worker.

14.9 In May 2017, John had been interviewed by a Housing Options Officer as he had made a housing application. The Officer could not accept the claim as it was believed that John lacked mental capacity to make a homeless application. Concerns were raised when John mentioned Sam who was 13 years of age. A safeguarding referral was made and shared with CMHRS and Children Social Care.

14.10 In June 2017, Sam was made subject to a Child Protection Plan due to concerns of physical abuse, emotional abuse and neglect. Children Social Care record extensive involvement with Jane and Sam dating back to 2003. This was the third time Sam had been subject to a Child Protection Plan and on this occasion, Sam had asked to be made subject to Child Protection arrangements.

14.11 In June 2017, John's Probation Officer reported concerns to Adult Social Care (ASC) regarding John's wellbeing. He was street homeless and unwell. ASC advised that John refer to CMHRS and seek medical attention at a hospital. John was engaging with i-access and was being seen fortnightly for methadone.

14.12 It was recorded that Jane used alcohol as a coping mechanism and her Care Coordinator agreed to make a referral for Family Therapy. In July 2017, it was recorded that Jane was in a relationship with a new partner and was looking to get a non-molestation order to stop John's access to her home and stop John from contacting her or Sam.

14.13 At the end of July 2017, Jane did not attend an appointment with Family Therapy. Attempts to contact Jane were unsuccessful, until August 2017 when Jane said she wanted Family Therapy, but could not attend due to her parents and Sam being unwell.

14.14 At the beginning of August 2017, Children Social Care recorded concerns that Jane was not being honest with professionals regarding her relationship with

John, and it was suspected that Jane and John were living together at Jane's home with Sam.

14.15 On the 29th August 2017, Jane was admitted to hospital having taken an overdose of prescription medication. Jane was found by Sam who was 13 years of age at the time. It was believed Jane suffered a stroke as a result of her prolonged immobility. Jane was initially in the Intensive Care Unit (ICU), before being moved to a High Dependency Unit (HDU). The following day, Jane's Care Coordinator attended a review of the Child Protection Plan, due to the concerns that Jane was not able to meet Sam's needs and had been drinking excessively with her ex-partner John. Children Social Care organised a Legal Planning Meeting and Sam was placed with a relative.

14.16 Jane self-discharged from hospital on the 1st September 2017. She was seen by a Community Mental Health Recovery Service (CMHRS) Doctor, a Community Psychiatric Nurse (CPN) and an approved Mental Health Professional (AMHP) prior to discharge. A Mental Capacity Assessment was undertaken and deemed that Jane had full capacity to make the decision to self-discharge.

14.17 On the 2nd September 2017, Children Social Care conducted a home visit. Jane was recorded as very distressed and shocked when Children Social Care informed her that they were taking legal action to remove Sam from her care. Jane subsequently engaged with requests from the care proceedings and self-referred to i-access (Drug and Alcohol Service).

14.18 Adult Social Care (ASC) received a referral from the Police on the 8th September 2017. Jane had reported that Sam had gone missing. Sam had gone to a friend's house two doors away, which Jane was aware of. Children Social Care were applying for a care order the following week for Sam's removal. Sam was removed from Jane's care on the 15th September 2017 after care proceedings were initiated and an Interim Care Order[10] was granted. Jane's level of distress and substance abuse escalated following Sam's removal.

14.19 In October 2017, John's Probation Officer raised concerns regarding John's lack of housing and whether a mental health capacity assessment could be completed. John was in prison at the time and ASC contacted the ASC Prison Team to see if they could undertake an assessment. In November 2017, John was seen by the ASC Prison Team. It was concluded that John did not have eligible care and support needs for ASC support, his primary need was for housing.

14.20 In November 2017, an independent psychiatric evaluation was undertaken at the request of Children Social Care, in relation to care proceedings for Sam. The report detailed information regarding Jane's history which included childhood sexual abuse and domestic abuse. It was also recorded that Sam was her Carer in 2013 (at the age of 9). Sam was removed from Jane's care

[10] An Interim Care Order is a temporary order made by the Court at the beginning of Care Proceedings and places a child in the care of the Local Authority.

due to physical and emotional abuse, one aspect of this being Jane's continuing contact with John, against the expressed advice of Children Social Care.

14.21 At the beginning of December 2017, Jane's Care Coordinator, informed Children Social Care that Jane had not attended her appointment with the Consultant Psychiatrist. Jane was not having any contact with Sam. Jane remained in contact with her Care Coordinator, who liaised with other services and agencies including Catalyst (a Mental Health Charity). Jane found the care proceedings difficult at times and her parents were residing with her and providing support.

14.22 In January 2018, Reigate & Banstead Borough Council Housing Team received a homeless application following John's release from prison. Interim accommodation was provided but John was evicted due to not residing there. He was assisted into appropriate accommodation and their involvement was fairly limited after this. Sanctuary Housing took over his support.

14.23 In early February 2018, Jane was supported by her father to attend Court, and she agreed for Sam to remain in foster care. Jane confirmed that John was out of prison and she had told him that she did not want any contact with him.

i. Jane was discharged from Catalyst due to non-engagement and called CMHRS to cancel her appointments in late February. Despite attempts by CMHRS to contact Jane, and an unannounced visit in early May 2018, the next contact with Jane was on the 9th May 2018 when she sent a text message requesting an appointment. Jane attended this appointment with CMHRS and reported that her mood had been mostly stable.

ii. Her future discharge from the team was discussed, and it was agreed that Jane would be supported to access Dialectical Behavioural Therapy[11] (DBT), which was one of the outcomes from a psychiatric assessment.

14.24 In July 2018, Jane was discharged from CMHRS. She was assured that her General Practitioner (GP) could refer her back to the team should she need support.

14.25 On the 20th August 2018, Police contacted the Surrey and Sussex Healthcare NHS Trust (SaSH) Crisis Line to request information about Jane as she had gone missing. At this point, John was staying with Jane and Pat.

i. A SCARF[12] report raised concerns that Jane was depressed because Sam did not want to have any contact with her was reviewed by the Safeguarding Borders Partnership Multi-Agency Safeguarding Hub (SaBP MASH) staff.

[11] A type of talking therapy based on Cognitive Behavioural Therapy specifically adapted for people who feel emotions very intensely.
[12] A SCARF is a Single Combined Assessment of Risk Form that enables officers and staff to raise concerns and observations in relation to the needs and vulnerability of individuals.

14.26 Jane was seen by a Mental Health Liaison on the 21st August 2018, when she was admitted to the Emergency Department after being found in her shed, having taken an overdose of her prescribed medication and John's methadone. Jane was declared medically stable later that day and discharged herself.

i. An urgent referral was made to the CMHRS and staff attempted to call and speak to Jane without success. Further attempts were unsuccessful, so the team carried out a home visit. Pat answered the door and said Jane did not want anything to do with Mental Health services. CMHRS requested to talk to Jane, but she refused. Jane later texted CMHRS asking if she could call the following week. Jane was discussed in the CMHRS allocations meeting and it was agreed to do a follow up call. The CMHRS wrote to her GP.

14.27 Throughout September and early October 2018, the CMHRS made several calls and sent text messages to Jane. Jane responded by text to say she was being well looked after by Pat. However, a later text was received by Jane advising that she was struggling and required help, her previous Care Coordinator offered to see her.

15. OVERVIEW

15.1 This section documents the key contacts agencies and professionals had with Jane and John within the agreed timeframe of the Review.

15.2 On the 3rd June 2019, Police and the ambulance service attended Jane's address as a neighbour had reported not seeing her for two days. Jane was agitated about Sam's removal and about the unsuitability of her housing. Difficulties were noted with Jane using the shower due to osteoarthritis. Bruising to her legs were noted, she reported this was due to falls due to osteoarthritis and she was prone to bruising as she takes Rivaroxaban, a blood thinner for deep vein thrombosis.

15.3 On the 2nd July 2019, John was seen by CMHRS. John reported he was hearing voices that were angry and he had been supported by his GP to increase his prescribed medication. John denied using substances on top of his prescribed medication but did state he was trying to reduce his daily alcohol intake.

15.4 On the 15th July 2019, Jane requested a letter from her GP to support her request to Raven Housing to move her to a ground floor flat due to her physical health needs.

15.5 On the 15th July 2019, John underwent an assessment of care and support needs and was found to qualify for further assessment by Adult Social Care in this regard.

15.6 On the 6th August 2019, Police were called by John. He was expressing concern that Jane had been feeling down and had recently taken an overdose. Police attended and forced entry into Jane's home and found Jane

seated on a settee breathing, but unresponsive. There was an empty bottle of vodka, two empty packs of paracetamol and a can of lighter fuel lying close to her. Paramedics attended and Jane was taken to hospital.

i. Jane was admitted to ICU for five days. She was observed to have five different sites of bruising. Once she was deemed fit to move to a general ward, Jane self-discharged herself from hospital.

ii. A SCARF and Vulnerable Adults at Risk notification (VAAR) was submitted by Police for Jane following her admission to hospital and shared with ASC MASH and Children Social Care. A Domestic Abuse Stalking and Harassment Risk Assessment (DASH) was completed and assessed the level of domestic abuse between Jane and John as medium risk[13].

15.7 Jane was referred to Mental Health Liaison by the Intensive Therapy Unit and was initially seen with her mother, but she was too unwell and was seen again when more alert. Jane was adamant that she would not harm herself again and planned to see her GP to discuss her mental health, which was believed to be the most appropriate course of action.

15.8 A letter was sent to her GP on the 12th August 2019. Jane's GP surgery wrote a letter to Jane requesting she make an appointment with the GP following her hospital admission, which she did for the 9th September 2019.

15.9 On the 12th August 2019, a safeguarding concern was sent to Adult Social Care (ASC) MASH by Raven Housing. Jane asked that her front and rear door locks were changed as John had her keys whilst she was in hospital.

15.10 On the 15th August 2019, Jane reported to Police that whilst she had given John permission to access her home to collect some items for her, when she returned home, she had discovered John had taken property without her permission. Jane subsequently arranged for the locks to be changed herself.

15.11 ASC MASH obtained additional information from Surrey and Borders Partnership NHS Foundation Trust (SaBP) that suggested Jane had a diagnosis of Borderline Personality Disorder, agoraphobia leading to panic attacks and anxiety. It was noted that whilst criteria for Section 42 (S42)[14] was not met, Jane may benefit from a Section 9 assessment (S9)[15].

15.12 John was arrested on the 15th August 2019, on suspicion of theft and his property searched. John denied the allegations. Jane later informed Police that some of the missing property was in fact intended to be given to John. Due to no recovered property, no witnesses and no other evidential opportunities, no further action was taken.

