Content warning: over 18s only

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

OVERVIEW REPORT

of the

Domestic Homicide and Safeguarding Adult Review

(FINAL)

relating to the death of Mary in November 2017

on behalf of:

REIGATE AND BANSTEAD COMMUNITY SAFETY PARTNERSHIP

&

SURREY SAFEGUARDING ADULTS BOARD

Report author: **Liz Borthwick**
Independent Chair

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1.0 PREFACE

1.1 This report of a Domestic Homicide Review examines agency responses and support given to Mary and her family before her death in November 2017. The Panel determined that the criteria for a DHR had been met under the DHR Statutory Guidance 2016 (paras 5(1), 18 and 27c)[1]
It important to note that Mary's death was unexpected. The official cause of death was confirmed at her inquest October 2020. The coroner stated in the Regulation 28 Report, that Mary died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time.
The DHR Review also seeks to understand the issues and family dynamics in the build-up to Mary's unexpected death. This will include:
i) Whether support was accessed within the community
ii) Whether there are identified gaps in provision
iii) Whether there were any barriers to accessing support.

By taking a holistic approach the review seeks to identify appropriate solutions to make the future safer.

1.2 DHR: Domestic Homicide Reviews became statutory under Section 9 of the Domestic Violence, Crime and Adult Act 2004 and came into force on 13 April 2011. The Act requires 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 person to whom they were either related, in an intimate personal relationship with or living with in the same household.

1.2.1 The Home Office defines domestic violence as:
Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.
Controlling behaviour is:

a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour. Coercive behaviour is an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim'. (These types of behaviours[2] are referred to as CCB (Coercive Controlling Behaviour) throughout the document).

[1] DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)
[2] Legislation relating to CCB.
Controlling or Coercive Behaviour in an Intimate or Family Relationship | The Crown Prosecution Service (cps.gov.uk)

This domestic abuse definition also includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.
It was expanded to include apparent suicides within abusive relationships in subsequent guidance. [3]

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

1.2.3 Suicide / unexplained death: Where there is a concern that a suicide was related to a history of domestic abuse, including Coercive Controlling Behaviours, this should also be considered for a DHR[4]. Families bereaved by a domestic homicide or by a suicide where domestic abuse was involved will have a wide range of support needs.

1.3 SAR: Safeguarding Adult Review:

Under the 2014 Care Act, Safeguarding Adults Boards (SABs), are responsible for Safeguarding Adults Reviews (SARs). SABs must arrange a SAR 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.

1.3.1 The statutory guidance (updated in 2018) to support implementation sets out the purpose of SARs, and principles for their conduct.[5]

Action to safeguard adults should include:

- promoting well-being and preventing abuse and neglect from happening in the first place
- ensuring the safety and wellbeing of anyone who has been subject to abuse or neglect.
- involving all those who can offer support and impact on reducing risk.
- taking action against those responsible for abuse or neglect taking place
- learning lessons and making changes that could prevent similar abuse or neglect happening to other people.

1.4 Time scales: The review will consider agencies' contact / involvement with the family. The review began March 2018 and concluded with submission to the Home Office in September 2020.
The Home Office agreed to the extension of the standard six-month deadline due to the additional parallel investigations, criminal court hearings and inquest.

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[3] Controlling or Coercive behaviour (CCB) HO guidancehttps://www.gov.uk/government/publications/statutory-guidance-framework-controlling-or-coercive-behaviour-in-an-intimate-or-family-relationship
[4] Suicide related to DA – HO Guidance https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/806951/Guidance_for_DHR_chairs_support_for_families.pdf
[5] SARs guidance https://www.gov..uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

1.5 Incident: The purpose of this review is to examine the circumstances surrounding Mary's tragic death, whose lifeless body was discovered by police officers **late November 2017**. Mary was found slumped on her knees against an upstairs door with a dressing gown cord tight around her neck. It appeared that this had been attached to a hook at the top of the door.

1.6 Confidentiality: The detailed findings of each review are confidential. Information is available only to participating officers / professionals and their line managers. A confidentiality agreement has been signed at each meeting of the DHR Panel.

1.7 Dissemination: The Executive Overview Report and Recommendations have been redacted to ensure confidentiality, with pseudonyms used for the subject (Mary) and her family. The reports have been disseminated to the following groups:

- Reigate and Banstead Community Safety Partnership
- Surrey Safeguarding Children Partnership
- Surrey Safeguarding Adults Board
- Surrey Community Safety Board
- Surrey DHR Oversight Group
- Surrey Domestic Abuse Management Board
- The Leader of the local Council and relevant Portfolio Holders in the Borough where the death occurred.
- East Surrey DA Working Group
- The Office of Surrey Police & Crime Commissioner (OPCC)
- The agencies involved on the DHR Panel (See Appendix 1)
- Mary's family

1.8 The DHR panel members wish to thank the family, friends and colleagues who participated in the review. We understand what a difficult time this must be and offer our sincerest sympathies on their tragic loss.

2.0 DETAILS OF THE INCIDENT

2.1 On the morning Mary died in **November 2017,** Police from the local Safer Neighbourhood team initially attended her home to check on her welfare, as she had been identified as a high-risk domestic abuse subject. Whilst in attendance at the premises, a neighbour approached officers also flagging concern for Mary. Officers immediately forced entry into Mary's home in Surrey and her lifeless body was discovered in the first-floor bathroom. She was found slumped with her knees up against the door with a dressing gown cord around her neck. A hook was attached to the cord which appears to have been attached to the top of the door. There were no significant injuries to Mary's body, the premises were secure and apart a broken wine glass in the bedroom, there were no signs of a disturbance. The police found a mobile phone next to her body which revealed that the last text messages she had sent were all to Gary.

2.2 At the time of Mary's death she was living alone in Surrey; her eldest child, Ashley aged 11, was residing with the natural father and Frankie (5) and Charlie (3) had been taken into foster care. In the **7 months** leading to her death in **November 2017**, Mary had contact with the police on **fourteen occasions** reporting that her relationship with Gary was becoming increasingly abusive and violent.

2.3 Mary's death prompted a thorough police investigation. Although the initial examination of the scene did not identify any involvement of another party, Mary's significant and recent domestic abuse history prompted consideration of a manslaughter investigation. Enquiries revealed that from the afternoon before she died until the early hours of the day of her death, Mary had been in Gary's company, despite him being subject to a restraining order not to have contact. The police Domestic Abuse Force Advisor reviewed the domestic abuse suffered by Mary and confirmed that it amounted to coercive controlling behaviour (CCB).

2.4 The police inquiry found no evidence of another person being involved in Mary's death in **November 2017** and concluded that sometime after 07.21 hrs on the day she died (last text sent) that Mary hanged herself in the bathroom of her house. The autopsy concluded by the Home Office pathologist determined that the cause of death was hanging, with the overall appearance of a case of self-suspension. Post-mortem enquiries revealed that Mary had significantly high levels of cocaine and alcohol in her system at the time of death. The Coroner called the DHR / SAR Chair as a witness during the proceedings. The Coroner concluded that the cause of death was hanging. It was not possible to determine whether Mary had intended to kill herself or whether she hoped she would be found in time.

It was reported that Gary had frequently visited Mary at her home and raised voices in the early hours were a regular occurrence. Mary's mental health and drug addiction were common knowledge in the local community. Two witnesses stated that they had seen Mary and Gary on together on the night before her death, in a local public house, stating they both seemed happy, chatting openly about how they were going to get the kids back.

3.0 THE DHR and SAR REVIEW

3.1 Surrey Police notified the East Surrey Community Safety Partnership (ESCSP) of Mary's death in January 2018. The ESCSP met in January 2018 and decided that the criteria for a DHR had been met. Liz Borthwick was appointed as Independent Chair, supported by Debbie Stitt as DHR coordinator (see Section 6.1 below).

3.2 The DHR was commissioned by ESCSP in accordance with the revised Statutory Guidance for the conduct of Domestic Homicide Review[6] published by the Home Office in December 2016. Following submission of their IMR, an Adult Safeguarding Review (SAR) was commissioned by the Surrey Safeguarding Adult Board.

3.3 It was agreed that the DHR and SAR would be a joint review. The DHR/SAR Panel included representatives from the Surrey Safeguarding Adult Board (SSAB). The ESCSP and the SSAB received regular updates on progress of the joint review and both had the opportunity to Quality Assure the report to ensure compliance with the DHR and SAR process.

3.5 The Chair of ESCSP notified the Home Office in January 2018 that there would be a DHR, followed by a further update in October 2019 that it would be a combined DHR / SAR. The Home Office agreed to extend the initial 6-month deadline (and to further extensions on several subsequent occasions) due to the numerous parallel processes taking place including a criminal court hearing (November 2018) and two Preliminary Inquest Reviews (August 2019 and October 2019). The inquest took place in October 2020. The DHR Chair attended as a witness at the Coroner's request. The Coroner stated in the Regulation 28 Report, that Mary died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time. (see para 1.1).

4 TERMS OF REFERENCE

4.1 Joint DHR / SAR Terms of Reference were agreed by the DHR / SAR Panel at their first meeting in 2018and were regularly reviewed and amended as further details of the incident emerged (see Appendix 2 for the final version.).

5. PARALLEL INVESTIGATIONS AND RELATED PROCESSES

5.1 *Inquest*
Preliminary Inquest Reviews (PIRs) were held on **9 August and 24 October 2019** and the inquest took place in **October 2020.** The DHR Independent Chair attended the Inquest as a witness. The outcome of the inquest has been detailed in paragraph 1.1: The coroner stated in the Regulation 28 Report, that Mary died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time.

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[6] https://www..gov..uk/government/uploads/system/uploads/attachment_data/file/575273/DHR-Statutory-Guidance-161206..pdf

5.2 ***Criminal Trial***

Gary was arrested for breach of a Restraining Order prohibiting him from any contact with Mary and manslaughter involving the criminal offence coercive control. The CPS authorised charges related to four separate breaches of a Restraining Order. At the criminal trial held in November **2018**, Mary's father became a witness for Gary, providing evidence that Gary only breached the order out of concern for Mary and the children. As a result, there was only one nominal finding of one breach of the Order. Mary's father also refuted allegations that Gary had ever acted in a controlling way towards Mary, stated that he (Gary) had only ever acted in her best interests. There was no evidence to put to the CPS regarding a possible manslaughter charge.

5.3 ***Care Proceedings***

The Care Proceedings agreed that the children would be placed as follows:

- Ashley to live with birth father and partner.
- Frankie to live with birth father and partner.
- Charlie to live with paternal aunt under a Special Guardianship Order (SGO).

5.4 ***Police Disciplinary Investigation***

Following a formal complaint by Mary's father to the police, the case was referred to the Independent Office of Police Complaints (IOPC). The IOPC referred the case back to Surrey Police's internal Professional Standards Department (PSD) who investigated the complaint. The PSD found that correct procedures were followed and there was no evidence of misconduct. This view was confirmed by the IOPC. A further appeal by Mary's father was not upheld.

5.5 ***Surrey Children's Social Care (CSC) Investigation***

CSC[7] carried out an internal investigation following a breach of inappropriate information sharing. Mary's father lodged a claim against Surrey County Council under the Human Rights Act 1998 and negligence under the Fatal Accidents 1996. Although out of time, SCC and Mary's father, via his lawyer, have agreed to defer this investigation (a 'limitation holiday') until after the result of the inquest was known.

6.0 PANEL MEMBERSHIP AND REPRESENTATIVES

6.1 ***Panel Membership:*** The Panel consisted of senior representatives from the following agencies (see **Appendix 1** for full list of officer attendees):

- Surrey Police
- Surrey Safeguarding Adult Board
- Surrey Safeguarding Children Partnership
- Surrey County Council Children's Social Care Services
- Independent DHR/SAR Coordinator
- Surrey County Council Adult Social Care

[7] Children's Social Care, Surrey County Council (previously Surrey Children's Services)

- Surrey Wide Safeguarding Team, Surrey Clinical Commissioning Groups (CCGs)
- Surrey and Borders Partnership Foundation NHS Trust (SaBPT)
- East Surrey Domestic Abuse Services (ESDAS)
- Primary Care

The panel met 5 times along with significant communication via email.

6.2 *Independence of Chair*
The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council. Liz left this position in 2015, with a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also chaired several joint DHR / Serious Case Reviews on behalf of the Home Office and Ofsted. Liz has no connection with the local Borough or any of the agencies in this case.

6.3 *Co-ordination*: Debbie Stitt was commissioned by the CSP to provide co-ordination and administration of the DHR/SAR process, including arranging meetings and taking minutes. Debbie has worked in Community Safety for many years and has a thorough understanding and knowledge of domestic abuse and the statutory processes involved in DHRs. Debbie has attended Home Office training in the running and delivery of DHRs and regularly attends AAFDA training.