[13] Medium risk: 'There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug, or alcohol misuse'.
[14] Ensures support to keep people safe who may be at risk of or experiencing abuse/neglect.
[15] To assess whether a person requires some form of care and support, and whether the nature of their needs is such that the local authority will be under a duty to meet them.

i. A SCARF, VAAR and a DASH were completed and shared with ASC and CMHRS. The DASH assessed the level of domestic abuse between Jane and John as 'medium' risk. A MARAC[16] referral was also made, however as the incident was graded 'medium' risk and not previously referred to MARAC, it did not meet the referral criteria. A referral for outreach domestic abuse support for Jane was made on the 5th October 2019.

15.13 On the 10th September 2019, John attended an appointment with his CMHRS Support Worker. John reported he was struggling with hearing voices telling him to end his life and his prescribed medication was no longer working for him. He reported feeling anxious and stressed and that he was isolating himself. John continued to engage with i-access for support with his substance misuse. His case was transferred from CMHRS back to his GP on the 16th October 2019.

15.14 On the 19th October 2019, East Surrey Domestic Abuse Service (ESDAS) reviewed the referral and a Duty Worker called Jane, but she chose not to engage with the worker. As a client led service, no further calls were made to Jane as she had chosen not to engage on this occasion.

15.15 On the 5th February 2020, Jane contacted Raven Housing following a decision by Reigate & Banstead Borough Council to close her housing register application. Jane was incredibly distressed and threatened to take her life before ending the call. There was no record of follow up contact or a safeguarding referral being made.

15.16 On the 17th March 2020, John reported to his CMHRS Support Worker that he was hearing voices instructing him to hurt himself or others. John stated that he could not control his anger and had thoughts of hurting others. He reported that he recently stabbed himself on the wrist as instructed by the voices.

i. A Placement Worker from Sanctuary Housing stated that staff had to contact the GP on John's behalf to get him medical help. John reported that he was feeling suicidal and that he had access to a gun[17]. John said he did not want to carry out the commands of the voices and felt his medication needed reviewing. A medication review was completed on the 24th March 2020, it was not possible to complete a face-to-face assessment as COVID restrictions had been implemented.

ii. No safeguarding referral was completed in relation to John's disclosure that he could access a firearm, nor was this reported to the Police.

15.17 On the 27th April 2020, a MARAC referral was made by Sanctuary Housing. John showed bruises to staff and due to previous concerns around him being

[16] Multi-Agency Risk Assessment Conference.

[17] Following Jane's death, John's residence was searched by Police in December 2021 and two imitation firearms (revolvers) were discovered, one was believed to be a pea shooter and the other a cigarette lighter. No offences were apparent and neither item was seized by Police.

a domestic abuse perpetrator, together with the knowledge of his previous convictions, the referral was put in with Jane as the primary victim and John as the perpetrator.

i. The Police Safeguarding Investigation Unit reviewed the MARAC referral and contacted John who did not wish to engage with Police and denied making an allegation of assault to Raven Housing. Contact was also made with Jane, she denied being the victim of an assault. Of note was that John was overheard in the background during this call and both Jane and John sounded intoxicated.

15.18 On the 7th May 2020, Jane was listed as a victim of domestic abuse and her case was being heard at a MARAC on the 21st May 2020, but ESDAS had not received a referral. ESDAS emailed the MARAC team to request the referral to be sent as soon as possible so that contact could be made with Jane before the MARAC.

15.19 On the 11th May 2020, ESDAS received a referral for Jane. An Outreach Worker called Jane, but there was no answer. No message was left as it was unknown how safe it would be to do so.

15.20 The Outreach Worker managed to speak to Jane on the 12th May 2020 and explained why ESDAS were calling. Jane stated that she did not need to talk to ESDAS and did not need any support, she thanked them and ended the call. A MARAC research form was completed on the 21st May 2020 with limited information for the meeting, outlining that Jane chose not to engage with ESDAS.

15.21 On the 12th June 2020, Adult Social Care (ASC) recorded information that was discussed at the MARAC on 21st May 2020. Records state that John was now staying with Jane at her address and that John had previously disclosed pushing Jane in the back during an argument in which Jane also assaulted him. ASC contacted Police that day to establish if there were any restrictions preventing John from visiting or staying at Jane's address, a response was received on the same day from Police advising there were no restrictions.

15.22 On the 25th June 2020, the SaBP MASH staff reviewed a safeguarding concern submitted by Raven Housing after Jane had threatened to jump from a tower block if Raven Housing didn't help her with an accommodation move. Raven Housing requested that the CMHRS contact Jane. It was noted Jane was waiting to hear back from her GP about counselling and that ASC MASH were referring her to the ASC Mental Health Team. Staff from Raven Housing assisted Jane with the downsizing application paperwork and a MASH referral completed.

15.23 On the 26th June 2020, Raven Housing contacted ESDAS as Jane had told a member of staff from Raven Housing that her partner John, had visited her on the 3rd June 2020, fallen down the stairs and broken his leg. Raven Housing knew that ESDAS had previously supported Jane and she had recently been

heard at MARAC. They wanted ESDAS to contact Jane as she was in contact with John to see if Jane needed any support.

i. Later that day, an ESDAS Outreach Worker called Jane, but she was unable to talk. At Jane's request, it was arranged for the Outreach Worker to call her back the following week, ideally in the afternoon. A follow up email was sent to Raven Housing with an update.

15.24 On the 30th June 2020 and the 1st July 2020, further calls were made to Jane by the Outreach Worker but there was no answer, no messages were left. On the 2nd July 2020, a further call was made to Jane. There was no answer, but on this occasion a message was left. The Outreach Worker sent a text message to Jane, giving her the ESDAS office number, her email address and requested a call, text or email response to let her know whether or not she needed any support.

15.25 On the 3rd July 2020, the Outreach Worker called Jane who answered, Jane said she was okay and was going to the GP on the 6th July 2020. According to GP records from this time, this would appear to be for pain relief management. Jane confirmed that she had the Outreach Worker's contact details and knew she could call if she needed to and thanked her.

i. The Outreach Worker emailed Raven Housing to update them that she had spoken to Jane, who was going to see her GP and that the ESDAS referral would now be closed as Jane had not wanted to further engage.

15.26 Raven Housing contacted Jane on the 8th August 2020, offering her the move to a property suitable for her needs i.e. ground floor. This was rejected by Jane. No further offers were made as this was a reasonable offer.

15.27 On the 16th October 2020, Adult Social Care (ASC) received a referral from Raven Housing. Jane had reported feeling suicidal due to her unsuitable housing and a safeguarding concern was raised. Raven Housing reported to ASC that Jane had issues with her benefits and housing which was impacting on her mental health. She was reported to be self-neglecting as well and might have needs for care and support.

i. ASC MASH records were reviewed, and an outcome recorded that there was "*no evidence or current risk of abuse or neglect and therefore no S42 enquiry required, but there may be some concerns of historical self-neglect and Jane could therefore benefit from a S9 assessment*."

15.28 On the 9th November 2020, Jane spoke with a GP that was not involved in her ongoing care. Jane was tearful and reported she had not seen Sam for three years. She was also struggling to complete the forms for Universal Credit and had financial problems. Jane was signposted to Citizens Advice for support.

15.29 On the 12th November 2020, Jane spoke with her GP. She admitted to drinking two to three bottles of wine daily and reported that she was assaulted

by her ex-partner three weeks earlier whilst sedated by drugs. Jane's GP encouraged Jane to report this to the Police.

i. Jane stated she was unintentionally losing weight and having difficulty swallowing. She was asked to attend a face-to-face appointment on the 16th November 2020 but did not attend. There was no further contact between Jane and the GP practice until February 2021.

ii. There was no reference to any safeguarding referrals or contact with support agencies following Jane's disclosure of assault. The GP records do not explicitly capture the nature of the assault (physical or sexual) or if the ex-partner she was referring to was John.

15.30 On the 17th November 2020, Jane called ESDAS. She sounded upset and asked for the contact number for the Department for Work and Pensions (DWP), as her benefits had been halved and she did not know what to do. On the 18th November 2020, the Outreach Worker called Jane but there was no answer. A message was left for Jane to call back.

15.31 On the 19th November 2020, the Outreach Worker called Jane and managed to speak to her and issues with her benefits were discussed. Jane stated that she does not go out and relies on a food bank who deliver food to her home.

i. Jane stated that she was agoraphobic[18] and has other health conditions. She declined food bank vouchers as she was already in receipt of this service. Jane said she was waiting for an ASC Social Worker to be allocated, the Outreach Worker advised Jane that she could still call ASC and ask to speak to the Duty Officer if she needed support. Jane agreed to do this. The Outreach Worker agreed to email the local DWP Office and ask for someone to call her.

ii. The same day, an email was sent by The Outreach Worker to the DWP with Jane's details requesting an update on benefits to be provided to Jane by telephone. The Outreach Worker explained that Jane was having issues with her ESA (Employment and Support Allowance) and PIP (Personal Independence Payment) and had health issues, meaning she could not leave the house. She also highlighted that Jane does not use the internet.

iii. The Outreach Worker received an 'out of office until 24th November 2020' reply to the email, so tried to call the Job Centre but reports there was continuous ringing with no option to leave a message.

15.32 On the 20th November 2020, the ESDAS Outreach Worker tried calling the Job Centre again on behalf of Jane and eventually managed to get through and spoke to a member of staff who said they would call Jane immediately.

[18] A fear of being in situations where escape might be difficult or that help wouldn't be available if things go wrong.

i. The Job Centre Worker called the Outreach Worker back to say she had tried to call Jane a few times with no answer, so had left a message with her details asking Jane to call her back. On the 23rd November 2020, the ESDAS Outreach Worker called Jane, but there was no answer. A message was left giving the Job Centre Worker's direct telephone number so Jane could return the call to discuss her benefits.

15.33 Jane contacted Raven Housing on the 23rd November 2020, stating that she was feeling suicidal as she had no money for the month and that the DWP had stopped her payments. Raven Housing contacted DWP who confirmed that payments had not been stopped and the next payment was due to be paid on the 25th November 2020.

15.34 On the 15th December 2020, John reported to Police that he had been assaulted by Jane whilst at her home address. John reported that Jane had poked him in the eye and kicked him in the hip. John had left Jane's address and was returning to his address, but told Police that Jane was by herself and may attempt to take her life.

i. Officers conducted an immediate welfare check and found Jane who was under the influence of alcohol. She was verbally abusive and attempted to push an Officer. Jane reported that John had thrown her down the stairs. As John had a small cut under his eye and had contacted Police in the first instance, a decision was made to arrest Jane.