7.0 SUBJECTS OF THE REVIEW

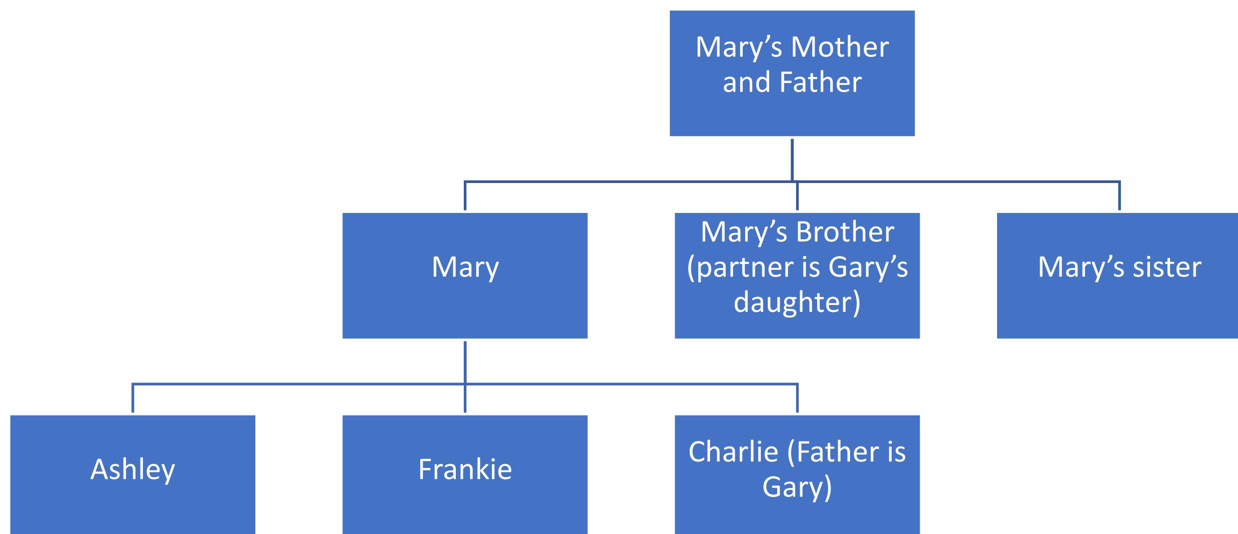
The main subjects of this review are:

DHR subject	Date of birth	Date of death
Mary - deceased suicide victim (female adult)	xx.xx.1988	**November 2017**
Gary - ex partner and perpetrator of controlling coercive behaviour	xx.xx.1974	
Ashley – child of Mary and her first partner	xx.xx.2006	
Frankie - child of Mary and her second partner	xx.xx.2012	
Charlie - child of Mary and Gary	xx.xx.2014	

Significant others and relationships

Mary's father	
Mary's mother	
Ashley's father and partner	
Frankie's father and partner	
Gary's first wife	Jane

The genogram below describes Mary's family.



8.0 METHODOLOGY

8.1 Contributors to the Review

8.1.1 Statutory and Voluntary Agencies:

Surrey agencies who may have been involved were requested to submit an Individual Management Review (IMR) in accordance with the statutory guidance. Agencies were asked to detail their involvement with Mary, Gary and the children for the timeframe June 2006-November 2017 but also to include any relevant contact before June 2006. Authors were independent of the incident and the reports were Quality Assured by the organisation. Those with no involvement were invited to submit a 'nil return'. IMRs were received from:

- Surrey Police (the Police)
- Surrey County Council Adult Social Care Services (ASC)
- Surrey County Council Children Social Care Surrey (CSC)

- Primary Care (Surrey GPs)
- Surrey and Borders Partnership Foundation NHS Trust (SaBPT)
- Surrey and Sussex Healthcare NHS Trust (SASH)
- Children and Family Health Surrey (CFHS)
- Central Surrey Health (Community Health Provider)
- Epsom & St Helier NHS Trust
- Registered Social Landlord
- Catalyst
- SECAMB
- Surrey Borough Council
- East Surrey Domestic Abuse Service (ESDAS)
- School's Children Centre
- In addition, further information was provided from MARAC[8]minutes and the Agreed Final Threshold for the care of the children.
- Surry and Sussex Health Care NHS Trust identified that they had no contact with Mary, Gary or the family.
- Drug and Alcohol Services: Catalyst
  Catalyst provided an IMR for the review and were also interviewed by the Independent Chair and invited to review the final report in their role as the largest provider of drug and alcohol services in Surrey. This provided further expertise and challenge to the review.

The Panel reviewed the IMRs, giving detailed consideration and professional challenge to the final documents, which have contributed significantly to this report.

8.1.2 Involvement of Family, Friends, Work Colleagues, Neighbours and the wider community

Information has been supplemented through conversations with friends to understand the personal backgrounds of Mary, Gary and the children.
Research by the Independent Chair relating to Mary, Gary and the children took place through telephone conversations as detailed below, Individuals were provided with the relevant Home Office leaflet (for family, friends, employers and colleagues) in advance. All those contributing was able to do so using the medium they preferred.

Two close friends of Mary were able to provide information about the 'voice of the victim'.

8.1.3 Contact with the families: Mary's family were provided with the Home Office Guidance leaflet for families, including information about advocacy at the start of the DHR. They have been updated regularly throughout the Review but chose not to participate.
The Independent Chair was unable to obtain information on contacting Gary. It appears that no agencies have up to date information on his whereabouts.

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[8] MARAC Multi-agency Risk Assessment Conference [Multi agency risk assessment conferences - Healthy Surrey]

8.1.4 Interviews with the children: Feedback from the eldest child Ashley was considered. However, close family members stated that the child had already gone through significant trauma and did not want to talk about the death. The Panel agreed that the voices of the children could be represented through information provided in the IMRs.

9.0 EQUALITIES

9.1 Mary was a 29-year-old heterosexual white British woman when she died. Mary's relationship began with Gary in **2012**.

9.2 Gary is a heterosexual white British man who was 44 years old at the time of Mary's death.

9.3 The nine protected characteristics of the Equality Act 2010 were considered (age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation). Two of these characteristics were considered by the Panel to have had an impact; *sex/gender* and *pregnancy*. These characteristics will be considered later within this report.

10.0 KEY PRACTICE EPISODES:

Social Care Institute for Excellence (SCIE)-Learning Together [9]

10.1 A wealth of information has been made available for this review through detailed IMRs along with MARAC minutes and information from the Care Proceedings. The Independent Chair and the DHR Panel agreed to utilise the SCIE model "Learning together" to identify the key episodes in Mary's life.

10.2 The Key Practice Episodes (KPEs) are identified below and will be referred to throughout the report.

- **KPE One:** Mary's teenage years
- **KPE Two:** Mary's young adult life and relationship with males
- **KPE Three:** Mary and Gary's relationship –substance misuse, mental health Issues and domestic abuse
- **KPE Four:** Child protection concerns for Ashley, Frankie and Charlie
- **KPE Five:** Mary seeking support
- **KPE Six:** Increasing violence and coercive controlling behaviour by Gary
- **KPE Seven:** Further child protection concerns for Ashley, Frankie and Charlie
- **KPE Eight:** Gary, high risk domestic abuse perpetrator
- **KPE Nine:** Police protection for the children
- **KPE Ten:** Mary's death

11. OVERVIEW OF MARY'S LIFE

This section describes Mary's life up until 2008.

[9] Scie: https://www..scie..org..uk/children/learningtogether/

KPE ONE: MARY'S FAMILY LIFE AND TEENAGE YEARS

11.1 Mary was born in 1988 in Surrey. Her parents have been married for over 35 years and Mary has an elder sister and younger brother. Mary's brother was involved in a relationship with Gary's eldest daughter. Mary became involved with several agencies when she was 14 years old. In **November 2002,** at the age of 14, Mary took an overdose following an argument with her parents (*Source: GP IMR*). Evidence from contact between Mary's father and Children's Social Care (CSC) indicates that Mary had a difficult relationship with her parents during her teenage years, highlighting reported aggression and violence between them although this is now disputed by Mary's parents (*Source: CSC IMR*).

Mary was initially referred to Children and Adolescent Mental Health Services (CAMHS) in **November 2002** after this incident of self-harm. An assessment at the time recorded Mary as being sexually active and "inappropriate with men. This flags concerns about victim blaming (as she was a child and unable to consent to sex) and that she may have been groomed which was not recognised). The records also stated that Mary's parents were finding her challenging to control due to behavioural difficulties and by **January 2003** her parents stated that they were unable to cope with her behaviour and were asking for her to be accommodated by Children Services. CAMHS made a referral to Children's Social Care (CSC) but there appears to have been no action taken. In **2003** CAMHS were unable to make further contact with Mary and her case was closed. (*Sources: GP and SaBPT IMRs),*

Mary became known to the police in **September 2003** when still living with her parents and siblings. Mary was reported to be playing truant and going missing from home. On one occasion she was discovered in the flat of a man who owned a takeaway shop again flagging possible grooming and Child Sexual Exploitation (CSE) however this was not identified at the time in any agency IMR. Police were called again to the family home address when Mary had allegedly assaulted her sister and was refusing to leave the family home at her father's request. Mary was described as having "anger management" issues. (*Source: Police IMR*).

12.0 VOICE OF THE VICTIM

(based on information provided by friends and IMRs)

12.1 Mary

Mary was described by her friends as being very beautiful, fun, and intelligent, strong willed and felt "she was always right". Her children meant everything to her. One of her friends stated 'Mary was very bright and a good person, very good with the children; she would read to them and play with them. Mary did have a few jobs as a cleaner, but it was difficult having children, so she was really a stay-at-home mum. Her friend felt that Mary did have an addictive personality, but that it was Gary who had introduced her to drugs. Mary's parenting skills were undoubtedly affected by the abuse she experienced, including drug use.
Mary's family has chosen not to engage in this process so there is limited further information.

13.0 THE FACTS

The below information has been drawn from a range of sources; the IMRs submitted by agencies (referenced where appropriate) and interviews with friends.

KPE TWO: MARY'S YOUNG ADULT LIFE AND RELATIONSHIP WITH MALES (2008 - 2014)

13.1. Mary met her first partner in **2005** and they started a relationship whilst both were students at a law school. Initially the relationship was very good, and they lived together. Their child Ashley was born in **August 2006**. Due to Mary's age (18 years old), previous mental health history and a disclosure that she had used cannabis and cocaine, she received a 'universal plus' health care service from CFHS [10](*Source: CFHS IMR*).

During this relationship the police were called by her partner twice. In **January 2008** when Mary allegedly damaged his car; this allegation was withdrawn shortly afterwards. **In February 2008** the police were called again as Mary had attended her partner's home address and damaged the front door trying to gain entry. Mary was cautioned for this offence. (*Source: Police IMR*). At this time Mary and her partner also came to the attention of CSC. A report in **2008** stated that Ashley had witnessed Mary being hit and that Ashley was swearing at eighteen months old. CSC carried out an initial assessment of the family, but no action was taken. (*Source: CSC IMR*). There is no evidence to suggest that she was asked about DA at that time. Mary and Ashley's father separated in **2009**. When they split up, it was reported that Mary appeared well supported by her family and especially her mother. At the time, concerns were raised by Mary's GP regarding her mental health and attempts were made by the health visitor to offer support to Mary, but she did not engage.

Mary had an unplanned pregnancy in **2010** resulting in a termination. She had a planned pregnancy in **2011** which unfortunately ended in an early miscarriage. *(Source: GP IMR)*

Mary continued to suffer from mental health issues and in **March 2011** she was seen by her GP and was referred to the Community Mental Health Recovery Service (CMHRS)[11] in **April 2011** for further support. *(Source: GP IMR*).

13.2 Mary met her second partner around **2011** and they appeared to have a good relationship. He bought a house and they moved in together. Shortly after the birth of their child Frankie in **January 2012**, they split up as he appears to have struggled to cope with the two small children. In March **2012** Mary went to his home with Frankie and caused damage to the front door. The police were contacted and on arrival Mary was distressed and refusing to leave. At the time, the DASH[12] recorded the incident as Standard Risk, a safeguarding referral was completed for Frankie and shared with health, CSC and a referral to ESDAS (*Sources: Police* CSC *and ESDAS IMRs*).
Frankie's father was unwilling to support a prosecution. In **May 2012** he alleged that Mary had continually called him requesting that they get back together, and she became abusive when he refused. He also received abusive emails. Frankie's father was assessed as being at

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[10] CFHS Home :Children and Family Health Surrey (childrenshealthsurrey.nhs.uk)
[11] Community Mental Health Recovery Services
https://www.sabp.nhs.uk/our-services/mental-health/community-services
[12] DASH: Domestic Abuse, Stalking and Harassment and Honour Based Violence Risk Identification and Assessment Checklist.