15.35 On the 16th December 2020, Police interviewed Jane for suspected ABH (Actual Bodily Harm) of her ex-partner John. During the interview, Jane alleged that John had raped her several weeks previously and believed that John had drugged her. Jane stated that John had also assaulted her on several different occasions with his walking stick, causing bruising to her head, hand and leg. Jane reported that John had stolen £40 from her which was due to be used for gas and electric and made threats to kill her as he had access to a firearm.

i. Whilst in custody, Jane was seen by the Criminal Justice Liaison and Diversion Services (CJLDS)[19] and a safeguarding concern was raised to ASC MASH following Jane's disclosures. Jane also reported drinking two bottles of wine a night. Jane was to be allocated to CJLDS Outreach.

ii. On the same day, ESDAS received a referral for Jane from Police and attempted contact with her, a message was left offering support and requesting a call back. Further attempts to contact Jane were made by ESDAS on the 18th December 2020 and the 29th December 2020 but were not responded to by Jane.

15.36 On the 18th December 2020, a decision was made by ASC MASH for a S42 enquiry to be conducted. ASC called Jane, but there was no answer, a voicemail message was left asking her to call back. It was recorded on the

[19] Provides early identification and screening of vulnerable people of all ages within the criminal justice system.

23rd December 2020 that the S42 enquiry was closed due to ongoing Police involvement and a protection plan that would be drawn up at a scheduled MARAC on 21st January 2021. It was recorded that ASC were unable to contact Jane or her family despite many attempts. In January 2021, CJLDS Outreach recorded that they had also been unable to contact Jane.

15.37 As part of the Police investigation, John was arrested, interviewed and denied all the allegations made by Jane stating that he believed they were malicious and made in retaliation for Jane's arrest. Whilst in custody, John declined a Liaison and Diversion Vulnerability Assessment. John was placed on Police bail with conditions not to contact Jane directly or indirectly nor attend her home address.

15.38 A safeguarding referral for John was received by ASC MASH who record on the 5th January 2021 that the criteria for S42 was met, but an enquiry did not take place. Further ASC records from this period indicate that John's care and support needs primarily relate to his physical health and that he was "*fully independent and able to protect himself from harm*". On the 9th February 2021, the S42 process was discussed with John by his i-access Support Worker. John reported he did not feel at risk and would not support the S42 enquiry.

15.39 Throughout the course of the Police investigation Jane was unable to provide an evidential statement, it is believed for reasons of being upset and scared of the process, which was further complicated by her alcohol and drug misuse.

i. Numerous attempts were made to engage with Jane and eventually it was agreed for a video recorded interview (VRI) to be conducted on the 28th January 2021. This was subsequently cancelled by Jane, who confirmed that she did not want the interview to take place. Further attempts were made to engage with Jane without success.

15.40 Officers made additional enquiries in an attempt to corroborate and support Jane's account, however these enquiries only revealed that Jane had not been at John's address at any time near the date of the alleged offences. With Jane unable to assist any further with the investigation and with Officers unable to gather viable third-party evidence the case was filed with no further action. Police were unaware that Jane had disclosed the assaults to her GP in November 2020 and that her GP had encouraged her to report this to the Police at the time of her disclosure.

15.41 Police records demonstrate a commitment and effort to safeguard Jane. This is supported and evidenced by an assessment with Jane via a Vulnerability Assessment Report (VAR) for Women conducted by an NHS practitioner whilst in Police custody.

i. The VAR recommended GP support, with a specific request that Jane was assisted in contacting Sam, checking on Jane's wellbeing post release and for contact to be made with Raven Housing to support an accommodation move. Police provided Jane with contact details for domestic abuse support services

and Jane indicated she would consider making contact. Two separate SCARF and VAAR submissions were submitted for Jane, assessing her vulnerability and needs required immediate specialist intervention.

ii. Although no DASH was completed, this was superseded by the NHS VAR and a referral to MARAC. Jane's home address was flagged on Police systems and a warning marker/flag that Jane was at risk of domestic abuse.

15.42 On her release from custody, Officers conveyed Jane home and provided her with a domestic abuse kit and gave a demonstration on how to use a door jammer for her ongoing safety. It was noted that her door already had 2 locks, a chain and bolt.

15.43 On the 6th January 2021, ASC received a call from Raven Housing, advising that Jane was smoking cannabis in her flat which breaches her tenancy, and she was abusive to her Warden that raised this with her. Advice was given to contact CMHRS if there were concerns about Jane's mental health.

15.44 On the 7th January 2021, MARAC research was tasked to an ESDAS Outreach Worker as the case was due to be heard at MARAC on the 21st January 2021. A phone call was made to Jane, there was no answer, but a message was left offering support. Two further attempts were made to Jane on the 8th and the 11th January 2021, offering support. There was no answer and messages were left on both occasions.

15.45 On the 21st January 2021, a MARAC meeting was held. Notes were added to Jane's record that ASC will try to encourage Jane to engage with ESDAS when she feels able. ASC records noted an action from MARAC to undertake a visit to Jane, but it was not clear which agency made this request nor which agency should undertake the visit. There was no record that a visit to Jane was undertaken by any agency following the MARAC.

15.46 On the 25th March 2021, Jane sent a text message to Raven Housing stating she intended to kill herself if she was not rehoused. Staff at Raven Housing tried to contact Jane, but without success and a request was made to Police to conduct an urgent welfare check.

i. Police contacted Jane by phone who was clearly in distress but declined any intervention by Police and was hostile to the prospect of Officers going to her house. The matter was passed to the South East Coast Ambulance Service (SECAmb), as it was a medical rather than a criminal issue.

ii. A safeguarding referral was made by Raven Housing and sent to SaBP MASH. On the 14th April 2021, a letter was sent by SaBP MASH to Jane's GP regarding Jane's threats to kill herself. The letter stated, "*it is your (the GP's) decision whether you feel the need to take any action in response to this or not*", rather than a clear request for support for Jane. No appointment was made for Jane with her GP following receipt of the letter.

15.47 On the 6th April 2021, Jane attended the Emergency Department via ambulance due to worsening chest pains, lower back pain and daily vomiting. She told the ambulance crew that she was unintentionally losing weight and that she had sustained some injuries from her partner but refused to go into detail. During the triage assessment she made the same disclosures regarding her partner to the nurse. No safeguarding concern was raised following Jane's disclosures of abuse.

15.48 On the 24th May 2021 and 8th June 2021, Jane wrote two letters to her GP. These letters were lengthy and handwritten, ranging across a wide number of different topics. These included Sam, her physical health and her fear of COVID, but reluctance to be immunised. The letter dated the 24th May 2021 states: "*I've had my head smashed open by John 3 times now, last time he had to call an ambulance. I have nowt to do with him anymore*". There was no record of any safeguarding referrals being completed by the GP or the information being shared with agencies.

15.49 On the 10th June 2021, staff at John's supported accommodation completed a safeguarding referral for John as he had disclosed being pushed by Jane. John had a recent fall on the 8th June 2021 and was taken to hospital, he self-discharged himself and went to Jane's address. They had an argument and John left. He was found by staff at his supported accommodation still in his hospital gown and immobile. John was bleeding and encouraged to attend hospital.

i. The referral was shared with ASC MASH, who concluded that S42 criteria was not met and the referral was passed to the ASC Substance Misuse Team for assessment.

15.50 On the 8th July 2021, John informed his Support Worker that he had been stabbed, punched and kicked whilst outside of Jane's address. Superficial healing wounds were observed on his arm. The Support Worker contacted staff at John's supported accommodation who were unaware of such an incident, but were aware John had a recent fall which resulted in bruising.

15.51 On the 22nd July 2021, the ASC Substance Misuse Team Manager met with John. It was noted that he was not addressing his physical health needs by attending hospital or GP appointments.

i. John agreed to a referral to Occupational Therapy, which was completed on the 5th August 2021. A response from Occupational Therapy was received on the 6th August 2021 stating that John, attending hospital or a GP would be the more suitable option as it does not appear that the Occupational Therapy Team are best suited to meet John's needs. On the 8th September 2021, a safeguarding referral was received by SaBP MASH and sent to ASC raising concerns regarding John's self-neglect. John was deemed to be in unsuitable accommodation for his physical needs.

ii. ASC Substance Misuse Team contacted Housing at Reigate & Banstead Borough Council who advised that John had declined suitable housing offered to him as he wished to remain in the Reigate area.

15.52 On the 1st September 2021, Jane attended the Emergency Department due to facial pain, toothache and a bleeding mouth ulcer. She did not wait to be seen. A clinician attempted to call Jane twice, but without success. Jane's GP was informed of her attendance and reported symptoms.

15.53 On the 4th September 2021, Jane attended the Emergency Department via an ambulance. She reported an injury to her hand by a knife whilst cooking and that this had happened 4 days ago. Once again, she did not wait to be seen. Jane's GP was informed of her attendance and reported injury.

15.54 On the 10th September 2021, ESDAS sent an email to MARAC as Jane was listed for a MARAC meeting on the 23rd September 2021, but no referral had been received. On the 13th September 2021, the ESDAS Outreach Worker made a call to Jane but there was no answer, a message was left advising Jane about the upcoming MARAC and offering support.

15.55 On the 14th September 2021, an email was received by ESDAS from the MARAC Team with an Outreach referral for Jane. The email also stated that Jane was recorded as the suspect in this particular incident. Two further attempts were made by ESDAS to contact Jane on the 15th September 2021 when Jane asked the Outreach Worker to call back later, and on the 16th September 2021 but there was no answer, a message was left to call ESDAS back.

15.56 On the 16th September 2021, Police attended an altercation between Jane and a male, which took place at John's supported accommodation. In order to de-escalate and diffuse the incident, Officers removed Jane and John from the accommodation and conveyed them both to Jane's home address where they stayed the night together.

i. John was described as struggling to get out of his chair, to stand up and to walk. He stated this was a by-product of brain damage that he had suffered after a series of falls. John also suffered with nerve damage and struggled to open the bottle of medicine he was required to take as it had the child-safe mechanism on the lid. John suffered a broken hip, and this was repaired with metal pins which caused him a great deal of discomfort. John was drinking four cans of lager a day and using prescribed painkillers. He was also taking antibiotics due to having his spleen removed. John refused to go to hospital.

ii. The Duty Manager at John's supported accommodation informed Officers that John would probably be asked to vacate his residency, as his presence was causing trauma and conflict for other vulnerable residents.

15.57 Given the documented history of domestic abuse perpetrated by John, Police acknowledge that taking Jane and John to Jane's accommodation would not

usually be a preferred course of action, however Officers were left to manage a dynamic situation with few available options.

i. The incident did not warrant arrest, John had no alternative accommodation, he had not been directly involved in the altercation and was presenting as highly vulnerable. In addition, Jane was requesting that they be taken to her home address in order that she could care for him.

ii. Jane and John had a desire to stay in each other's company and there was no legal basis to prevent their association. A SCARF report was completed and shared with ASC MASH. A decision was made that S42 criteria was met for John, but an enquiry did not take place. On the 23rd September 2021, John met with his Support Worker who completed a mental capacity assessment which concluded that John did not lack capacity to make his own decisions.

15.58 On the 22nd September 2021, Adult Social Care attempted to contact Jane following the recent Police incident. A message was left asking her to call ASC back.