Standard Risk of harm and a safeguarding referral was completed for Frankie. Mary was told to cease any direct contact with her ex-partner in accordance with his wishes, which she complied with. (*Source: Police IMR*)

13.3 Following the police reports of these incidents and a referral from maternity services, the health visiting services tried to engage with Mary to increase their understanding of the impact of substance misuse upon her parenting capacity. Support was offered to Mary to address her own emotional needs and how it could impact on her ability to meet the needs of her children. (*Source: CFHS IMR*)

KPE THREE: MARY and GARY'S RELATIONSHIP (including substance misuse, mental health and domestic abuse) and early concern for the children 2014-2015

13.4 Mary met Gary in **2012**. At the time he was married and had two children with his wife Jane. Gary had a minor criminal record when he met Mary but there were no previous convictions for domestic abuse. Gary worked in the family cleaning business but changing demands meant he soon had significant debt and faced bankruptcy. Gary had been found in possession of drugs and there was police intelligence that he supplied cocaine, amphetamine and cannabis. Information indicated that Mary and Gary were both involved in substance misuse and that drugs appeared to be a dynamic in their relationship. Mary alleged that Gary supplied her with drugs in order to control her. *(Source: Police IMR).*

This may have been the first recorded incident of CCB.

13.5 A female (thought to be Mary) and Gary were involved in a minor incident in **October 2013** when the female went to buy cigarettes from a local shop. The female was challenged about her age and she threatened to get her boyfriend who would "not be pleased". Gary arrived and verbally abused the shopkeeper who was fearful of being assaulted. Gary was interviewed by the police but refused to name the female he was with. From the description of the female and the fact that she stated she had two children; the police believed it was Mary with Gary. (*Source: Police IMR*).

13.6 Early **April 2014** Mary became pregnant with Gary's baby **Charlie**. Mary visited her GP and said that the pregnancy was planned with Gary but that he had left and was staying with his mother. Mary said she "*felt low, was not coping and could not be bothered*". One IMR states that Mary had considered ending the pregnancy several times. Mary was referred to CMHRS for an urgent Psychiatric assessment with the GP stating that Mary was ***"****tearful, not getting out of bed, strained relationship with partner". Mary had thoughts of self-harm but would not "because of the children"*. (*Source: GP IMR*) There is no evidence that she was asked about DA.

13.7 Mary's appointment letter for a psychiatric assessment was sent to a previous address so she was unable to attend. She was contacted by the mental health team late **April 2014** and

said she was feeling better and being supported by the midwife. The midwife had compiled a plan for Mary to recommence her fluoxetine[13]. (*Source: SaBPT IMR*)

13.8 The midwife contacted CSC in **April 2014** because Mary had disclosed that she had experienced domestic abuse in a previous relationship and that since she became pregnant, her relationship with Gary was deteriorating. Following discussion, the midwife agreed to monitor the situation and refer if necessary. Late **April 2014** the midwife re-referred because traces of cocaine had been found in Mary's urine even though Mary said she had not taken cocaine since **December 2013**. The case was referred for Children and Family assessment[14]. Two weeks later a further urine sample again showed positive for cocaine. Mary now admitted to taking drugs stating that she was scared to admit to this in front of Gary as he was 'anti-drugs'. Police intelligence suggests this was not the case and he had significant drug involvement. This is another example of possible CCB. A contract was drawn up with Mary and Gary regarding cooperating with professionals and ceasing substance misuse. Charlie was born prematurely in **August 2014** and bloods on birth identified recent cocaine use by Mary. As a result, an Initial Child Protection Conference (ICPC)[15] was convened and all three children became the subject of Child Protection Plans under the criteria of neglect. The Child Protection Plan included the requirement that Mary should be drug tested through hair-strand analysis and that a full parenting assessment of both parents should be completed. (*Source CSC IMR*) However there is no evidence that Gary was required to undertake the same which may have compounded Mary's sense of isolation and repeat victimization.

13.9 On 27 November 2014 Mary called 999 and informed the operator that Gary's ex-wife Jane had made a threatening / abusive phone call to her. Mary went on to describe that Jane had previously attended her home and attacked her, spat at her in the street and threatened to throw acid in her face. In the background the operator heard a man (believed to be Gary) becoming agitated, telling Mary to put the phone down. Mary told the operator that she wanted to sort the situation out and that phoning the police would cause problems as Gary and Jane had children together. The operator was concerned about the behaviour of the man and officers attended the address. Frankie and Charlie were in the house at the time of the visit and Mary made a statement. The police spoke with Jane and she admitted phoning Mary but stated that it was Mary who was abusive to her and she had retaliated. Jane denied making any threats. Mary and Gary were advised by the police that the matter could not progress as there was no supporting evidence. A DASH does not appear to have been completed in relation to Mary despite the call operators concerns.
Mary alleged that Jane had spat in her face at a nail bar in **October 2014**. The owner of the nail bar provided a witness statement which supported Mary's account. Jane denied the assault. The OIC (Officer in Charge) had enough evidence to obtain a summons against Jane and informed Mary, who stated she now did not want it to go to court as this would cause problems for Gary who was progressing his divorce and negotiating access to his children.

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[13] Fluoxetine is an antidepressant used for the treatment of major depressive disorder.
[14] Children & Families Assessment is the assessment process used in children's social care which replaced initial and core assessment.
[15] The local authority will call an Initial child protection conference when they have investigated concerns about child abuse and they believe a child is suffering or likely to suffer, significant harm.

(Evidence of CCB and the power Gary has over Mary). No further action was therefore taken by the police. (*Source: Police IMR*).

13.10 In May 2015 a Child Protection Conference Review took place and as no agency had expressed any concerns about the children it was decided that the Child Protection Plans and CSC involvement should cease.

13.11 On **18 September 2015**, Mary contacted the police as Gary was refusing to leave the house and had become argumentative. Mary alleged that the previous day Gary had gone through her phone and smashed it and she described him as being controlling. (Evidence of CCB). Later, Mary called the police back and said Gary had left. Police officers tried to return her call on her mobile but there was no answer. The following day, police officers attended the address and Gary answered the door. Mary was spoken to and agreed to make contact to complete a risk assessment but stated that she had no mobile phone. As Mary did not make contact, the police again visited the house. Gary answered the door and was hostile and aggressive. Mary eventually came to the door with Charlie in her arms. The police officer observed that Mary was calm, had no visible injuries and that Charlie appeared happy and healthy. This may have been a protective approach to calm Gary when he was being aggressive and reflects further evidence of CCB. A DASH[16] risk assessment was completed and recorded as Standard Risk and a Safeguarding referral Child at Risk form was completed and shared with CSC, health and education. (*Source: Police IMR*). The case was allocated for a Children and Family Assessment however Mary denied that there we significant problems and the case was closed by CSC two weeks later (*Source: CSC IMR*).

13.12 On **20 December 2015** Mary drove to Gary's first wife's house (Jane), as she had discovered that Gary had stayed there the night before. Jane came out of the house (possibly armed with a knife) and they both traded threats and abuse. During this incident, Mary deliberately drove her car at Jane causing her to jump out of the way. Mary also damaged a car belonging to a third party. When the police arrived, they found Mary in her car hysterical, Jane shouting from an upstairs window and Gary in the driveway also shouting and refusing to assist the police in any way. Three children were at the address. A Safeguarding referral was completed for the children at the property and Mary was arrested. Gary later told the police that "*his relationship with Mary had become turbulent and that she remained paranoid and jealous of his relationship with Jane*". He also said that Mary had historic problems with depression and recreational drug use. This is a potential example of victim blaming by Gary and attempts to groom professionals which is a common tactic used by perpetrators of CCB. During Mary's interview, she told officers that her relationship with Gary was good and that they were looking for a larger house together. (*Source: Police IMR*). During her time in custody Mary was assessed by Criminal Justice Liaison Diversion Service (CJLDS)[17] and disclosed that she had anxiety and depression but denied any thoughts of self-harm. (*Source: SaBPT*). CSC were also contacted, and the family were visited once by a social worker. Mary and Gary denied that Mary had taken drugs and he said that she was a good mother. However, this is

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[17] Criminal Justice Liaison Diversion Service provides access to healthcare and support service for vulnerable young people who come into contact with the criminal justice system and pre-sentence.

contrary to the view Gary had given to the police above; if this had been cross checked professionals may have identified grooming and CCB behaviours earlier. In February 2016 CSC closed the case as there had been no further incidents. (*Source: CSC IMR*).

13.13 The investigation resulted in Mary being charged with criminal damage to a motor vehicle, driving without due care and attention and a Section 4 Public Order Act. She pleaded guilty to all the offences and received fines and 4 penalty points on her driving license. Jane received a summons for Section 4 Public Order Act and pleaded guilty and received a fine. At the time of the offence Charlie was at home being looked after by Mary's father. A Safeguarding referral was again submitted for Charlie. (*Source: Police IMR*).

KPE FOUR: CHILD PROTECTION ISSUES 2014 - 2016

13.14 Overview:
Evidence shows that the children were suffering neglect due to Mary and Gary's drug abuse and her mental health issues. Mary was experiencing DA and CCB which had an impact on her parenting although this appears not to have been recognised by the professionals at the time. Charlie was born prematurely with cocaine in the child's system. Prior to discharge from hospital a health strategy meeting took place around concerns for Charlie. Gary said he did not understand why CSC were involved as he minimised Mary's drug use. (*Source: CFHSS IMR*)

13.15 A Child Protection Conference was convened, and all the three children (Ashley, Frankie and Charlie) became subjects of a Child Protection Plan under the criteria of neglect. The Child Protection Plan included the requirement that Mary undertook drug testing through hair strand analysis and that a full parenting assessment of Mary and Gary should be completed. *(Source: CSC IMR).* However, there is no evidence to suggest that Gary was required to address his drug use or behaviour under the CPP.

13.16 The midwife and health visitor continued to support Mary. In **August 2014** it was noted that Mary was responding to Charlie and Frankie in a warm appropriate manner and was responsive to their needs. A health visitor asked Mary about domestic abuse and she reported that she had difficulties with a previous partner but denied any abuse in her current relationship. *(Source: CFHS IMR).*

13.17 In line with the system within CSC in **2015** there was a change of social worker soon after the Child Protection Plan was agreed. The new social worker visited the family for six months and saw the children regularly in the family home although there is no evidence that the children were seen without Mary and Gary. Surrey Drug and Alcohol Service (SADAS)[18] informed the social worker that Mary had presented for an assessment and confirmed she was on the waiting list for counselling. SADAS confirmed that they could not carry out drug testing which would need to be bought privately. The worker seeing Mary reported that she thought that there may be aspects of coercive and controlling behaviour by Gary in relation to Mary. There is no evidence that this information was shared. During this period up until **April 2015**,

[18] Surrey Drug and Alcohol Service is no longer functioning. Since 2015 this service has been delivered by Catalyst https://www.catalystsupport.org.uk/drug-and-alcohol-services-surrey/

there was no evidence that Mary was using cocaine but there was no drug testing confirmation. The parenting assessment was not completed. The social worker left in **March 2015**.

13.18 No concern was expressed by any agency about the care of the children during this period and in **May 2015** a Review Child Protection Conference decided that the Child Protection Plan should cease along with involvement by CSC. (*Source: CSC IMR*). The police did not attend the review conference, as per normal practice, but sent a report to the meeting that Mary had been the victim of an assault by a woman who spat in her face. They also stated that there was "soft intelligence" that cocaine was being stored at her home although this could have been down to Gary given his known drug involvement. This was discussed at the meeting, but it was not felt to be a justification for continuing the plan as it considered the information could be malicious. (*Source: CSC, Police IMRs)*.

KPE FIVE: MARY SEEKING SUPPORT.

13.19 In April 2016 Mary referred herself to Catalyst[19] and was initially given brief interventions and harm reduction advice that included her attending SMART[20]. An assessment indicated that Mary wanted to become drug free. A meeting between a counsellor and Mary was arranged but the date needed to be changed. When Catalyst contacted Mary, she said she was clean and doing "okay" (*Source*: *Catalyst IMR).*

13.20 In **May 2016,** the police sent a report to CSC stating that that Mary had reported Gary had been drunk, and that there had been an argument which woke the children (further evidence of domestic abuse). Mary declined an offer of Domestic Outreach Abuse Services (*Source: CSC IMR*). A DASH risk assessment was recorded as standard risk and a 39/24[21] was completed for the children who were in the house at the time but were described by the police as being happy and playing. *(Source: Police IMR)*

KPE SIX: INCREASING MUTUAL VIOLENCE AND COERCIVE CONTROLLING BEHAVIOUR BY GARY WITHIN THE RELATIONSHIP

13.21 In **November 2016,** CSC received a referral from Mary's father who asked to remain anonymous. He was worried about Mary's mental health and thought she was using drugs again. The Duty social worker contacted Frankie's school who confirmed that there were concerns of poor school attendance and an incident when Frankie had grabbed a knife and thrown it at Mary. (*Source: CFHS IMR*). A Children and Family Assessment was completed in **January 2017** with a recommendation for a Child in Need Plan (CIN)[22]. The plan was to ensure that Mary could meet the needs of the children and to establish the role of Gary in the children's lives. The CIN meeting was held in **February 2017** and attended by all professionals, Mary

[19] Catalyst –a non- profit organisation working with people who are dealing with issues relating to substance misuse and mental health.
[20] SMART-Self -Management and Recovery Training support groups (alcohol and drugs)
[21] 39/24: The name of the safeguarding referral form at the time – now SCARF
[22] A child in need is defined under the Children Act 1989 as a child who is unlikely to achieve or maintain a reasonable level of health or development or whose health and development is likely to be significantly or further impaired, without the provision of services.

and Ashley's father, but Gary did not attend. At the meeting it was agreed that there was no further role for CSC and that the case would be referred to the local Family Support programme (FSP).[23] (*Source: CSC IMR*). It is not known whether the referral to the FSP included details of the domestic abuse that Mary was experiencing or whether a referral to ESDAS was made.

At the same time Mary was in significant rent arrears and her Registered Social Landlord (RSL) was preparing to take legal action. Mary met with the RSL and advised that she was suffering anxiety / mental health issues and that her parents had promised to clear the debt before the court hearing **17 January 2017**. (*Source: RSL & ESDAS IMRs*).

13.22 On **25 March 2017** Mary and Gary were witnessed having an argument. Mary arrived at the location in her car and Gary in his. During the altercation Mary was alleged to have assaulted Gary and kicked his car before returning to her own. (Police IMR)

Charlie was in Mary's vehicle when she drove it into Gary's car. The police attended, confirmed the damage to Gary's car and identified Gary as the victim in this incident. Gary refused to assist in the investigation or complete a DASH form. He said that he and Mary were living apart. The police visited Mary a few days later. Mary denied any assault or causing any damage to the car and only admitted to having had an argument with Gary. Charlie was in the house when the police visited and was reported to be happy and healthy. The incident was given a risk rating of Standard and generated an Outreach referral for Gary and a Safeguarding referral for Charlie. (*Source: Police IMR*). The matter was dealt with within the MASH (now Surrey Children's Single Point of Access (C-SPA)[24] and it was originally allocated for a Children and Family (C&F) Assessment[25]. Following a MASH threshold review it was agreed the Family Support Programme (FSP) would work with the family and address concerns.

13.23 On **15 May 2017** the FSP referred the family back to the CSC as they had not been able to engage with Mary and the family and the issue raised in **March 2017** had not been addressed (*Source: RBBC IMR*). There was a discussion within the MASH as to whether a threshold for allocation to CSC had been reached despite the decision in March that there should be a C&F assessment. The FSP had updated the MASH that Mary faced eviction for non - payment of rent on **1 June 2017**. A management decision was confirmed in the MASH that the threshold had been met for a C&F Assessment.

13.24 On **9 June 2017** Mary was taken to the local A&E department by her father and complained of pain all over her body as a result of a reaction to taking speed. The hospital raised safeguarding concerns with ASC and CSC. (*Source: NHS Trust Hospital IMR*). There does not appear to have been any consideration whether Mary was being coerced into taking drugs or evidence that she had been asked about DA.

[23] The county model for delivering the "troubled families programme". The Surrey Family Support Programme - Surrey County Council (surreycc.gov.uk)

[24] Multi- Agency Safeguarding Hub (Adults). Following a restructure, referrals for children are now made to Surrey Children's Single Point of Access (C-SPA)

[25] Child & Family Assessment 4.6 Assessment | Surrey Safeguarding Children Partnership (procedures.org.uk)

13.25 On **13 June 2017** it was decided by the MASH that the threshold was met for a Child & Family assessment and a social worker in the Assessment and Intervention Service (AIT) was allocated to the case.

13.26 On **16 June 2017** Ashley's father contacted CSC to express his concerns about the care being provided for the children and wanting advice on how to enable Ashley to live with him. (*Source: CSC IMR*)

13.27 On **19 June 2017:** Gary allegedly let himself in to Mary's home and she fled to a neighbour's house who called the police. Gary told the police that he often attended Mary's house to see the children. This behaviour showed a high-risk indicator of serious harm, showing high levels of power and control and the fear levels generated by it.

13.28 The day after, on **20 June 2017:** Mary's father phoned the police to say Mary had been involved in a domestic incident with Gary. The police visited her home and found her in a distressed state and there was evidence of a disturbance in the room. Mary said that Gary had tried to strangle her and red marks were evident around her neck. (High risk of indicator of serious harm). Gary was also found in possession of drugs and was arrested. Two neighbours were interviewed and stated that the arguments were a regular occurrence, with one neighbour stating that she took the children into her house when she heard voices raised. Later that day Mary was interviewed, and she provided a history of the relationship and described the increasing domestic abuse that she was experiencing.

Mary described unreported incidents where Gary had grabbed her by the throat, supplied and encouraged her to take cocaine including posting it through the letterbox. Mary said she had a desire to be free of the relationship but found it difficult as Gary would text and call, showing ongoing CCB and stalking. The police recorded that the house was very untidy with many rooms not having lightbulbs and there was no bedding on the children's bed. The state of the house was reported but there appeared to be no investigation by professionals as to the reasons why. Mary explained that Ashley had gone to live with the biological father because of the situation with Gary. (*Source: Police IMR*). The police made a referral to ESDAS[26] who contacted Mary and explained about Refuge accommodation, but Mary said she was coping. (*Source: ESDAS IMR*).

13.29 The police searched Gary's house and found evidence of the manufacture of Cannabis. He was charged with assault.
The police recorded that Mary appeared to support police action. The DASH risk was recorded as Medium, a MARAC referral was arranged and a further referral made to ESDAS.

13.30 On **23 June 2017** Mary self-referred herself again to Catalyst, showing she wanted to change her life. An assessment including a risk assessment was carried out. Mary was given

[26] ESDAS: East Surrey Domestic Abuse Service www.esdas.org.uk

information about Surrey Drug and Alcohol Care SDAC[27] and the Rape and Sexual abuse Support Centre in Guildford.[28].

13.31 In **July 2017** Mary attended a police station on another matter and detailed several allegations against Gary. The allegations included acting in a controlling manner toward her, staying late at night, taking her keys, accusing her of cheating and using violence towards her. Mary displayed some bruising on her arms. She told the police she suffered from anxiety and depression and his behaviour made matters worse (CCB and high-risk factors). A DASH was completed and was assessed as High Risk. A further Outreach Referral was completed. A safeguarding referral was completed for Frankie and Charlie and rated RED and was shared with CSC. Mary was given information regarding a move to a Refuge and showed an interest in this happening. The IMR stated that the nature of the allegations mirrored those contained in her statement relating to the incident in June 2017. The Crown Prosecution Service (CPS) would not authorise a charge of coercive controlling behaviour but a summons was issued for assault. (*Source: Police IMR*)

13.32 On **7 July 2017** a call was made from a mobile number linked to Mary with a female voice saying, “Get out of my house” and a male voice mumbling. The police attended Mary’s home, but she said she had not phoned and there was no incident. The police did state that Mary was spoken to alone and outside the hearing of Gary. Gary also denied any incident and left the house. The phone was an unregistered prepaid mobile which Mary denied was hers. Officers rang the phone which did not appear to be in the house. The police carried out welfare checks on Mary over the next few days and the event was then closed as a potential hoax call.

13.33 On **9 July 2017** Gary’s car was found in the early hours by the police parked diagonally across a road in a London suburb. Gary was with the car but had no keys. He told the police he and Mary had had an argument about Gary staying at home to look after the children whilst she went out. Mary had driven off in her car with the BMW keys, leaving him stranded. The police visited Mary at home who had been asleep. She denied any knowledge of how Gary’s car ended up in that location. The police noted that the keys to the car were on the hallway floor close to the front door. The police determined that Gary was the victim with a DASH risk of Standard, although there is no evidence whether the police reviewed Gary’s history as a perpetrator. A Children’s Safeguarding referral was assessed as AMBER, but no question was raised about who was looking after the children. (*Source: Police IMR*)

13.34 On **5 July 2017** in the early hours of the morning, Gary attended a local hospital to receive minor treatment to his arm. The police were called by the hospital and Gary was very uncooperative and stated that he had been attacked by a person with a hammer. In the police interview Gary described the incident and said that Mary had consumed drink and drugs and had tried to provoke an argument, goading him to fight with her. Gary said he attempted to avoid the situation but that they ended up on the sofa. Gary denied sexually assaulting her. He accused Mary of following him back into the garden and attacking him with a hammer. Mary

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[27] SADAC https://sdac-helpline.co.uk/
[28] Rape & Sexual Abuse centrehttps://www.rasasc.org

did admit to hitting Gary but stated it was in self-defence. This demonstrates retaliatory violence and how dangerous the situation was becoming for her.

The police made a referral to Adult Social Care (ASC) (*Source: ASC IMR*)

13.35 On **19 July 2017** the AIT social worker visited Frankie for a one-to-one session at school. Frankie described witnessing domestic abuse and said that Gary had tried to strangle Mary (high risk indicator of serious harm). Frankie was more positive about Gary as a parent saying he played, but that Mary shouted. This may show that Gary was grooming the children against Mary.

KPE SEVEN: FURTHER CHILD PROTECTION ISSUES

13.36 On **20 July 2017**, Mary told the police and a social worker that a few days earlier she had informed Gary that their relationship was over and that they needed professional help. Mary said that Gary started to punch her and provoked an argument. Mary claimed that Gary pushed her on the sofa and sexually assaulted her. She stated that she felt intimidated by Gary and controlled by his presence and that he wanted her to withdraw her statement regarding the assault on *20 June 2017* (when he was accused of attempting to strangle her). These incidents show evidence of high risk of DA; strangulation, separation CCB, sexual assault and physical violence. Whilst giving her report, Mary was clearly under the influence of drugs and it was agreed that she needed sleep before making a statement. Enquiries with neighbours revealed that Gary was often at the address and that there were regular arguments. Gary handed himself into the police **20 July 2017**. He said that he was bullied by Mary, his mental health had deteriorated and that she was paranoid about him cheating on her. Gary stated that Mary had threatened to kill the children and herself. He stated he wanted to leave the country to get away from the situation and that Mary made the allegations so she could get back with Frankie's father. This demonstrates Gary's attempts at professional grooming as he attempted to discredit and isolate Mary further.

13.37 The police, working with CSC and ESDAS, provided local accommodation, money, and a safe mobile (TECHSOS)[29] and a place at a refuge in the Midlands. Mary's father was consulted and assisted. Gary was released on conditional bail not to contact Mary or the children, or to visit the house. The CPS advised that they required a full Rape and Serious Sexual Offences (RASSO) file before making any charges.
Mary stayed in the refuge only a couple of nights and used her secure phone to contact Gary. She said she felt isolated and lonely which is not uncommon for victims who have experienced coercive control and abuse.

13.38 On **25 July 2017** Mary stated she could not remember what she told police because of drugs and on **27 July 2017** she informed the OIC (Officer in Charge) that she wished to drop all charges against Gary because everything happened due to the drugs they were taking. A police and social services strategy meeting took place on **26 July 2019** involving the police, CSC, the school and health and it was agreed a child protection enquiry should commence as

[29] TechSOS – mobile phone with immediate access to the police.

soon as possible due to serious concerns around the children's safety and wellbeing. It recommended an increase in contact with Mary, but this was often difficult and the police thought that Mary was deliberately evasive. This may have been Mary trying to minimise the risks she faced from Gary now that she has given a statement. The DASH was assessed as High Risk. A Children's Safeguarding referral for Charlie and an outreach referral to ESDAS were submitted.

13.39 On **30 July 2017,** with Mary back at home, she called the police and told them that she had phoned Gary on **22 July 2017** on the TECHSOS phone from the Refuge to discuss their child and because he had told her family how much he loved her and missed her. After this call Mary said he bombarded her with messages and calls, some of which were abusive. Mary said that whilst out shopping, Gary had parked alongside her showing evidence of stalking and made throat cutting gestures with his finger and said, 'I am going to cut your throat you are dead' and drove off. Mary said she was in fear of Gary and he was arrested for threats to kill and breach of bail conditions. Outreach and MARAC[30] referrals were made by the police.
During Gary's police interview he made a statement denying any threats and stated that Mary had contacted him and that his contact was only ever about concern for Mary and the children.

13.40 On **31 July 2017** the social worker phoned Mary and talked to her about her contact with Gary. Mary said she had met him in town and he had given her speed and threatened to kill her. Mary said she could not cope on her own and needed support from CSC. An Independent Domestic Violence Advisor (IDVA) was involved and applied for a Restraining Order on Mary's behalf. During this period Mary was in contact with ESDAS about changing the locks to her house through her registered social landlord.

13.41 On **1 August 2017**, Mary gave an ABE[31] interview in which she was very emotional. She said she had met Gary a couple of times as she had felt low and needed to know he loved her and the children. She said that on one of her visits to Gary, he threw her on the bed, and she hit him with a lamp in self-defence. During the interview, Mary said that Gary wanted her to drop the rape charges as he would end up on the sexual offences register. Gary was released on bail as the CPS was unwilling to charge on the current level of evidence. Mary went to stay with her parents and in recognition of her vulnerability and safeguarding the SIU (Safeguarding Investigation Unit) tried to keep in regular contact with her.