15.59 On the 23rd September 2021, the MARAC meeting was held, actions agreed included for the Police Domestic Abuse Team to conduct a welfare visit to try and see Jane and encourage engagement with ESDAS.

i. SaBP wrote to Jane's GP following the MARAC regarding Jane's ongoing weight loss and raised a concern regarding self-neglect. The letter stated there was an outstanding S9 assessment, but that ASC and ESDAS were having difficulty engaging with Jane. ASC records from the MARAC meeting note that John was a "*very high-risk offender*". There was no record that a S9 assessment was completed for Jane.

15.60 On the 29th September 2021, Jane contacted Raven Housing threatening to kill herself if she was not offered support in an accommodation move. Raven Housing agreed that they would bid on properties for Jane until such time she was able to bid on them herself.

15.61 Police visited Jane on the 3rd October 2021 as agreed at MARAC. Jane said she was "*annoyed*" with all the visits and phone calls she was getting from Police and ESDAS. John was present at the address, Police report that he was lethargic, and Jane stated she was looking after him. Jane asked that she have less contact from support services as it was starting to "*annoy her*".

15.62 On the 6th October 2021, Jane self-referred to i-access and was sent a first appointment for the 11th October 2021. At her next appointment on the 18th October 2021, Jane mentioned domestic abuse from her ex-partner John and following a discussion with the i-access Team Manager, it was decided to raise a safeguarding concern until a further face-to-face discussion with Jane.

i. On the same day, John was served a notice to vacate his supported accommodation because he had been bringing Jane to his property which was contrary to his housing agreement.

15.63 On the 20th October 2021, a taxi was arranged to bring Jane to her next appointment with i-access, but she did not attend. i-access called Police to carry out a welfare check. Police attended Jane's address but received no reply. They then attended John's address and although Jane was not present, she was on the phone with John. It was confirmed that Jane had in fact been at home but had refused to answer the door to Officers.

i. Officers tried to engage with Jane but were repeatedly sworn at over the phone. It was concluded that at that time Jane was safe and well at home and an update was provided to i-access. Jane's appointment with i-access was rescheduled.

16. ANALYSIS

16.1 The Review Panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

16.2 Eleven organisations have provided Individual Management Reports (IMRs) detailing relevant contacts with Jane, John and Sam. MARAC completed a report for the Review. The Review Panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

16.3. The lessons learnt and recommendations / action plans to address them, are listed later in this report in Section 18 and 19.

16.4 The following is the Review Panel's analysis of the agencies' interventions:

Adult Social Care Surrey County Council (ASC)

16.5 Tenacious efforts were made to work with John who was often reluctant to engage with ASC and other support services. There was evidence of Multi-Agency liaison to try to support John's complex set of needs which spanned across health, housing and social care issues.

16.6 ASC MASH correctly identified the need for assessment of care and support needs and/or an adult safeguarding enquiry. However, there were instances where ASC did not meet duties under the Care Act including completing a S9 Care Act assessment of need for Jane, despite there being indications that there was a risk of abuse or neglect and adult safeguarding enquiries under S42 Care Act.

16.7 In October 2020, ASC received a referral from Raven Housing that Jane was feeling suicidal because of her unsuitable housing. ASC MASH reviewed the referral, recorded it as an adult safeguarding concern and determined that the

S42 Care Act criteria were not met. However, the person in the Lead Enquiry Officer wrote a recommendation of: *“no evidence or current risk of abuse or neglect and therefore not S42 but there may be some concerns of historical self-neglect and could therefore benefit from a S9 assessment."*

i. The person in the safeguarding adult decision maker role wrote: *“Whilst Jane does present with care and support needs, there is no indication that she is suffering from a form of abuse / neglect and that she is not able to protect herself from harm. It appears she has been contacting the appropriate agencies but may need an assessment to discuss her concerns and the main issue appears to be related to housing.”*

ii. The referral was passed to the Mental Health Duty Team, who recorded an outcome of 'no further action' on the 2nd November 2020, but no rationale for this decision was recorded.

16.8 The IMR Author noted that Raven Housing included information which appeared to show Jane had care and support needs. Jane should therefore have been offered an assessment under S9 Care Act. She would have either accepted that offer and the assessment taken place or, if she had refused the offer of an assessment, ASC should have proceeded with the assessment as far as possible as there was a risk of self-neglect (as per S11 Care Act and paragraph 6.20 Care and Support Statutory Guidance).

16.9 In January 2021, ASC record a case note following the MARAC meeting on the 21st January 2021 that states “*Action from MARAC - DA visit requested*”, but it does not say which agency made this request nor which agency this request was made to. It does not say what role ASC had to play, either in making or responding to this request. There is no record of any action taken by ASC following this MARAC meeting, or in response to the email by the Safeguarding Advisor.

16.10 Whilst there was evidence that S42 enquiries were completed for John, this was not always consistent when criteria appeared to be met. In January 2021, ASC MASH decided that S42 criteria was met for John and an adult safeguarding enquiry was needed. One did not take place. The adult safeguarding work was passed between three teams before being taken forward, but the work done did not include an adult safeguarding enquiry.

16.11 It was not clear to the IMR Author why the Safeguarding Advisor in the Reigate and Banstead team was offering an opinion about whether the S42 Care Act criteria were met. That decision had already been made by others and the case was not being dealt with within the team where the Safeguarding Advisor worked. In addition, a S9 Care Act assessment showed John had care and support needs that he had experienced or been at risk of abuse and the circumstances of the precipitating incident and the collateral information known to ASC would give reasonable cause for concern that he was not able to protect himself.

16.12 In June 2021 John's mobility worsened. John disclosed having a fall and also that he had been pushed by Jane. John was spending less time at his supported living placement as he was finding the stairs difficult. As a result, he was spending more time at Jane's home and this was having a negative impact on her.

16.13 ASC Substance Misuse team tried to get an Occupational Therapist involved to support a change in accommodation for John, but the Occupational Therapist declined to get involved recommending John needed to see his GP or go to hospital. This response seems to have been based on the reluctance John had to use health services.

i. ASC Substance Misuse team then contacted the District Council Housing Department and shared their concerns about the problems John's housing situation was causing him. The work with John on his health and accommodation issues was undertaken without noticing the impact that John living with Jane was having on Jane's emotional wellbeing and the risks to her were unrecognised.

Children Social Care Surrey County Council

16.14 Jane and her family had been known to Children Social Care from 1994, although there does not appear to have been the level of concern seen latterly, from 1994 through to 2003. Referrals evidenced a continuing pattern of domestic violence, mental health concerns and dependency issues, which culminated in Sam being brought into care. Jane's relationship with Sam was fractured after Jane took an overdose in 2017 and it was Sam who found her.

16.15 It was not clear what support services Jane accessed to attempt to address her problems and understand how these impacted on her parenting capacity, but as part of the Public Law Outline process before Care Proceedings were initiated, all of these areas of concern would have been laid out for her.

16.16 The primary focus of Children Social Care is on the child/children and how their needs will be best met. In Jane's case there were successive periods where her children were on Child Protection Plans and there must have been evidenced capacity to make improvements for these to have been stepped down or closed. It appears that Jane's ability to sustain change was compromised by the various challenges she faced.

16.17 One of the challenges in working with parents similar to Jane is how to assist them to access the support they need. Very often it is only the initiation of care proceedings, particularly when there are repeated cycles of child protection intervention that triggers a realisation that things must change.

16.18 Children Social Care response was consistent and ensured Sam was their primary focus. However, it is relatively unusual for children in care to distance themselves from their biological parents, which perhaps should have been subject to more scrutiny and restorative support than was evidenced.

East Surrey Domestic Abuse Services (ESDAS)

16.19 Jane was known to ESDAS since 2011, due to being a victim of domestic abuse perpetrated by John. She had accessed their support regarding injunctions/non molestation orders and liaison with housing to feel safer in her area.

16.20 There was mention of substance misuse from other agencies recorded in notes from MARAC, but this was not something Jane spoke with ESDAS about in terms of accessing support for addressing substance abuse/dependency.

16.21 Contact with Jane ceased completely between December 2013 and October 2019 and there were no notes of any contact or referrals in this period. Without a request for help, a referral notifying ESDAS of a risk or need for support or information from another agency they would not make unsolicited attempts to contact clients, so this gap in contact does not present as unusual or outside their historic and current working practices.

16.22 There were occasions where Jane was listed to be heard at an upcoming MARAC. When the ESDAS worker went to review the case record ahead of the MARAC, it was discovered that no referral had been received in relation to Jane regarding the incident prompting the MARAC referral.

16.23 Agreed practice dictates that any high-risk domestic abuse victim gets referred by Police to the relevant Domestic Abuse Service as part of the safeguarding actions they complete. A referral can be made without the victim's consent in high-risk cases, so ESDAS would have expected a referral, and would have made contact with Jane upon receipt of that as soon as possible.

16.24 On the 26th June 2020, ESDAS received an email from Raven Housing as a worker had concerns of domestic abuse in relation to Jane and knew ESDAS had previous been involved at a MARAC where Jane's case had been heard. This was an example of good practice and demonstrated not just the recognition of domestic abuse and the potential for a victim to need support, but for proactive information sharing to try and most safely and appropriately support Jane.

16.25 There were recorded mental health problems relating to Jane who disclosed agoraphobia and "*other mental health issues"* alongside financial difficulties which would have likely had an impact on her mental wellbeing as well. The correct multi-agency forum for sharing this information and seeking to create a plan of action to support Jane was the MARAC, due to domestic abuse being a significant factor suspected and notes indicate her case was discussed several times. This would have meant that those agencies had access to this information and the wider picture of Jane's lived experience could have been established.

16.26 ESDAS adhered to client led ethos, and information sharing was mutually demonstrated. Efforts were made to repeatedly offer support and advice to Jane at every available opportunity.

16.27 The fact that Jane did call the ESDAS office to request support with benefits shows that she had clearly felt able to reach out when she needed support, and highlights of those attempts being made to engage even when support was declined.

16.28 Some delay in receipt of Outreach referrals from Police may have caused an increased reluctance in Jane to engage. If ESDAS had managed to speak with her and offer support nearer the time of the incident prompting a referral, it is possible she may have felt more inclined or able to accept support and disclose her experiences. This is supposition and even when referrals were made in a timely manner, engagement attempts did not prove successful and were declined by Jane.

16.29 When Jane did disclose her mental health deterioration and struggles, the ESDAS worker ensured that the appropriate support was in place or being sought, so that other agencies were aware of these concerns and barriers for Jane in potentially accessing services such as the Job Centre.

16.30 There was good practice highlighted relating to information sharing by Raven Housing and ESDAS. There were positive, proactive attempts to offer support and advice to Jane and make ESDAS's service as accessible as possible.