13.42 On **1 August 2017**, Mary told the police that Gary had asked her to drop the charges against him and that she was frustrated that he had not been charged. At the time Mary was believed to be with her family, away from Gary and not in any physical danger. A decision was made not to arrest Gary as the full RASSO file was still awaited. A further ABE interview was arranged with Mary for **2 August 2017** to bring charges against Gary.

13.43 By **August 2017:** Mary was in serious financial difficulties trying to pay her rent. (*Sources: RBBC / RSL IMR*). Mary was threatened with eviction and ESDAS intervened to try to halt the process. (*Source: ESDAS IMR*).

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[30] MARAC: Multi Agency Risk Assessment Conference
[31] ABE: Achieving Best Evidence interview [Achieving best evidence in criminal proceedings (cps.gov.uk)]

KPE EIGHT: GARY- A HIGH RISK DOMESTIC ABUSE PERPETRATOR.

13.44 On **8 August 2017** a Niche[32] occurrence was created by the police regarding the management of Gary as a high-risk perpetrator. The aim of this was to proactively address and prevent offending behaviour through the local Tasking and Coordination meetings. A 4P[33] plan was completed including an intelligence profile highlighting supply of drugs, possible access to firearms and outstanding allegations. The information appeared on Borough and Divisional briefing sites. The 4P plan also included activity to increase welfare checks for Mary.

13.45 The social worker visited Mary at home and saw Frankie and Charlie on **10 August 2017.** Mary appeared in a better state and had not been drinking. It was observed that the children were quite demanding of Mary's attention. Mary told the social worker that she had taken them out for a meal with Gary and that he had come back to put them to bed. The social worker highlighted the risk associated and that any contact between Gary and the children needed to be supervised by a third party. Mary told the social worker that she struggled with Frankie's behaviour, who had taken kitchen knives and hidden them under the bed pillow. (*Source: CSC IMR*). This is a further indicator that Mary was experiencing high levels of CCB and possible stalking which would have made it exceedingly difficult to leave the relationship with Gary.

13.46 The Child & Family (C&F) assessment[34]was completed on **16 August 2017**. This listed concerns about the children as follows.

- *Impact of Domestic Abuse*
- *Mary's inability to protect the children in her on/off relationship with Gary*
- *Mary's drug use and the impact on caring for the children*
- *Neglect of the children, e.g. dirty house, poor attendance at school*

There is concern that the language in the assessment did not consider the struggles Mary was experiencing with extreme CCB and domestic abuse and there appears be an element of victim blaming.
Ashley was not made a subject of the Child Protection Plan as the child was now living with the father and was safeguarded. At the family group conference, the following actions were agreed:

- *Paediatrician referral for Frankie*
- *ESDAS children group*
- *No contact between Mary and Gary*
- *Domestic abuse outreach support for Mary including substance misuse counselling.*

13.47 On **17th August 2017** a MARAC meeting reviewed Mary's High-Risk domestic abuse case, with Gary listed as the perpetrator. All key agencies attended, and Safeguarding Risk Plans were agreed.

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[32] Niche –Police Crime Information System
[33] The 4P plan, Pursue, Prevent, Protect and Prepare, provides a framework to manage the high-risk Domestic Abuser and safeguard those effected.
[34] Child & Family (C&F) Assessment [4.6 Assessment | Surrey Safeguarding Children Partnership (procedures.org.uk)]

On **22 August 2017:** Mary met with Catalyst again and she was given advice about a mental health support charity.

13.48 On **23 August 2017** the AIT social worker visited Ashley at the father's home. Ashley said whilst living with mum, there was an expectation of being a carer for Frankie and Charlie, getting them dressed for school, changing nappies etc. Ashley was clear about wanting to stay with Dad (*Source: CSC IMR*).

13.49 Mary's parents were going on holiday abroad and the school phoned the social worker in **early September**, concerned about how Mary would cope on her own with the children.

13.50 Mary had another session with Catalyst on **5 September 2017** and explained she had been using drugs again and sharing equipment. A Hepatitis C test was carried out which was negative.

13.51 On **6 September 2017**, Mary contacted the police and provided information about where Gary was staying, aware he was wanted on warrant. The police attended the address, but Gary was not present. Mary called the police and said that Gary had been making nice then abusive calls to her. Mary said that Gary wanted to come over to see her but she refused and told him about the panic alarms that had been installed by the police in her home. Mary said she did not think Gary would visit her.

13.52 On **7 September** 2017, the police attended Mary's home and arrested Gary for an outstanding warrant for a driving offence. Gary tried to escape through the garden. Gary was also arrested for intimidating a witness whilst on bail for rape, assault and coercive controlling behaviour. The police considered taking the latest matter to the CPS due to the high risk but an expert lawyer said that everything should be treated together and a full RASSO file submitted. One of the phones seized by the police on Gary's arrest contained messages between Gary and Mary on" how they could avoid prosecution". (*Source: Police IMR*) Gary was kept in police custody on a Failure to Appear warrant. The investigation into witness intimidation failed to establish a case beyond reasonable doubt and there was insufficient evidence to proceed.

13.53 On **7th September,** Mary also gave an ABE interview which disclosed the following about her relationship with Gary:

- *He was her best friend*
- *I don't know where he is gone, what has happened*
- *Now he is horrible, jealous when pregnant*
- *Checked her Facebook, phone*
- *Nice one minute then verbally abusive*
- *Threatens to stab her*
- *She'd like to go for meal with friends, he claims she does not love him, does not like her wearing make-up.*
- *If she goes out, he accuses her of sleeping with someone else.*
- *He is feeding her drugs-he knows I want to be clean.*

- *I could not breast feed as he kept putting coke in front of my face, said that if I told social services, they would take the children away.*
- *I have been trying to keep the children safe, but he is not letting her.*
- *He is hiding my phone charger which is dangerous in case anything happens to the children.*
- *He took my cigarettes- it's a control thing, he knows I smoke when stressed.*

KPE NINE: POLICE PROTECTION FOR THE CHILDREN

13.54 On **8 September 2017** a safeguarding review took place with the police concluding: "*I do not believe the children have been safeguarded sufficiently in these circumstances. It is clear that they live at the address with domestic, drug and alcohol abuse and have witnessed violence from both their parents. They are both drug users and it is unclear who looks after the children when they are incapacitated through drink and drugs. A strategy review has been carried out and the children are on CP plans, however I do not believe this is sufficient in the circumstances, with Gary out of custody and mum willing to recommence a relationship with him, as well as the drug / alcohol / neglect situation* (*Source: Police IMR*).
In consultation with CSC, Frankie and Charlie were taken into police protection under s46 of the Children Act[35]. Frankie was collected from school and Charlie from kindergarten. Mary had been phoned by her social worker and was aware of the situation and was advised to use the DA tool kit already provided, including the TECHSOS phone and to move out of the area initially to a refuge. Mary declined a safe place unless the children went with her. She agreed to stay with a friend. Police body worn video footage shows how distressed Mary was by the children being taken into care.

13.55 On **11 September 2017**, the social worker again spoke with Mary who said she was not willing to agree to the children being voluntary accommodated under Section 20 and that she wanted to care for them. On the same day, a visit was made to Mary's sister to see if she could accommodate the children but it was deemed not possible, as she also had four children. Mary's sister said that she was moving to Wiltshire along with Mary's parents and asked to be considered for longer term care of the children.

13.56 On **12 September 2017,** an application was made for an Emergency Protection Order. The following day the social worker received an email from the foster carers of Frankie and Charlie. The foster carer said that Frankie told her about frequently waking up and Mum was not there. Frankie was also talking about 'beating people up a lot'. On the same day Mary had a phone session with her Catalyst counsellor and she explained the children had been taken into care.

13.57 On **15 September 2017**, a Court hearing was held which granted an Interim Care Order (ICO) on both children. The children were told about what would be happening and neither Frankie nor Charlie seemed concerned that they would not be going back to Mary.

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[35] Section 20 of the Children Act 1989 sets out how a local authority can provide accommodation for a child if that child is in need of it. Voluntary accommodation can be either a foster carer or a family member who has been approved by the local authority.

13.58 On **20 September** 2017, the social worker met with Charlie as Mary had told her that Charlie was not happy in foster care. On the same day the social worker met Gary who told her he wanted to see both children. The social worker told Gary he would need to speak with his solicitor as the bail conditions stated no contact with Mary or the children.

13.59 On **21 September 2017** Mary's family returned from their holiday and told the social worker that they would rent a property for Mary, near the family in Wiltshire.

13.60 A family group conference took place on **28 September 2017** which was attended by Mary and her parents. Mary's parents said that they had found a house for Mary to rent near them and they did not accept that Mary was colluding with Gary. They stated they would have a hair strand test done privately to check for drug use as it had not been done. The next day the Family Group Conference (FGC) coordinator spoke to Frankie's father, with reference to his contact with Frankie. He was not happy with the contact arrangements which meant that the FGC could not be implemented.

13.61 On **2 October 2017** the social worker saw Frankie at school to ask about home life and relationship with Mum. The next day there was a case management hearing[36] with Mary, her father, Frankie's father and his new partner in attendance. The Court asked for parenting assessments of Mary and Frankie's father and viability assessment regarding Mary's mother and father, her sister and husband. A risk assessment was requested for contact between Charlie and Gary. It was agreed to have a hair strand drug test for Mary and Gary and a psychiatric test for Mary. A 'Looked After Child' review was held on **4 October 2017** with Mary's sister attending on Mary's behalf. Following this meeting the social worker spoke with the police about regarding the outcome of criminal charges against Gary. The police told the social worker that he had pleaded guilty to trying to strangle Mary but that Mary would not cooperate further with the police unless the children were returned. The police also reported that a formal complaint against the police had been received from Mary's father regarding their actions taking the children into police protection.

13.62 On **6 October 2017** Mary had her final session with her drug support counsellor and she reported she had not taken cocaine; she was looking forward to moving away. A future care plan was discussed including Cocaine Anonymous, and SMART. Mary was discharged as drugs free (*Source: IMR Catalyst*). Mary had also attended sessions at Frankie's school's children centre working on her parenting skills (*Source: Children Centre IMR).*

13.63 On **13th October 2017** the social worker visited the children, and noted that they were growing quickly, eating lots although Frankie was wetting the bed. ESDAS emailed the social worker and confirmed they were working with Mary offering support and that now she seemed to want to take control of her life.

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[36] Case Management Conference is an initial hearing where the judge, the attorneys, and the parties involved meet to discuss the issues involved in the case.

13.64 ***Parenting assessments:***

13.64.1 On **16 October 2017**, the social worker met with Ashley's father and his partner to progress obtaining a Child Arrangement Order (CAO)[37] for Ashley to remain living with them. Ashley was seen alone and seemed very happy and healthy. A week later she completed the first session of parenting assessment with Ashley's father.

13.64.2 A second parenting assessment with Mary was completed and on the same day a viability assessment took place with Mary's mother and father. The parents disputed that there had been problems bringing up Mary and denied that they let Mary stay with an older boyfriend. They stated that Mary was with Gary the day the children were taken into police protection. The social worker described her concerns about the lack of insight into the history they had with Mary and her relationship with Gary and drugs (*Source: CSC IMR*).

13.64.3 On **21October 2017** the social worker visited Frankie and Charlie at the foster carer's home. They seemed very happy and both were now sleeping in separate beds. The following day the social worker observed positive contact between Frankie and father.

13.65 On **27 October 2017** the social worker visited Gary' ex-wife who said that as far as she knew Gary never took drugs and was never physically abusive to her during their relationship, although there appear to have been no checks made with the police.

13.66 On **30 October 2017** the social worker met with Frankie's father for a further parenting assessment, and she told him that Frankie wanted to live with him and not Mary.

13.67 Following a visit by the children to see Mary, the foster carer contacted the social worker to say that the children were terribly angry and hungry because Mary had not provided the children with anything to eat.

13.68 On **7 November 2017** Mary had a further parenting assessment. The social worker observed the contact between the children and their mother. Mary arrived late, gave them pizza and fizzy drinks and found it hard to be consistent with the children. The foster carer then reported an incident whereby Frankie was in the bath holding the genitals and mentioned teabagging[38].
The social worker responded to the allegation by convening a strategy discussion.

13.69 On **10 November 2017** the social worker visited Mary's sister in Wiltshire. It was clear that she and her husband did not feel able to look after Frankie and Charlie as they had several children themselves. On the same day, Mary went to the local hospital A&E department with an injury to her right hand saying she had tried to push a paving stone back into the pavement. (*Source: NHST hospital).*

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[37] Child Arrangement Order: https://www.citizensadvice.org.uk/family/ending-a-relationship/making-agreements-about-your-children/making-child-arrangements/

[38] Tea bagging is a slang term for a sexual act in which the male puts his scrotum into his partner's mouth over and over, like a tea bag. This can be an act of male domination which might be used to humiliate his partner.

13.70 On **16 November 2017** Gary pleaded guilty to assaulting Mary on 20 June 2017 and was sentenced to 180 hours unpaid work. A Restraining Order was issued prohibiting him from contacting Mary directly or indirectly.