16.31 No recommendations were made by the IMR Author.

Multi-Agency Risk Assessment Conferences (MARAC)

16.32 The MARAC Chair identified three meetings where Jane was the subject of discussion, the 21st May 2020, 21st January 2021 and the 23rd September 2021. These meeting were well attended, with representatives from the Police, Children and Adult Social Services, East Surrey Domestic Abuse Service, East Surrey Domestic Abuse Service, Surrey and Borders NHS Partnership, Probation Services and Housing.

16.33 The reason for the delays in these MARAC meetings taking place was due to agendas being set out two weeks in advance of each meeting. This meant that cases that came up in the fortnight prior to any MARAC meeting, if not treated as 'emergency cases', would normally have to wait until the next available meeting.

16.34 It was acknowledged by the MARAC Chair that no minutes were kept for these meetings, due to information shared being available on MODUS for all parties as were action plans, etc. This has since been addressed with Surrey County Council now employing a dedicated team of MARAC administrators who take and circulate minutes and actions in every meeting. MARAC administrative staff now have capacity to search MODUS for outstanding

actions and where repeat cases are discussed at MARAC, any outstanding actions are addressed by the Chair.

16.35 Good practice was identified by agencies on receiving the MARAC referrals, which are referenced in paragraphs 15.21,15.43 and 15.57.

Raven Housing Trust

16.36 Raven Housing had contact with Jane on a number of occasions during the timeframe of the Review. These contacts related to repairs to her property and requests to be moved to a property suitable for her needs.

16.37 Between June 2019 and August 2019, Jane had requested support in moving to another property as she wished to downsize (due to bedroom tax making her current property unaffordable). A number of appointments were made to support Jane, but she did not attend. Jane's next contact with regards to her need to downsize was in June 2020. Staff from Raven Housing assisted her with the downsizing application paperwork and a MASH referral completed.

16.38 Safeguarding referrals were not always completed for Jane. In February 2020 when Jane was distressed by the outcome of the decision made in relation to her housing, Jane threatened to take her own life and ended the call. There was no follow up for her wellbeing, such as requesting a welfare check or submitting a safeguarding referral to MASH.

16.39 In August 2020, Jane was offered a ground floor property suitable for her needs which she rejected. No further offers were made as this was a reasonable offer.

16.40 Raven Housing received a text message from Jane on the 29th September 2021, threatening to kill herself should she not be offered some support. Good practice was evidenced, whereby Raven Housing agreed that they would bid on properties for Jane until such time she was able to bid on them herself.

16.41 The IMR Author acknowledged that it had been difficult to engage with Jane throughout the life of her tenancy. Jane would reach out in times of crisis and once support had been offered/given, she would disengage. However, on the occasions Jane sought support, there was a willingness from staff to provide support whether that be home visits, phone calls or via text message.

Reigate & Banstead Borough Council Housing Team

16.42 The only communication had with Jane was through a housing application which was dealt with in line with their Housing Allocation Policy and Standard Procedures. Jane was housed in a Raven Housing property.

16.43 John was a complex adult with extensive offending, health and substance misuse issues. He was assisted into appropriate accommodation and involvement was fairly limited after this as Sanctuary Housing took over his support.

16.44 The IMR Author is satisfied that both cases with Jane and John were dealt with effectively and in line with legislation and appropriate tailored advice was given. Therefore, the Author does not wish to make any recommendations.

Sanctuary Supported Living

16.45 Sanctuary Supported Living supported John on his release from prison. During this time, all efforts were made to assist John and all safeguarding referrals made. No recommendations were made by the IMR Author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

16.46 The CMHRS Support Worker and Care Coordinator had contact with Jane for a long period of time. They provided practical support, attending appointments with Jane. They also provided advice on parenting and strategies, frequently liaising with Children Social Care.

16.47 There was repeated good practice of health professionals liaising with Jane's GP and sharing information. Individual practitioners were responsive and took extra steps to try and engage with Jane, addressing her needs and demonstrating a caring and compassionate approach. In addition, it was noted the importance for continuity in a CMHRS Support Worker to build a trusting relationship with Jane.

16.48 Relevant referrals for support were made on separate occasions such as a referral to Family Therapy which demonstrates that staff understood the importance of the 'Think Family'[20] approach. Timely referrals to other agencies were also noted, as were follow up contacts.

16.49 Appropriate referrals for support were also made for John and timely liaison and communication with other agencies was also noted. There are repeated good practice examples of health professionals liaising with the GP and regularly reviewing John's medications. Various contacts, such as telephone calls and home visits were undertaken in line with relevant guidance, allowing for timely risk assessments and the subsequent plans and review of medication.

16.50 The application of SaBP's internal policies and procedures was evident, such as Dual Diagnosis Policy and the Suicide Prevention Strategy. This strategy sets out SaBP's approach to reducing suicide in Surrey based on national and local intelligence/evidence, local learning and national suicide prevention recommendations. Co-produced training is delivered through the Recovery College. SaBP are also a part of the Zero Suicide Alliance. All SaBP staff now undergo Suicide Prevention Training through the 'Joiners Model'.

[20] "Think Family" - An approach which seeks to ensure that the support provided by relevant services is co-ordinated and focused on problems affecting the whole family.

16.51 The lack of routine questions about domestic abuse was evidently a significant theme. It was found that there was a vital indicator of domestic abuse as Jane had reported and professionals recorded: "*I get abused constantly*" and "*he gets nasty if he does not get his own way*". However, it was not clear from records whether professionals had asked Jane specifically about domestic abuse or considered her disclosures being related to domestic abuse. John was known as a domestic abuse perpetrator, but it was not clear from his records whether professionals had asked him specifically about domestic abuse or provided support or signposting to John.

16.52 Joint working across agencies, particularly with the housing department should have been more robust and practical. It was known and evident to all agencies that John was susceptible to falls. He sustained numerous injuries due to falls in the community, yet he was placed on the 3rd floor.

16.53 Whilst examining Jane's electronic records, record attachments, communications and letters, the IMR Author noted that Jane had mentioned her dog on several occasions (being fond of the dog). No support was considered around this topic, Animal Assisted Therapy (AAT) could have been recommended.

Surrey and Sussex Healthcare NHS Trust (SaSH)

16.54 According to SaSH records, Jane had a diagnoses of emotional unstable personality disorder, anxiety, depression, she was also known to misuse alcohol and other substances, mainly cannabis. There was a common theme throughout her attendances and admissions to Hospital that Jane would self-discharge against clinical advice. She either did not attend outpatient appointments, did not wait to be seen in the Emergency Department or took her own discharge.

16.55 Jane took three intentional mixed overdoses, the first was when Sam found her unconscious. The second overdose was almost exactly a year after the first and was a very serious attempt to end her life. Jane described her mood as very low since Sam had been in foster care for the past year and she sustained a long-term injury to her arm as she was laying in the same position for approximately 30 hours before she was found.

16.56 The third overdose on the 7th August 2019 was the first time in SaSH records that Jane mentions her ex-partner John. John was the person to raise the alarm when she had not been seen for 24 hours, although Jane does not name him. Jane was found to have had extensive bruising, which was photographed, and body mapped. Jane's mother believed she had been assaulted. A safeguarding concern was raised around Jane's unsuitable housing and mobility, but not about her bruising. There was no evidence of enquiry or discussion about a referral to domestic abuse support services.

16.57 In April 2021 during an attendance to the Emergency Department, Jane disclosed that her ex-partner John had caused some injuries to her and refused to discuss this any further. It does not appear that staff tried to

discuss this again during her attendance. She disclosed that since her last overdose she has been less well, has reduced mobility, was almost fully housebound, she was smoking nine cannabis joints a day and drinking 1.5 litres of wine a day. She was medically unwell, with a very low weight of 37kg. She had a chest infection and back pain but was assessed as being fit for discharge. It was documented that '*there are no safeguarding concerns*'.

16.58 In July 2021, Jane did not attend an appointment for a chest review. In September 2021 she presented with some facial pain and toothache but did not wait to be seen, three days later she attended with an infection to a knife wound on her hand which she claims was sustained four days prior whilst cooking. These could have been opportunities for routine enquiry by staff and may have resulted in disclosures by Jane. Jane did mention that her ex-partner/partner had harmed her on two occasions, but no name given. No action was taken by staff.

16.59 Throughout her admissions Jane was reported as being very anxious, sometimes aggressive particularly when wanting to self-discharge herself.

16.60 John attended hospital in the region of 40-50 times in the timeframe of the Review, often with reports of assaults, facial injuries, fractures, falling down stairs and serious injuries being sustained as a result. There are reports of his 'partner' calling the ambulance and accompanying him to the Emergency Department. There was no recorded name for his partner.

16.61 Neither Jane nor John are mentioned by name in the others medical notes as a next of kin or mentioned on admission as having a connection. The only recorded connection was that Jane's address was used as a temporary address for John. At the time of the documented events, it was not realised that there was a connection between them.

Surrey and Sussex Probation Service

16.62 Jane and John were not known to the Probation Service during the timeframe of the Review. However, they had prior contact with John over a number of years and Involvement with him ended in January 2018. Much of John's offending had been linked to drug use, in particular those of an acquisitive nature.

Surrey Heartlands Integrated Care Board (ICB) - For GPs

16.63 Jane was well known to her GP practice and had a close long-term professional relationship with her GP. The practice demonstrated good attempts to engage with Jane and to ensure her routine reviews were undertaken, even when she struggled to engage with services. All reasonable attempts were made to provide continuity of care, driven in part by other GPs, but also by Jane herself. The benefits of continuity of care in the doctor-patient relationship are well documented and it was clear from her medical records that Jane valued having one GP who, in her own words, "*knows about everything*".

16.64 Jane was recorded as experiencing agoraphobia and panic attacks from 2010 and appeared to have left her home as little as possible. It was of interest that the time periods covering the COVID-19 Pandemic, when most GP contacts moved to telephone/video appointments, they did not change the consulting pattern for Jane.

16.65 On the 12th August 2019 a discharge letter was sent from the Hospital to the GP. Jane had taken a large paracetamol overdose, with a delay in her being found. She was admitted to intensive care for five days; at the point of being deemed fit to move to a general ward, she self-discharged. The letter from psychiatric liaison professional found that she had no ongoing suicidal thoughts and did not require further mental health input. This was in the context of two life-threatening overdoses in the space of two years.

16.66 The surgery wrote to Jane on the 16th August 2019 asking her to make an appointment following her hospital admission, she spoke with her GP on the 9th September 2019**.** There does not appear to have been any discussion regarding her mental health or the circumstances leading up to the overdose which was a missed opportunity to explore her ongoing difficulties and whether Jane would benefit from further support and/or referrals.

16.67 On the 12th November 2020 Jane disclosed to her GP that she thought she had been assaulted under drug sedation by John three weeks earlier. She had not reported this to the Police, and her GP encouraged her to do so. There was no mention of signposting to the SARC[21], RASASC[22] and Domestic Abuse Outreach services which should have been at least discussed with her.