13.71 A further Parenting Assessment with Mary took place and on **18 November 2017** and Frankie's father contacted the social worker to say that he had seen a Facebook page stating Mary had stabbed someone with a fork.

13.72 On **20 November 2017** the police were contacted early in the morning by a member of the public who had found Mary lying underneath a parked car in her dressing gown. Mary was intoxicated and had a black eye. Mary said she was syphoning petrol in order to burn some of Gary's possessions. Mary said she received her black eye after being attacked by Gary's new partner and her friends on **17 November 2017**. Gary's new partner stated that Mary accused her of having an affair with Gary and threatened to stab her. She had driven to Gary's new partner's house and an exchange took place with Mary stabbing Gary's new partner with a fork and the new partner punching Mary in self-defence. (*Source: Police IMR*). Mary was taken to the local hospital and was seen in A&E (*Source: NHSHT IMR*).
A Safeguarding referral was submitted to ASC via the MASH and the police tried to contact Mary after **20 November 2017** but were unsuccessful.

13.73 In late **November 2017** the social worker met Gary for a parenting viability assessment. Gary said he was missing the children and denied any sexual assault of Mary. During the meeting the social worker disclosed to Gary that it was unlikely she would be recommending that the children be returned to Mary. Gary stated he wanted custody of Charlie and he was then advised of the legal process required. Following this meeting the social worker told the Local Authority lawyer that she had met with Gary and he wanted to be assessed to care for Charlie. She stated that she had told Gary she would not be recommending that Charlie should live with Mary or with her parents.

KPE TEN: DEATH OF MARY.

13.74 At midday in late **November 2017** the police forced entry into Mary's home after receiving no response following a welfare visit. Mary was found dead. The ambulance service attended but resuscitation was not attempted as blood pooling and rigor mortis was present. (*Source: SECAMB IMR*). Operation Recorder was set up by the Police to investigate the circumstance of Mary's death.

14.0 ENGAGEMENT WITH OTHER AGENCIES AND IMR FEEDBACK

This section has been compiled from the Individual Management Reviews (IMRs) submitted by the agencies involved in this case. The IMRs aimed to provide an accurate account of an agency's involvement with Mary, Gary, and the children up until Mary's death, evaluate their actions and identify improvements for the future. All IMRs have been challenged robustly by the panel and, where appropriate, have been subject to review and revision.

Some IMR comments have been included under the relevant KPE in the Facts section of the report, to provide a clearer, chronological overview. Where this is the case, the IMR Source: is clearly referenced.

14.1 SURREY POLICE IMR

14.1.1 Mary first became known to police in **2003** and had a history on police files until **2012** as a perpetrator. Gary was known to the police when he met Mary and had a minor criminal history. From **2012** the police responded to the following:

- Two calls from Mary alleging offences against Jane, Gary's wife
- Nine calls from Mary making allegations about Gary's abusive behaviour
- Four incidents responded to whereby Gary was identified as the victim and Mary the suspect.
- One call from Jane (Gary's first wife) alleging an offence against Mary
- Two calls relating to concerning behaviour of Mary and allegations of wounding.

14.1.2 During the period of **2012-2017** the police also stated that there were three unrelated allegations of threatening/abusive behaviour against Gary unconnected to his relationship with Mary (**2013 / 2014 / 2017**). In each there was not enough evidence to prosecute but all the victims were women known to him, with the behaviour relating to verbal abuse about debt or 3rd party disputes.

14.1.3 In **2015**, the police had uncorroborated intelligence that Gary was involved in the supply of controlled drugs; this information appeared not to have been shared with partners for example CSC. This would have been helpful to have known at the case conference for Ashley, Frankie and Charlie at which Mary and Gary said they were drug free.

14.1.4 LESSONS IDENTIFIED: The Police

i. The police assessed that there was very good application and awareness of practices under the police DA Policy throughout all the incidents identified in their IMR. The training had clearly become embedded in the ethos of assessing and responding to incidents involving Mary, Gary the children and others which were very challenging for those involved. The IMR states that the police response was proportionate and professional.

ii. The IMR identifies that the older children, Ashley and Frankie, had vital evidence regarding home life. Although the police investigators considered interviewing the children, no proactive steps were made to obtain this information directly or indirectly with other agencies e.g. the social worker working with the children. This information could have added clarity.

iii. The assessments of intelligence reports relating to Mary and Gary did not appear to have considered safeguarding of the children. This intelligence could have assisted partner agencies.

iv. The police could have highlighted earlier Mary's history of repeat victimization (possible grooming and CSE in childhood), mental health issues and linking domestic abuse,

mental health and substance misuse. Getting to know victims better is a key part of the Officer in Charge role (OIC) and would enhance the service to the victims and give a better understanding of their needs.

14.1.5 ACTIONS TO BE IMPLEMENTED:

i. That when assessing intelligence, anything related to the Safeguarding of children is addressed and that consideration of confidential sharing is carried out.

ii. That all police officers and police staff involved in the response to / investigation of domestic abuse need to ensure that accounts are obtained from the children involved / witnessing incidents with appropriate expert advice and assistance. This should be included in relevant police training.

iii. That once incidents of DA have been referred to the Safeguarding Investigation Unit (SIU), an experienced investigator reviews the historical as well as current police involvement with the individuals. This is to inform investigative and risk management strategies.

iv. Where possible, when incidents are linked because they involve the same individuals or arise from the same domestic situation, they are allocated to one OIC. This is to ensure a single oversight and help risk management strategies**.**

14.2 CHILDREN SOCIAL CARE, SURREY IMR (CSC)

14.2.1 CSC became involved with Mary in **2002** when her parents reported they were struggling to cope with Mary's behaviour. This was telephone contact only. During **April 2014-June 2015** a CPP was put in place for Mary's children due to the fact she had taken cocaine whilst pregnant.

14.2.2 From **February 2017 to November 2017** CSC were extensively involved with the children in the final three months of Mary's life. The children were taken into police protection and the social worker engaged with the children and built relationships with them. The social worker not only met Mary and Gary but also the father of Frankie and the father of Ashley.

14.2.3 ***LESSONS IDENTIFIED - SURREY CHILDREN'S SOCIAL CARE (CSC)***

The CSC IMR identified four main aspects of working with victims of domestic abuse could be improved:

i. ***Better social work input to MARAC:*** it is essential that CSC representatives who attend MARAC meetings are briefed directly by the family social worker and that any essential outcomes from the MARAC discussion are relayed back directly to the social worker. This is to ensure that consideration is given to what role, if any they can play in the future protection of the victim.

ii. ***The use of neglect as a category for Child Protection Plans where domestic abuse is a factor:*** If neglect is used as the category for the CPP, there is a risk the focus on the emotional harm of a child witnessing domestic abuse is weakened or lost. A manipulative perpetrator can also use the CPP as a weapon to control and coerce a victim and to blame their partner for social work intervention due to their 'neglect', which shifts the focus away from DA. The reality is that the child witnesses frightening violence and abuse and

the victim becomes further isolated from services that could provide vital advice and support.

iii. ***Closer working with the police around criminal process when children witness / experience domestic abuse***. The social worker obtained important information about the children's direct experience of domestic abuse. This information could have been useful for the criminal investigation and helped further identify the level of DA the children and Mary were exposed to so appropriate support could have been provided earlier.

iv. ***The need for vigilance in managing confidential information*** when working with separated parents where domestic abuse is a risk. There was a breach of data protection where the social worker disclosed information to Gary about the likely outcome of the parenting and viability assessment. Although the motivation of the disclosure was to achieve the best outcome for the children, the breach could have allowed Gary to use this information in a coercive and controlling manner in relation to Mary.

The DHR/SAR Panel commented on the need for social care professionals to be aware of perpetrators using grooming techniques to elicit information they can use to further control and abuse their partners. Disclosure of any confidential information can significantly heighten the risk to victims of DA and children – the outcome of which can be catastrophic.

14.2.4 GOOD PRACTICE IDENTIFIED

The IMR highlighted some particularly good practice by some social workers working directly with Ashley, Frankie and Charlie. The children were seen without Mary and Gary with the worker using tools and games to enable the children to express their feelings and talk freely.

14.2.5 CSC ACTIONS TO BE IMPLEMENTED

i. **Better support for families involved in care proceedings.**

There is extensive pressure on a social worker when children are taken into care and the linked legal processes. Many families have complex needs which are best met through a multi-disciplinary approach. Surrey has since introduced a Family Safeguarding Model based on a simple concept, to get people who are working with the same family to work in a team and share their concerns and risks to improve outcomes. Bringing together under one roof a blend of children's social workers and professionals who work with adults allows help to families in a holistic way[39]

ii **Need for Continuity of key worker in child protection.**

CSC identified the impact that a change of worker can have on work practice and relationships with the family. The 'start again syndrome' is an issue that commonly occurs in assessment of child protection cases as highlighted by Brandon Berlderson.[40] Often family history is lost and there is an absence of critical reflection. A change in social worker in 2017 did not lead to a 'start again syndrome' but limited the capacity of the social worker to build up a supportive relationship with Mary. The IMR highlighted that Mary was trying to turn her life

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[39] https://www.surreycc.gov.uk/jobs/job-sectors/childrens-social-work/childrens-social-worker-locations/family-safeguarding-team

[40] Analysing child deaths and serious injury through abuse and neglect. A biennial analysis of serious case reviews. Brandon, Berlderson, Warren, Howe, Gardener, Dodsworth, Black DCSF Publications 2008

around in **August 2017** and supported the CPP but that a change in social worker would not have enhanced the relationship.

iii A CFA (Child and Family Assessment) was undertaken by the Assessment and Intervention Team (AIT) and the work then passes to the child protection and Court proceedings team. The case transfer normally takes place at the first core group meeting and within one week of the Initial Child Protection Conference (CPC). From May 2019 CSC have changed the process and transfer to the Family Safeguarding Team will occur at the initial CPC. Although effort is being put into a stable workforce at CSC given the nature of social work, the IMR highlights it will be important to have robust supervision arrangements to understand risks and compensate for any weakness in the system.

14.3 SURREY COUNTY COUNCIL ADULT SOCIAL CARE (ASC) IMR

ASC had limited involvement with Mary, principally as a result of the safeguarding referral from the Police. There were five referrals between **July 2017 – 30 November 2017** the last regarding Mary's death. ASC also attended the MARAC meeting on **17 August 2017**.

At no time was there consideration as to whether enquiries under S42 of The Care Act should be undertaken or whether there should have been a referral to Surrey Adult Safeguarding Board (SSAB). On completing the IMR the author felt there was evidence that opportunities to safeguard Mary were missed and therefore a notification of a death or serious incident relating to Mary was submitted to SSAB in August 2019.

14.3.1 Good practice identified.

i The iAccess team met with Mary to discuss whether there was any support they could offer her.

ii ASC was present at MARAC where it was recorded that Mary may have support needs and was experiencing risk of abuse/neglect.

iii. Referral records did highlight Adult Safeguarding Concerns.

14.3.2 Lessons Learnt.

There were five occasions when ASC should have recognised safeguarding concerns which met the criteria for a S42 Care Act enquiry. For two of the referrals (**5 July 2017** and **21 July 2017**) the decisions around a safeguarding enquiry should have been made within 48 hours. Instead, it took a further 3-4 weeks to be implemented.

The IMR highlights that there should have been adult safeguarding enquiries, in particular that:

i. Decision making was confused, and the following queries should have been addressed:

- a. *Is this an adult safeguarding concern?*
- b. *Have the statutory criteria for a S42 enquiry been met?*
- c. *Was there abuse or neglect?*
- d. *There was no adult safeguarding enquiry under section 42 Care Act as there should have been.*
- e. *Decisions were not made in a timely manner.*

f. *Decision making did not evidence being informed of the understanding of coercion and control.*
g. *There was no thorough assessment of wider risk around someone experiencing domestic abuse.*

ii. Due to the pressures in the MASH, the team were unable to process the referral and passed it to a different team to that working with Mary at the time. This resulted in decisions being made without all the information that ASC had available.

14.3.3 Actions to be implemented by ASC

i. The quality of response to adult safeguarding concerns relating to domestic abuse needs to be improved including quality of risk assessment and recognising and responding to issues of coercion and control.

ii. Improved arrangements to be put in place to handle non urgent safeguarding referrals.

14.4 PRIMARY CARE: GP IMR

Mary had been registered with the same GP for several years along with Ashley, Frankie and Charlie. The contact by the GP with the children was unremarkable. Gary was not registered with Mary's GP.

As already described Mary had intermittent depression although a mental health diagnosis was not made. The IMR noted the high number of professionals involved with Mary (18 GPs and 5 nurse/nurse practitioners). Mary rarely saw the same GP twice although no specific reason was identified for this. The practice was a teaching practice and therefore there would be a steady turnover of GPs.

14.4i LESSONS IDENTIFIED: Primary Care / GPs)

i. There was no evidence from GP records that any primary care professional involved with Mary considered domestic abuse as a possible explanation for her mental health and substance misuse relapse.

ii. An issue with 'coding' was identified when domestic abuse has been picked up by other agencies. The MASH enquiry of May 2017 is the first time that domestic abuse is mentioned and if the coding on Mary and the children's records was improved, practitioners may have more confidence in asking about domestic abuse.

14.4ii Good Practice

The IMR identified good practice as follows:

Safeguarding of the children.

- When Mary was pregnant with Charlie and experiencing a relapse in her depression, a referral was made back to mental health services with a written message left for the health visitor asking them to contact Mary. (Previous Safeguarding Reviews have identified that this has not always happened).
- When Charlie was not brought in for the re-scheduled development check, the GP identified the child was subject to a CPP and phoned the social worker the same day.

Safeguarding of Mary

The Nurse practitioner showed good practice by identifying the need for a follow up appointment with the GP.

14.4iii Actions to be implemented by Primary Care:

i. Commissioning of IRIS project for Surrey CCGs to be reviewed when the Domestic Abuse Bill is published.

ii. All GP practices should ensure that appropriate coding is applied where there is domestic abuse reported and children living in households are witnessing domestic abuse.

14.5 CENTRAL SURREY HEALTH IMR (CSH) ***inc Children and Family Health Surrey***

Mary and the family first became known to CSH in **June 2006** prior to the birth of Ashley. Mary received universal plus visiting support due to her age, previous mental health issues and the disclosure that she used cannabis and cocaine.

Community health records indicated that Mary had a previous history of an abusive relationship with both Ashley and Frankie's fathers. The IMR states that the health visitors struggled to engage with Mary at that time.

14.5.1 In **February 2014** the health visiting service became actively involved in trying to engage with Mary again. Health visitors continued to offer support and advice to Mary and Gary around their understanding of the impact of drug misuse on their parenting capacity. Mary was also offered support in addressing her own emotional needs.

Concerns were raised by Frankie's school about the poor home conditions and poor school attendances. Mary's ability to meet the needs of the children were raised (due to her mental health, substance misuse and the abuse she was experiencing from Gary. The health visitors tried to engage with Mary, but this proved very difficult, as is often the case with those experiencing CCB.

14.5.2 LESSONS IDENTIFIED by CSH:

i. There is the need to capture the voice of the child (listening and interpreting) when living with domestic abuse and neglect.

ii. There is a need to ensure there is an opportunity to revisit the enquiry around domestic abuse to include coercive control.

iii. Health visitors struggled to engage with Mary as she often had no phone or could not respond to messages. Improving engagement with people who are hard to reach is currently being investigated.

***14.5.3 ACTIONS TO BE IMPLEMENTED BY CSH*:**

i. Training to be implemented on the importance of capturing the voice of a child and referenced in templates used on children's records e.g. health needs assessments by school nurses. Routine domestic abuse enquiries are included in the family health needs assessment, but it is not always possible to enquire as a partner may be present. Practitioners are asked to revisit the enquiry and a reminder to revisit every 6-8 weeks will now be added to the assessment template.

ii. A new Safeguarding Supervision Policy is being implemented which includes tools for safeguarding supervisors to complete. The use of a chronology will be referenced in the supervision policy and this will be used to identify non or disguised compliance.
iii. There will be training to raise awareness around professional challenge, optimism and curiosity.

14.6 MENTAL HEALTH IMR (Surrey and Borders Partnership Foundation NHS Trust (SaBPT)

14.6.1 Mary became known to the SaBPT Child and Adolescent services in **2002** after an incident of self-harm. Mary was referred again to SaBPT in **March 2011** by her GP relating to mood swings and was assessed by a doctor at the end of **April 2011**. Following the assessment Mary was seen as low risk of self-harm and she would be reviewed in three months. A referral was made to IAPT[41] and was agreed. A review appointment was arranged for Mary but cancelled by CMHRS with another offered, Mary did not attend. Eventually due to this happening on several occasions Mary was referred to her GP.

14.6.2 A further referral was received from Mary's GP when she was pregnant with Charlie as she was in low mood and tearful. Mary again missed several appointments but when the Community Practice Nurse contacted her, she said she was seeing the midwife and her GP. A further referral was made from Mary's GP in **April 2014** and Mary attended. Mary told the social worker she was feeling much better. Late **April 2015** it was agreed following a team meeting, to close Mary's case.

14.6.3 SaBPT and the CDS[42] team were involved with Mary when she was arrested in **December 2015.** There was no further contact with SaBPT although MASH Adult Social Care did make an enquiry to the MASH mental health team as to whether Mary was still seeing SaBPT. In **October 2017** a Safeguarding referral from the police was reviewed by the MASH Community Practice Nurse (CPN) and SaBPT were advised there was no further action for mental health.
Gary was the subject of two SCARF[43] reports (July 18; August 18) but there was no further action required by SaBPT.

14.6.4 The IMR states that when Mary visited SaBPT services, relationships were discussed. It was unclear if Mary and Gary were seen separately and whether a routine domestic abuse enquiry was made.

14.6.5 LESSONS IDENTIFIED by SaBPT

It was unclear whether there was an opportunity to speak to Mary on her own and to make routine enquiries around domestic abuse.

[41] IAPT: Improving Access to Psychological Therapies https://www.england.nhs.uk/mental-health/adults/iapt/
[42] Criminal Justice Liaison and Diversion Scheme: https://www.sabp.nhs.uk/our-services/mental-health/liaison-services/CriminalJusticeLiaison
[43] SCARF: The police's new referral form for Safeguarding Children and Adults, replacing the 39/24

The DHR/SAR panel highlighted that routine enquiry around DA should be implemented and where such enquiries have been made, they should be recorded clearly on the case management system regardless of whether it is a positive or negative response.

14.6.6 Actions to be implemented by SABPT.

i. DASH training to be further embedded across the trust.
ii. Audit of Safeguarding adult enquiries in relation to domestic abuse across directorates with a specific focus on routine enquiry.
iii. All people supported by SaBPT to have an opportunity to be seen without their partner.

14.7 THE NHS HOSPITAL TRUST (NHS HT) IMR

14.7.1 Mary was known to the NHSHT as she had delivered three children in the same hospital. She was also seen in A&E in **June** and **November 2017** with injuries sustained whilst drinking alcohol and taking recreational drugs. Mary was discharged on both occasions and safeguarding concerns were raised with CSC.
The IMR identified that there was good information sharing on all attendances and appropriate actions taken with multi-professional and multi-agency ongoing referrals. The A&E records show that safeguarding referrals were appropriately made to children and adult safeguarding services. Domestic abuse was discussed; Mary did not disclose any concerns at this stage.

14.7.2 Lessons Identified by NHS HT
None.

14.7.3 Actions to be implemented NHS HT
None

14.8 SOUTH EAST COAST AMBULANCE SERVICE NHS TRUST IMR (SECAMB)

SECAMB only had two contacts with Mary, one in **November 2017** when Mary was found by police under a car after she had tried to get fuel from a car to burn Gary's belongings. The second was when Mary was found deceased at her home.

14.8.1 Lessons Identified by SECAMB
None

14.8.2 Actions to be implemented.
None

14.9 EAST SURREY DOMESTIC ABUSE SERVICES IMR (ESDAS)

14.9.1 Engagement with Mary commenced in **2012** via a referral from the police. A call was attempted but diverted. A letter was then sent but there was no contact again until **June 2017**. A police referral was made to ESDAS as Mary had been involved in an incident where Gary had allegedly tried to strangle her. ESDAS received a further referral in **July 2017** about Mary being interested in going into a refuge. Contact was made with

Mary, but she said she was being supported although was grateful for the contact. ESDAS did have concerns around the safety of Mary and informed the police. When Mary requested urgent refuge accommodation, ESDAS were involved trying to find a place which they did in the Midlands.

ESDAS supported Mary following a further incident in late **July 2017** when Gary was arrested and was on bail. Mary told ESDAS that Gary was controlling and abusing her. ESDAS engaged with the RSL to get the locks changed on Mary's home and help sort her rent arrears and her eviction notice.

14.9.2 At the MARAC in **August 2017:** ESDAS supported the police in trying to visit Mary. Following the children being taken into care, Mary was in contact with ESDAS and said she was trying to move to Wiltshire to be near her parents so she could get the children back. Mary also requested counselling but was advised by ESDAS that the list was closed and that she should also contact her GP.

14.9.3 ESDAS worked with the CSC social worker around Mary's parenting assessment and provided information about their engagement with her, with Mary's agreement. ESDAS records showed that Mary was proactive in seeking support and was focused on regaining control of her life so she could be reunited with her children.
The IMR states that ESDAS staff followed internal procedures and, in some cases, exceeded requirements. ESDAS partnership work was good and there were significant moments which indicated that Mary had trust in the service e.g. where Mary took advice and acted upon it.

14.9.4 LESSONS IDENTIFIED by ESDAS

ESDAS has become aware of more connectivity between IDVA support at the Specialist Domestic Violence Centre and the outreach element of ESDAS services for establishing contact. Sharing this information would have been helpful when they were unable to contact Mary in October 2017 and would have enabled ESDAS to have been more proactive in attempting contact.

14.9.5 Actions to be implemented by ESDAS.

i. Improve communication between the Surrey IDVA[44] Service and ESDAS Outreach Services.

14.10 REGISTERED SOCIAL LANDLORD (RSL) IMR

14.10.1 There were several home visits to ensure the tenancy conditions were being adhered to. There was no other contact until **January 2017** when a Moneywise (Benefits Officer) met with Mary as she was in significant rent arrears and needed advice.

[44] IDVA Independent Domestic Violence Advisor

14.10.2 In **August 2017** the RSL, in partnership with ESDAS, changed the locks to Mary's house to prevent Gary entering. The RSL had contact with Mary's social worker and were aware of her being discussed at the MARAC.

14.10.3 Lessons Learnt RSL
None.

14.10.4 Actions to be implemented.
None. The RSL worked closely with ESDAS throughout and was aware that Mary was experiencing domestic abuse. They changed her locks, liaised with MARAC and arranged for advice and support around her significant rent arrears.

14.11 CATALYST[45] IMR (Drug, alcohol and mental health support)

14.11.1 Mary referred herself to Catalyst in **April 2016** acting on information from SaBPT. Mary was offered a Level 2 intervention including harm reduction advice and attendance at SMART (Self-Management and Recovery training) sessions [46]. Mary was supported until **July 2016** but was sometimes difficult to engage.

14.11.2 Mary self-referred again to Catalyst in **June 2017** and was triaged and assessed. She was provided with information re a food bank and a mental health charity. Catalyst attended a Child Protection Conference in **August 2017** and by **October 17** Mary reported no further use of cocaine and her contact ceased.

14.11.3 Lessons Learnt by Catalyst

i. Catalyst Senior Management team want to ensure that they address children and adult safeguarding in line with County Council policy.

ii. Catalyst is rarely involved in serious incidents, but it has made the organisation reflect on the need that Safeguarding is routinely raised even if team members do not have a concern. Carrying out the IMR has highlighted the need for Professional Curiosity, to not just focus on what is being told/known but to also explore the unknown or the need to find out/re-check.

iii. Producing the IMR has enabled Catalyst to reflect on policy and practice and update as required.

iv. Catalyst was proactive in trying to engage with Mary. However, that engagement needed to be better recorded, including non-engagement. Information provided by Mary should have been sometimes followed up and clarified e.g. domestic incidents.

v. Preparing the IMR also identified the need to broaden the discharge process to include care plan goals, onward referral should be part of a more formal handover for high-risk individuals.

vi. There was no record of gender choice of the key worker at the assessment. Mary did engage with a male worker, but the organisation has identified that gender issues are important when considering domestic abuse cases. The process has also identified the need to know more about the impact of the perpetrator's behaviour on Mary's recovery and therefore enable them to signpost to other services.

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[45] Catalyst https://www.catalystsupport.org.uk/
[46] SMART Recovery: https://www.smartrecovery.org/

vii. Although Mary did meet her goals in the care plan, there was no multi agency meeting involving Catalyst e.g. they were unaware she was a MARAC subject and so did not attend.
viii. Although Catalyst has updated its Domestic Abuse Policy there needs to be more training and learning from individual cases.

14.11.4 Actions to be implemented by Catalyst.

i. To review and update the Catalyst Safeguarding Policy for children and vulnerable adults in consultation with commissioners and key providers.
ii. To update operational policies to ensure that Safeguarding is a standing agenda item at all referral and team meetings.
iii. To review and update the Serious Incident Reporting and Guidance Policy and procedures in collaboration with commissioners.
iv. To improve the quality of recording for both internal and external communications and correspondence on case management systems
v. To implement a discharge handover process to joint working partners for clients re-safeguarding and domestic abuse.
vi. To record that choice of gender of case worker has been offered and confirmed at assessment.
vii. To implement a process to ensure that the impact of perpetrator on recovery is addressed within an assessment, care plan, interventions and at discharge.
viii. To have annual training and information sharing on the role of MARAC and MAAPA for all team members.
ix. To update and deliver revised domestic abuse training which incorporates best practice in report writing and reviews.