16.68 Jane wrote two letters to her GP dated the 24th May 2021 and the 8th June 2021. Within these letters, Jane states *"I've had my head smashed open by John three times now, last time he had to call an ambulance. I have nowt to do with him anymore".* There was no record to suggest this disclosure was noted or responded to by the practice.

16.69 John was registered at the same GP practice for a number of years. There is no suggestion that any of John's injuries were caused by a 3rd party, he was not known as a victim or perpetrator of domestic abuse. He was supported by the practice to the best of their ability, given the challenges of his frequent intoxication, difficulties engaging and at times, hostile approach to those trying to assist him.

Surrey Police

16.70 Surrey Police records detail a significant history of contacts and interactions with Jane and John. Police recognised the level of need required to support Jane's vulnerability and as the victim of domestic abuse. Police responded to

[21] SARCs (Sexual Assault Referral Centres) are specialist medical and forensic services for anyone who has been raped or sexually assaulted.
[22] RASASC (Rape and Sexual Abuse Support Centre) supports survivors of all genders over the age of 13 from across Surrey, who have been raped, sexually abused or have had an unwanted sexual experience.

incidents in a proportionate and sensitive manner and remained resolute in addressing Jane's safeguarding needs.

16.71 The IMR author was satisfied that detailed and timely SCARF notifications were implemented with a high level of compliance, which ensured relevant information was shared with partner agencies. Corresponding DASH and VAAR notifications were submitted in all cases where they were required. Several of these referrals provided a comprehensive account of the risks and level of need facing Jane.

16.72 On the 15th August 2019, Jane reported to Police that whilst she had been in hospital, John had stolen some items from her home address. The subsequent investigation conducted by Officers lasted approximately two months. In interview, John gave a prepared statement which confirmed his attendance at Jane's flat, but he denied taking any property without permission. Jane subsequently informed Officers that some of the reported missing items were in actual fact intended to be given to John, additionally a number of the reported missing items were later found in her flat. A supervisory review concluded that there was little prospect of a conviction and therefore the case was filed as no further action.

16.73 Officers assessed the level of risk of domestic abuse posed towards Jane as 'medium', indicating there are identifiable indicators of risk of serious harm. The definition of medium risk used by Surrey Police states *'the offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug, or alcohol misuse'.*

16.74 The assessment of 'medium 'risk was perhaps not commensurate to the seriousness of the offence, and as such, evidences that Officers recognised the high-risk indicators in Jane's history that required an enhanced response. This is further evidenced by the supervisor's comment that '*this is a high harm case with aggravating factors that raises the level of risk*.'

16.75 The IMR Author agreed with the decision to take no further action in this matter against John as evidential difficulties meant the threshold for a charging decision by the Crown Prosecution Service would not be met. However, the IMR Author identified that Police did not adopt a proactive approach in relation to the arrest of John, which did not take place until seven weeks after a statement had been provided by Jane. An explanation recorded within Police documentation suggests that a contributory factor to this oversight was an Officer's acknowledgement of supervisory error.

16.76 The IMR Author was unable to understand why an outreach referral took almost seven weeks to submit to ESDAS. Although it was acknowledged that as a 'medium' risk case, there could have been an issue with gaining consent to share Jane's information with partner agencies.

16.77 The IMR Author believes neither omissions are systemic issues, nor was it believed that John's late arrest directly impacted on Jane's safety as neither party are understood to have had any contact during the period leading up to John's arrest. However, by taking expeditious and prompt action in both instances, Officers may have afforded ESDAS the opportunity for a timelier

intervention with Jane and also aided the potential recovery of property in the criminal case by diminishing the opportunity for natural loss and disposal of evidence. Although it was important to note that as Jane chose not to engage with ESDAS on this occasion, the delay in referral submission was unlikely to have impacted on the outcome.

16.78 On the 15th December 2020 John reported to Police that he had been assaulted by Jane whilst at her home address. Whilst being interviewed, Jane made counter-allegations against John including assault, theft, threats to kill and rape.

i. The subsequent investigation undertaken by specialist Officers from the Safeguarding Investigation Unit lasted approximately three months, during which time John was arrested, interviewed and denied all the allegations. He stated that he believed they were malicious, made only in retaliation for Jane's arrest.

ii. John was placed on Police bail with conditions to neither contact Jane directly or indirectly nor attend her home address. There was no evidence to suggest that John breached the conditions imposed by Police, thus superseding the need for consideration of a Domestic Violence Protection Notice (DVPN)[23].

iii. The VAR conducted with Jane by an NHS practitioner whilst in Police custody recommended 'Crisis' mental health support and GP support, with a specific outreach request to "*assist Jane with signposting to relevant persons to see if contact could be made with Sam, to check on Jane's wellbeing post release and finally to support Jane regarding contact with her housing officer to enquire as to state of her move"*.

iv. The VAR form was then the responsibility of the NHS practitioner to forward to the relevant partner agencies. It was shared with the Officers in the Safeguarding Investigation Unit who offered Jane leaflets for outreach domestic abuse support in attempt to encourage her to engage with services. Jane indicated that engagement was something she would consider.

v. Although there was no evidence that a separate formal outreach referral was completed by the investigating Officers, submitting an additional outreach referral would only duplicate information already known to partner agencies and with the absence of new information, it would have been unlikely to change the provision of services offered to Jane at this time.

vi. Further safeguarding measures implemented by Surrey Police included the use of a Location of Interest Marker registered on the CAD system (Computer Aided Dispatch) in relation to Jane's home address. Together with domestic abuse warning markers/flags already placed on Jane's Police record. This ensured that Jane was highlighted to Officers attending her home address as being at significant risk of domestic abuse.

16.79 The IMR Author agreed with the decision to take no further action in this matter against John as evidential difficulties meant the threshold for a charging decision by the Crown Prosecution Service would not be met. The

[23] A DVPN is an emergency non-molestation and eviction notice which can be issued by the Police to a perpetrator, when attending to a domestic abuse incident.

IMR Author noted the high-risk domestic investigation was thorough and comprehensive, with the appropriate lines of enquiry and safeguarding measures pursued.

16.80 No recommendations were made by the IMR Author.

17. CONCLUSIONS

17.1 The Review Panel has formed the following conclusions after considering all of the evidence presented in the reports from those agencies that had contacts with Jane, John, Alex, Pat and Sam.

17.2 The Review Panel commends the agencies that had contact with Jane, John and their children for the thoroughness and transparency of their reports. Whilst all of the lessons identified will be addressed by the action plans set during this Review, many would not have had a significant bearing on the circumstances surrounding Jane's death. The Review Panel has however, recognised the following as being key issues, albeit some with the benefit of hindsight:

17.3 Jane experienced a number of significant traumas in her life, including childhood sexual abuse, domestic abuse, health conditions that caused her considerable pain and the removal of Sam from her care. Jane had two life threatening overdoses, resulting in admission to the ICU in the space of two years. There was a lack of professional curiosity into the circumstances of her overdoses.

17.4 Domestic abuse was identified by all agencies but does not appear to have been routinely discussed with Jane or John until a 'trigger incident' such as an assault or a MARAC referral.

17.5 Jane had a number of long-term professional relationships that may have provided her with a safe and supported environment to discuss her everyday experience of domestic abuse. There is evidence of Jane disclosing significant domestic abuse to her GP, but no safeguarding referrals were completed and so the information was not shared with support agencies to reflect a more accurate picture of the abuse Jane was experiencing.

17.6 At times where there had been a 'trigger incident' there is a suggestion that Jane may have felt overwhelmed by the volume of contact made with her from support agencies. There is benefit in using routine contact with victims to ask about domestic abuse.

17.7 There were missed opportunities to undertake S9[24] assessments and S42[25] enquiries for Jane and consider what additional support could be offered to her to keep her safe from abuse.

17.8 Domestic abuse has additional impacts on people with care and support needs. Perpetrators can use a victim's dependency to assert and maintain

[24] To assess whether a person requires some form of care and support, and whether the nature of their needs is such as the local authority will be under a duty to meet them.

[25] Ensures support to keep people safe who may be at risk of or experiencing abuse/neglect.

control. In particular, Jane's substance misuse and physical health needs may have made her feel increasingly dependent on John.

17.9 Whilst S42 enquiries were completed for John, this was not always consistent. Not completing appropriate assessments for Jane and John's care and support needs may have made them more reliant on each other for their care needs to be met.

17.10 There is evidence of a co-dependent relationship, but John and Jane were often considered separately by agencies. As such there are potential missed opportunities by agencies working with Jane and John to identify how their co-dependency was interlinked with emotional and psychological abuse.

17.11 When John's accommodation was deemed unsuitable for his physical needs and that he may be asked to leave, there was no consideration given to the likelihood he would go to Jane's address and the increased risk to Jane that this presented.

17.12 Whilst there is evidence of agencies recognising Jane's substance misuse issues, there is little analysis of the effect substance misuse can have on victims of domestic abuse, including how this can impact on their mental capacity, recollection of events, decision making and increased vulnerability.

17.13 The impact on Jane of losing the care of Sam does not appear to have been fully recognised by agencies. Jane's level of distress and substance abuse appears to escalate following Sam's removal. Recognition and response is required to meet the needs of parents whose children are removed from their care.

17.14 Evidence shows that removal of children has an '*immediate and enduring impact'* on women's lives. Women who have children removed from their care often have long-standing, entrenched and complex needs. In some cases, the removal of a child can lead to premature and preventable mortality (PAUSE, 2023)[26] and consideration should be given to the importance of agencies being more aware of the impact of child removal on women.

18. LESSONS LEARNED

18.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the action plan template in Section 19 of this report.

Adult Social Care Surrey County Council (ASC)

18.2 There were instances where ASC did not meet their duties under the Care Act, including carrying out adult safeguarding enquiries under S42 and completing a S9 Care Act assessment of need for Jane. This was despite there being indications that there was a risk of abuse or neglect, so an

[26] PAUSE (2023) https://www.pause.org.uk/news/pause-contributes-to-new-research-on-paper-youre-normal-narratives-of-unseen-health-needs-among-women-who-have-had-children-removed-from-their-care/

assessment should have taken place even if Jane had refused that assessment.

18.3 There was uncertainty at times whether work that ASC needed to do would be best done by their locality team, mental health team, or substance misuse team. It appears they lack a shared expectation about that.

18.4 Despite involvement with both Jane and John, ASC identified that the involvement was not as effective as it could have been in understanding where events in the life of one was having an impact on the other person. Jane and John's records could have been linked to assist staff.

Children Social Care Surrey County Council

18.5 Care proceedings are extremely difficult for parents and whilst there are attempts throughout the process to support parents, 'losing' a child to the care system would have further impacted on Jane's mental health.

18.6 There is a need to consider how best to access parents with substantial dependency issues and co-existing mental health issues at an earlier point and to work with agencies which can focus on the adult needs in parallel with those being worked on for the child.

18.7 Consideration of parental access to support within family care proceedings through referral to support services, may enable assessment and provision during and after any care proceedings have concluded. It must be remembered however, that a parent's willingness or ability to access support and/or treatment for issues impacting on their capacity to parent are key aspects of the evidence put before the Courts.

MARAC

18.8 At the time of referrals, MARACs were being heard monthly which proved to cause issues. A recommendation was made to hold MARACs on a fortnightly basis, with a two week 'cut-off' period for agencies to adequately prepare their research in good time for the meetings. This was agreed upon and changed from monthly to fortnightly in April 2021.

18.9 It was identified by the MARAC Chair that no minutes were kept from any of the three meetings held. At that time, it was believed that this was not necessary, due to the information shared being available on MODUS[27] to all parties as were action plans. The MARAC Chair confirmed that other than information pertaining to attendees, there was little information to adduce in relation to the actual meetings. Minutes are now taken at all MARAC meetings.

[27] Modus is a case management system developed over many years working alongside domestic abuse agencies to enable them to record, monitor and process their client records with an intuitive and reliable design.

Raven Housing Trust

18.10 Raven Housing Trust identified that there was not a uniformity of actions when staff had a safeguarding concern. There were also occasions where safeguarding referrals were not always completed for Jane.

Reigate and Banstead Borough Council Housing Team

18.11 The housing team had limited involvement with Jane and John. No learning was identified by the IMR Author.

Sanctuary Support Living

18.12 This service had involvement with John. No learning was identified by the IMR Author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

18.13 There is a need for staff to exercise professional curiosity regarding routine questions around domestic abuse, which will now be included in the Trust's Safeguarding Training and reminders in team meetings.

18.14 Information from SCARF reports were not robustly analysed. SCARF/MASH processes are currently being reviewed internally.

Surrey and Sussex Healthcare NHS Trust (SaSH)

18.15 Both Jane and John lived chaotic lifestyles where they were frequently coming to harm, whether that be self-harm, accidental or abuse as a result of poor mental health and substance dependency. Their compliance and engagement was a barrier to receiving help and support.

18.16 There was a lack of routine and selective enquiry around the causes of the injuries to both adults. It was accepted that it had been caused by an assault, a fall down the stairs or over the dog.

18.17 Since the timeframe of this review, better connections with the local domestic abuse services and mental health teams have been established. SaSH have a HIDVA[28] in post since May 2021, and during the past two years there is a raised awareness and visibility and empowered staff. The workforce is more familiar with the onward referral mechanisms and the support that is available, including MARAC. Of note is that funding for the HIDVA role is due to be withdrawn in March 2024, the need to continue this role is evident every day in the work undertaken and the outcomes for survivors.

18.18 SaSH also have a Frequent Attenders meeting whereby patients who frequently attend the Emergency Department are reviewed and consideration is given for onward referral for additional support services.

[28] HIDVA (Health Independent Domestic Violence Advice Service) work with healthcare staff and patients to improve the identification of domestic abuse and ensure referrals are made for further support.

Surrey Heartlands Integrated Care Board (ICB) - For GPs

18.19 Previous Surrey DHRs with similar themes to this case have also demonstrated how one individual practitioner can become overwhelmed by both the complexity and chronicity of a patient's problems and the risk exists of losing focus and objectivity.

18.20 Surrey Heartlands ICB acknowledge that learning from this case should be shared, to support practices in developing clinical and safeguarding supervision for patients with multiple complex long-term problems. Safeguarding supervision sessions have been in place for practice safeguarding leads since the end of 2021. GP practices are encouraged to develop their own supervision pathways alongside these.

18.21 The two letters from ASC MASH in April 2021 and October 2021 provide helpful information in relation to specific issues, but the intended and desired outcome is not sufficiently clear and can be too easily lost in a huge amount of incoming correspondence in any agency. Professionals need to be clear in the requests they are making to other teams and agencies and clearly communicate reasonable and realistic expectations.

18.22 There is a further missed opportunity in May 2021 when Jane disclosed being physically assaulted by John on three occasions. There is no reference to any safeguarding referrals being made or contact with support agencies to share this information. No GP appointment was offered to Jane following receipt of this information.

18.23 Jane's difficulties in engaging with services meant that she did not always receive the services and follow up appointments that she could have benefited from. Whilst it is difficult to draw any recommendations from this, practitioners need to be mindful of continuing to support engagement in those individuals who have difficulties doing so. The role of supervision for frontline staff can help maintain objectivity and focus, and to explore different avenues to support engagement. This could help to mitigate against a sense of professional helplessness.

Surrey Police

18.24 The IMR Author submits that Surrey Police responded to incidents in a proportionate and sensitive manner and remained resolute in addressing Jane and John's safeguarding needs. No learning was identified by the IMR Author.

19. RECOMMENDATIONS

19.1 The DHR Panel's recommendations and up to date action plan at the time of concluding the Review on 14th August 2023 are detailed in the template below.

Adult Social Care Surrey County Council

Recommendation	Scope of recommendation i.e local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Include the learning from this DHR in the work ASC have underway to address similar learning from other reviews where we may not have met our statutory duties under s9, s11(2) and s42 Care Act 2014.	Local	The Director of Adult Social Services for Surrey Adult Social Care will deliver sessions to all our staff at Team Manager level and above on the statutory duties under S9, S11(2) and S42 Care Act 2014. The Principal Social Worker and / or Head of Adult Safeguarding will deliver in-depth sessions to all staff at Team Manager level and above on our statutory duties under S9, S11(2) and S42 Care Act 2014, which includes the learning from this SAR as a case study. Team Managers to use the materials from the sessions they attended with the Principal Social Worker / Head of Adult Safeguarding to	Adult Social Care SCC	To have included the learning from this DHR in relation to meeting statutory duties under s9, s11(2) and s42 Care Act in the materials we are using for our work to improve our practice on these issues.	30th April 2023 30th April 2023 30th Sep 2023	**Completed** **Completed**

		cascade sessions to their teams and services.				
Share the learning from this review about the uncertainty about which of our teams was best placed to take forward work with Jane and John with our Quality Improvement Group and ask them to consider how this can be avoided in future.	Local	Put an action plan in place with the steps Adult Social Care will take to act on this learning.	Adult Social Care SCC	The Head of Adult Safeguarding gave a presentation to the Quality Improvement Group on the learning for ASC regarding the uncertainty about which of the ASC teams was best placed to take forward work. For the Quality Improvement Group to have agreed a plan on the actions needed to address this learning.	31 July 2023 31st Oct 2023	**Completed**

Children Social Care Surrey County Council (CSC)

Recommendation	Scope of recommendation i.e local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
For Children and Adult focused services to have a "Think Family" approach to families with multi-layered vulnerabilities.	Local	Where both Children Services and Adult focused services are involved with a family simultaneously, albeit for different reasons, that they take a whole family approach to ensure that all agencies contribute to and are aware of the holistic needs of the family as a whole.	CSC Surrey County Council	Children's Services network meetings (Child in Need/Child Protection/Looked After Children) are visible within the child's record and have representation from Adult/adult focussed services where appropriate to ensure that all professionals are aware of the family's whole picture.	Ongoing	
Where children become estranged from parents post Care Order, that this is explored at every Looked After Child Review and efforts are made to try and reconnect families at a level that is achievable for them.	Local	Regular review of contact arrangements between parents and their children who are in care, and continued risk evaluation to ascertain if contact is in the best interest of children and how relationships can be supported and maintained with parents/ family.	Children Social Care SCC	Needs and risks are regularly reviewed to ensure that the issue of contact is consistently assessed.	Ongoing	

MARAC

Recommendation	Scope of recommendation i.e local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Formal minutes to be taken at every MARAC meeting, to ensure all information is accurately recorded.	Local	Surrey County Council to employ administrators to take formal minutes at MARAC meetings.	Surrey County Council	A dedicated team of MARAC administrators have now been employed to SCC since July 2022, who take and circulate minutes and actions in every meeting.		**July 2022**
The frequency of MARAC meetings to be reviewed. MARAC meetings are currently being held on a monthly basis.	Local	With the increasing volume of referrals to the MARAC and delays of up to 30 days before referrals could be considered at MARAC meetings, meetings should be held fortnightly to reduce both the number of cases considered at each meeting and subsequently waiting times.	Surrey County Council	In March 2021, fortnightly MARAC meetings were introduced to reduce the time between meetings and reduce the time between referral and MARAC case discussion		**April 2022**

Raven Housing Trust

Recommendation	Scope of recommendation i.e local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
Principles of basic safeguarding to be highlighted to all new members of staff, regardless of their role in the organisation.	Local	Safeguarding is now part of the corporate induction for all new starters meaning that all newcomers have at least a basic knowledge of the organisation's role within the safeguarding process and who to consult should they have concerns.	Raven Housing Trust	Induction Courses run on a quarterly basis for all new staff to ensure they are aware of the signs to look out for relating to safeguarding concerns.	Ongoing	
Training awareness on safeguarding to be implemented for all staff on an annual basis.	Local	Mandatory online learning package has been developed with regards to safeguarding which must be completed on an annual basis by all members of staff no matter their level within the organisation.	Raven Housing Trust	Ensure staff, especially those visiting homes, are aware of signs to look for relating to safeguarding concerns.	Ongoing	

Surrey and Borders Partnership NHS Foundation Trust

Recommendation	Scope of recommendation i.e local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
To embed professional curiosity around domestic abuse in daily practice and signpost to appropriate services.	Local	a) To make DA routine questions mandatory - currently ongoing work including liaison with SystmOne (S1) Department. b) Analysis of SCARF reports to be improved - currently ongoing work within the Trust c) Raise the profile of DA and routine enquiry by showcasing best practice. This is to be included in the planned learning events and Safeguarding Conference later in 2023. We will endeavour to focus on domestic abuse across the life course.	SaBP	Introduction of a New forum - Ambassadors against Domestic Abuse. Learning from this Review was addressed at the SaBP learning event on the 3rd May 2023. The session provided an opportunity to identify gaps and offer peer support.	Ongoing May 2023	**Completed**
Understanding the mindsets and behaviours of perpetrators of domestic abuse and violence.	Local	To understand the mindsets and behaviours of perpetrators who abuse to disrupt safeguarding from	SaBP	SaBP to explore implementation of the Alleged/Suspected Perpetrator	Ongoing	

		occurring, seeking to end the cycle of abuse (NHSE Safeguarding), and ability to signpost to relevant local service.		Screening Tool and liaise with East Surrey Domestic Abuse Services (ESDAS) as to how we can progress this work and to link with Surrey wide perpetrator service.		

Surrey and Sussex Healthcare NHS Trust

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion
To ensure ongoing funding and partnerships are continued between local domestic abuse services and acute healthcare providers in the form of the HIDVA role continuing long term.	Local / National	Communicate the importance and need for this role at every opportunity.	Surrey Heartlands ICB/ Surrey County Council	In the 2-year project that we have had a HIDVA in post working alongside the Safeguarding teams, we have seen an increase in awareness, referrals and support being provided for survivors of Domestic Abuse.	31st March 2024	

Surrey Heartlands Integrated Care Board (ICB) - For GPs

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date
Learning from this case is shared and used to support practices in developing clinical and safeguarding supervision for patients with multiple complex long-term problems.	Local	Learning is embedded into level 3 primary care safeguarding updates and safeguarding supervision for practice leads.	ICB (designated GP for safeguarding)	Domestic abuse training day scheduled for 7th June 2023. Supervision sessions June and September 2023.	September 2023	
Surrey-wide safeguarding update training for GPs and other clinicians includes the recognition of high-risk domestic abuse, and recommended referrals/actions resulting from this.	Local	Level 3 update sessions in 2023 include high-risk DA and response.	ICB (designated GP for safeguarding)	DA training day 7th June 2023. Level 3 safeguarding updates September and November 2023.	December 2023	

APPENDIX A - GLOSSARY

AAT	Animal Assisted Therapy
ABH	Actual Bodily Harm
ASC	Adult Social Care
CAD	Computer Aided Dispatch
CJLDS	Criminal Justice Liaison Diversion Service
CMHRS	Community Mental Health Recovery Service
CPN	Community Psychiatric Nurse
DASH	Domestic Abuse Stalking and Harassment
DBT	Dialectical Behavioural Therapy
DHR	Domestic Homicide Review
DPD	Dissocial Personality Disorder
DVPN	Domestic Violence Prevention Notice
DWP	Department of Work and Pensions
EFT	Emotional Freedom Techniques
ESA	Employment Support Allowance
ESDAS	East Surrey Domestic Abuse Services
GP	General Practitioner
HDU	High Dependency Unit
HIDVA	Health Independent Domestic Violence Advice Service
ICB	Integrated Care Board
ICU	Intensive Care Unit
IMR	Internal Management Review
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
PIP	Personal Independence Payment
ONS	Office of National Statistics
RASASC	Rape and Sexual Abuse Support Centre
S9	Section 9
S42	Section 42
SAB	Safeguarding Adults Board
SaBP	Surrey and Borders Partnership
SAR	Safeguarding Adults Review
SARC	Sexual Assault Referral Centre
SaSH	Surrey and Sussex Healthcare
SCARF	Single Combined Assessment of Risk Form
SECAmb	South East Central Ambulance Service
VAAR	Vulnerable Adults at Risk
VAR	Vulnerability Assessment Report
VRI	Video Recorded Interview

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
1.- Include the learning from this DHR in the work ASC have underway to address similar learning from other reviews where we may not have met our statutory duties under s9, s11(2) and s42 Care Act 2014.	Local	The Director of Adult Social Services for Surrey Adult Social Care will deliver sessions to all our staff at Team Manager level and above on the statutory duties under S9, S11(2) and S42 Care Act 2014. The Principal Social Worker and / or Head of Adult Safeguarding will deliver in-depth sessions to all staff at Team Manager level and above on our statutory duties	Adult Social Care SCC	To have included the learning from this DHR in relation to meeting statutory duties under s9, s11(2) and s42 Care Act in the materials we are using for our work to improve our practice on these issues.	30th April 2023 30th April 2023	**Action completed**

		under S9, S11(2) and S42 Care Act 2014, which includes the learning from this SAR as a case study. Team Managers to use the materials from the sessions they attended with the Principal Social Worker / Head of Adult Safeguarding to cascade sessions to their teams and services.			30th Sep 2023	**Action completed**
2.- Share the learning from this review about the uncertainty about which of our teams was best placed to take forward work with Jane and John with our Quality Improvement Group and ask them to consider how	Local	Put an action plan in place with the steps Adult Social Care will take to act on this learning.	Adult Social Care SCC	The Head of Adult Safeguarding gave a presentation to the Quality Improvement Group on the learning for ASC regarding the uncertainty about which of the ASC teams was best	31 July 2023	**Action completed**

this can be avoided in future.				placed to take forward work. For the Quality Improvement Group to have agreed a plan on the actions needed to address this learning.	31st Oct 2023	**Action completed**
3.-For Children and Adult Focused services to have a "Think Family"approach to families with multi-layered vulnerabilities.	Local	Where both Children Services and Adult focused services are involved with a family simultaneously, albeit for different reasons, that they take a whole family approach to ensure that all agencies contribute to and are aware of the holistic needs of the family as a whole.	CSC Surrey County Council	Children's Services network meetings (Child in Need/Child Protection/Looked After Children) are visible within the child's record and have representation from Adult/adult focussed services where appropriate to ensure that all professionals are aware of the family's whole picture.	**Action ongoing**	**Action ongoing**

4.- Where children become estranged from parents post Care Order, that this is explored at every Looked After Child Review and efforts are made to try and reconnect families at a level that is achievable for them.	Local	Regular review of contact arrangements between parents and their children who are in care, and continued risk evaluation to ascertain if contact is in the best interest of children and how relationships can be supported and maintained with parents/ family.	Children Social Care SCC	Needs and risks are regularly reviewed to ensure that the issue of contact is consistently assessed.	**Action ongoing**	**Action ongoing**
5.- Formal minutes to be taken at every MARAC meeting, to ensure all information is accurately recorded	Local	Surrey County Council to employ administrators to take formal minutes at MARAC meetings.	Surrey County Council	A dedicated team of MARAC administrators have now been employed to SCC since July 2022, who take and circulate minutes and actions in every meeting.		**July 2022**
6.- The frequency of MARAC meetings to be reviewed.	Local	With the increasing volume of referrals to the MARAC and delays of up to 30	Surrey County Council	In March 2021, fortnightly MARAC meetings were introduced to reduce the time between		**April 2022**

MARAC meetings are currently being held on a monthly basis.		days before referrals could be considered at MARAC meetings, meetings should be held fortnightly to reduce both the number of cases considered at each meeting and subsequently waiting times.		meetings and reduce the time between referral and MARAC case discussion		
7.- Principles of basic safeguarding to be highlighted to all new members of staff, regardless of their role in the organisation.	Local	Safeguarding is now part of the corporate induction for all new starters meaning that all newcomers have at least a basic knowledge of the organisation's role within the safeguarding process and who to consult should they have concerns.	Raven Housing Trust	Induction Courses run on a quarterly basis for all new staff to ensure they are aware of the signs to look out for relating to safeguarding concerns.	Ongoing	**Action ongoing**

8.- Training awareness on safeguarding to be implemented for all staff on an annual basis.	Local	Mandatory online learning package has been developed with regards to safeguarding which must be completed on an annual basis by all members of staff no matter their level within the organisation.	Raven Housing Trust	Ensure staff, especially those visiting homes, are aware of signs to look for relating to safeguarding concerns.		**Action ongoing**
9.- To embed professional curiosity around domestic abuse in daily practice and signpost to appropriate services. Understanding the mindsets and behaviors of perpetrators of domestic abuse and violence.	Local	a) To make DA routine questions mandatory - currently ongoing work including liaison with SystmOne (S1) Department. b) Analysis of SCARF reports to be improved - currently ongoing work within the Trust c) Raise the profile of DA and	SaBP	Introduction of a New forum - Ambassadors against Domestic Abuse. Learning from this Review was addressed at the SaBP learning event on the 3rd May 2023. The session provided an opportunity to	ongoing Completed	**Action ongoing**

		routine enquiry by showcasing best practice. This is to be included in the planned learning events and Safeguarding Conference later in 2023. We will endeavour to focus on domestic abuse across the life course. To understand the mindsets and behaviours of perpetrators who abuse to disrupt safeguarding from occurring, seeking to end the cycle of abuse (NHSE Safeguarding), and ability to signpost to relevant local service.		identify gaps and offer peer support. SaBP to explore implementation of the Alleged/Suspected Perpetrator Screening Tool and liaise with East Surrey Domestic Abuse Services (ESDAS) as to how we can progress this work and to link with Surrey wide perpetrator service.		
10.- To ensure ongoing funding and partnerships	Local	Communicate the importance and need for this role	Surrey Heartlands ICB/ Surrey	In the 2-year project that we have had a HIDVA in post	Ongoing	**Action ongoing**

are continued between local domestic abuse services and acute healthcare providers in the form of the HIDVA role continuing long term.		at every opportunity.	County Council	working alongside the Safeguarding teams, we have seen an increase in awareness, referrals and support being provided for survivors of Domestic Abuse.		
11.- Learning from this case is shared and used to support practices in developing clinical and safeguarding supervision for patients with multiple complex long-term problems.	Local	Learning is embedded into level 3 primary care safeguarding updates and safeguarding supervision for practice leads.	ICB (designated GP for safeguarding)	Domestic abuse training day scheduled for 7th June 2023. Supervision sessions June and September 2023.		**Action ongoing**
12.- Surrey-wide safeguarding update training for GPs and other clinicians includes the recognition of high-risk domestic abuse, and recommended referrals/actions resulting from this.	Local	Level 3 update sessions in 2023 include high-risk DA and response.	ICB (designated GP for safeguarding)	DA training day 7th June 2023. Level 3 safeguarding updates September and November 2023.		**Action ongoing**

Appendix C -
position statement

Publication Statement

Joint Domestic Homicide Review/Safeguarding Adults Review

'Jane'

The Surrey Safeguarding Adults Board (SSAB) in collaboration with Reigate & Banstead community safety partnership (CSP) has today published the findings of a joint Domestic Homicide Review (DHR) & Safeguarding Adult Review (SAR) regarding Jane.

This review was jointly commissioned to ensure that there was an independent review of the circumstances surrounding the death of Jane, in order to identify any insights and learning about the ways in which professionals and agencies worked together to safeguard her.

The purpose of this review is to promote learning and improve practice, not to re-investigate or to apportion blame. As well as highlighting areas of good practice, the review identified important learning and key areas for further improvement both locally and nationally.

Jane's family have suffered a great loss, and we thank those who knew Jane and contributed to the review

The review considered the following specific issues.

• Children and Adult focused services to have a "Think Family" approach to families with multi-layered vulnerabilities.

• Embedding professional curiosity around domestic abuse in daily practice and signpost to appropriate services.

• Awareness on safeguarding to be implemented for all staff on an annual basis

As well as highlighting good practice, the review identified important learning and key areas for further improvement both locally and nationally.

Both the SSAB and the CSP accepts the recommendations in full and will work with agencies to share and embed this learning within respective organisations and the wider system. The SSAB and CSP will hold involved agencies to account and seek assurance that the recommendations are implemented and also monitor the impact of changes to ensure that others are protected in the future.

Teresa Bell,
Independent Chair
Surrey Safeguarding Adults Board
May 2025