14.12 REIGATE & BANSTEAD BOROUGH COUNCIL IMR

14.12.1 Mary became involved with several departments at the local council: Benefits, Housing and the Family Support Service

Mary's first contact was in **2006** with the Benefits team, followed by an application to join the housing list in **2008**. In **2009** Mary presented as homeless and she was provided with a range of housing support/advice.

In **2017** Mary was referred to the Family Support Team. Numerous unsuccessful attempts were made to engage her. The case was closed, and she was referred to the MASH.

14.12.2 Lessons Learnt by the Borough Council

i. The Housing Team have adopted a process to capture and share learning as a regular item at team meetings.
ii. That all departments across the Council should be made aware of safeguarding referral processes and the role and responsibilities of the Safeguarding Leads.
iii. The process of producing an IMR highlighted the number of teams involved with Mary and therefore it would be valuable to adopt a similar approach of carrying out a team review of anonymised cases where there has been a death or the potential for significant ham and identify any improvement in practice.

14.12.3 Actions to be implemented by the Borough Council.

i. To deliver DA Awareness Training for all the Benefits team.
ii. Publicise the roles of the Safeguarding Lead and safeguarding processes.
iii. Teams to carry out anonymised case reviews in order to improve practice.

14.13 THE CHILDREN'S CENTRE IMR

The Children Centre met Mary following a referral from the home-school link worker in **September 2017**. The children were in care and Mary was suffering from anxiety and depression. Mary attended Family Links until late **November 2017** and had supervised contact, but it is not clear whether DA advice /signposting was discussed.

14.13.1 Lessons Learnt.

None

_14.13.2_

Actions to be implemented.

None

15.0 ANALYSIS

15.1 This analysis is based on information provided in the IMRs. Where relevant this includes an assessment of appropriateness of actions taken (or not taken) and offers recommendations to ensure lessons are learnt by relevant agencies. The analysis has been structured around the terms of reference. The Chair and Panel are keen to emphasise that these comments and recommendations are made with the benefit of hindsight.

15.2 _Awareness of the potential presence of coercive control and how this impacted on the behaviour of the victim and perpetrator._

_15.2.1_ From the chronology it is evident that many of the agencies involved in Mary's life were aware of the potential presence of coercive control. Mary displayed evidence of trauma associated with experiencing significant CCB and abuse in her relationship with Gary. (*Source: Police IMR*).

i. In **2006** police were called twice by Ashley's father and in **2008** Mary was cautioned for damaging Ashley's father's car. (*Source: Police IMR*). There were reports, although never confirmed, that Ashley saw Mary being hit by dad.

ii. Mary had a short relationship with Frankie's father, which although happy at the time, ended with Mary again going to Frankie's father's house and causing damage to the front door. (*Source: Police IMR*). Frankie's father completed a DASH which was assessed as standard. Mary was told by the police to cease any direct contact with him, which she complied with.

iii. There were several incidents where Gary claimed to have been a victim of Mary's aggression.

It should be recognised that Mary's behaviour towards Gary in particular, displayed evidence of trauma associated with experiencing significant CCB and abuse, including retaliatory violence.

15.2.2 Mary's mental health issues were well documented within the IMRs provided and the incidents with her partners appear to relate to loss and her difficulty in managing her anger. Both relationships ended acrimoniously but there was no evidence of controlling coercive behaviour although CSC stated that there was a police record reporting that Ashley had seen father assaulting Mary. It would appear no action was taken.
Mary appears to have grown up in a somewhat troubled household (although this is disputed by Mary's family), was groomed by men from an early age and had experienced DA several times most notably from Gary.

15.2.3 **Coercive control:** The IMRs identify there is no doubt that Mary became a victim of controlling coercive behaviour and abuse when she began a relationship with Gary. Within the chronology there are many examples including the following (*Source: Police IMR*):

i. Police information indicates that Gary was a drug user and a supplier of cocaine, amphetamines and cannabis. Mary alleged that Gary supplied her with drugs to control her.
ii. In **November 2014** when Mary phoned the police to say that Gary's ex-wife Jane had made threatening and abusive calls to her. The operator heard a man (believed to be Gary) becoming very agitated and telling Mary to put the phone down. The operator was so concerned about the man's behaviour that officers attended Mary's house.
iii. **September 2015:** Gary refused to leave Mary's house and was being abusive leading Mary to phone the police saying that Gary was controlling and had smashed her phone. The next day, having seen Gary, she refused to make a statement to the police.

The police identified their concerns about Mary suffering coercive control on several occasions.

iv. In **May 2016** Gary attended the house drunk and was abusive, accusing Mary of being unfaithful. The DASH risk assessment was recorded as Standard. Mary said it was an isolated incident.
v. In **June 2017** Mary's father phoned the police to report a domestic incident between Mary and Gary. Mary alleged that Gary had tried to strangle her and on police attendance, she had visible marks on her throat. She stated this had happened twice before and he had posted cocaine through her letterbox encouraging her substance abuse. The DASH was assessed as Medium Risk, an escalation.
vi. In **July 2017** Mary attended a police station on unrelated matters but made several allegations against Gary including him acting in a controlling manner and showed bruises on her arms. The DASH was assessed as High Risk and an outreach referral was completed along with information around moving to a refuge.
vii. Other incidents of CCB have been identified throughout this report.

15.2.4 The police have had extensive training in all aspects of domestic abuse through its DA Matters programme. From evidence and the escalation of risks identified through the DASH, it appears that the police have a thorough understanding around the behaviour of victims and perpetrators and controlling and coercive control.

However, this needs to be refreshed regularly for all front-line police, including the impact of mental health on DA-related trauma and its link to increasing risk of harm.

15.2.5 It is apparent from the IMRs that social workers (adults and children), health professionals and other agencies who support vulnerable adults (e.g. drug and alcohol support) do not fully understand the behaviours surrounding controlling and coercive behaviour. ASC identified within its IMR that following a review of several of its safeguarding cases, there was a lack of understanding of all the characteristics of domestic abuse. A lack of a trauma informed approach may well have compounded Mary's experiences as a victim/survivor of DA. There appears to be little kindness shown towards her by some professionals and a strong narrative around her that places her as solely responsible for her situation and as someone with anger issues due to a few incidents.

All agencies should have viewed the DA as escalating and high risk at an earlier stage, and linked Mary's poor mental health to the trauma impact of coercive control and stalking. All agencies should have had a thorough understanding of the definition of 'Serious Harm' relating to the DASH as they may well have then understood the severity of the situation at an earlier stage. Serious harm has been defined as *'behaviour of a violent or sexual nature which is life threatening and/or traumatic, and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible'* (Source: Risk Management Authority, 2013).

15.2.6 There appears to be a lack of understanding regarding the issues and risks relating to Mary's use of violence against Gary. Research indicates female violence usually occurs in the context of violence against them by male partners (retaliatory violence). Although research shows in general that women and men perpetrate equivalent levels of physical and psychological aggression, evidence suggests that men perpetrate sexual abuse, coercive control and stalking more frequently than women.[47]

15.3 Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator.

Two characteristics seem pertinent to consider when reviewing why Mary died.

- *Sex/Gender*
- *Pregnancy*

15.3.1 Sex/Gender

Mary was more likely to have suffered abuse because she was a female. Research shows that females are more likely to be repeat and chronic victims of domestic abuse. There is some evidence that Mary was involved either as a victim or perpetrator of domestic abuse in several relationships.

15.3.2 Pregnancy

Although Mary was not pregnant at the time of her death, it was well known to health professionals that she had a history of abusive relationships. Information provided within

[47] A review of research on Women's use of violence with males. SC Swan 2008 www.ncbi.nih.gov

the IMRs indicates that Mary and Gary's relationship was deteriorating during her pregnancy with Charlie. Pregnancy itself is a high-risk indicator. During the pregnancy, traces of cocaine had been twice found in Mary's urine and Charlie was born prematurely with cocaine in the system (*Source: CSC and SFH IMRs*). As a result, all three of Mary's children became subject to Child Protection Plans under the criteria of neglect.

Friends stated that Mary had started taking drugs when her relationship with Gary began. She also started drinking to block out the–trauma she was experiencing with Gary. Research highlights that abused women may use drugs and alcohol as a coping mechanism particularly in cases of psychological and emotional abuse which can lead to low self-esteem, depression and anxiety and drug and alcohol abuse.[48] The IMRs indicate that Mary had continued to take drugs during her pregnancy, which should have alerted professionals that there were wider issues to consider.

15.4 *Were opportunities missed for professionals to routinely enquire about domestic abuse, coercive, controlling and stalking behaviour which should have led to a referral to a domestic abuse support service?*

Mary and the family were involved with several agencies during the period of this DHR / SAR. It appears that a judgement may have been made by some professionals that Mary's problems related to her lifestyle with Gary, drinking, taking drugs and thus resulting in a volatile relationship. There did not appear to be a clear understanding by professionals of DA, in particular CCB, and therefore there was a sense that they perceived Mary as making lifestyle choices instead of understanding the lack of choices experienced by someone experiencing CCB.

Friends of Mary stated there was a sense that professionals wanted her to fail and there were comments made about "the type of lifestyle and relationship they had" which speak to a culture of victim blaming that impacted Mary's experiences of agencies.

15.4.1 Primary Care: There was no evidence that GPs or any other Primary Care professional considered domestic abuse as a possible explanation for Mary's mental health and substance misuse relapse from 2014 onwards and particularly through 2016-17.

Within Surrey, domestic abuse training in all its forms is embedded within Level 3 Safeguarding Children since 2012. However, despite this, the level of detection of domestic abuse in Primary Care is low. Standing Together case analysis of DHRs identified that GPs are the one agency who have been involved in nearly all DHRs to date and that there were often missed opportunities to routinely enquire about domestic abuse[49].

15.4.2 Children & Family Health Surrey (CFHS): Despite clear evidence of Gary's controlling behaviour over Mary, this was not viewed by professionals as domestic abuse. Mary had considered terminating her last pregnancy several times, however,

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[48] Shipway L (2004) Domestic Violence A Handbook for Health Professionals.

[49] Domestic Homicide Review (DHR) report for Standing Together Nicola Sharp -Jeffs and Liz Kelly 2016

Gary influenced her not to. Mary also said that she did not want Gary to know that professionals were aware of her cocaine use when she felt depressed. Mary said Gary would be angry, but she was not frightened of him. At no point was a referral to specialist DA support service considered.

15.4.3 Surrey and Borders Partnership Trust (SaBPT): There was intermittent contact with Mary from 2011 onwards. Staff in the service use a person-centred approach during assessment where relationships are discussed, but there is no clarity as to whether staff asked specifically about domestic abuse during her appointments. It was noted that when Mary attended her appointments with Gary it was not clear whether there was an opportunity to speak with Mary alone and provide the opportunity to routinely enquire about domestic abuse.

15.4.4 The police showed good awareness and practice of their domestic abuse policy. Appropriate referrals were made to ESDAS e.g. in 2016, but Mary declined at that stage as she felt it was an isolated incident. In June 2017 following a further incident between Mary and Gary which was reported by Mary's father, the DASH was assessed as Medium Risk, a MARAC referral was recommended and a further referral to ESDAS was made. An ABE interview was also conducted. Mary engaged with ESDAS, who worked with other agencies to provide support e.g. working with the housing association to change the locks on Mary's house to prevent access by Gary.
Working with ESDAS the police tried to ensure Mary's safety by securing a refuge place, provision of a safe mobile phone (TECHSOS) and financial support. The police, CSC and ESDAS provided a coordinated response to the ongoing issues that Mary was experiencing from Gary.

15.5 Police: To review whether there was adequate professional curiosity during engagement with Mary and Gary.

15.5.1 Professional curiosity is the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value.

15.5.2 As already described, Mary was involved with many agencies over several years. There were many opportunities for professionals to ask questions to build up a picture of what was happening in Mary and the family's life. The police identified in their IMR that they did not consider sufficiently Mary's mental health issues to identify fully what support she may need. Health practitioners focused on Mary's mental health and substance abuse and did not fully explore issues around the domestic abuse she was experiencing. CSC focused on the needs of the children which is their priority but whether there was enough curiosity about Mary's mental health is unclear.

15.5.3 Mary displayed many barriers to allowing officers to become more professionally curious (see below). This meant that it was difficult for professionals to always build up

a complete picture of Mary, her needs and the support she needed. Professionals could possibly have overcome this by adopting a 'trauma informed approach' to understanding the DA and CCB she was experiencing. Her actions should have been considered as her way of safety planning in a high-risk situation. It should have been essential for all professionals to also understand the risk posed by Gary and failure to do so created a difficult barrier for Mary to overcome.

Barriers identified include:

- ***Disguised compliance***

This involves parents and carers appearing to co-operate with professionals in order to allay concerns and stop professional engagement *(Reder et al, 1993)*.

Mary missed health and drug support appointments but she would then phone up to re-arrange and this pattern continued. Mary and Gary denied the use of drugs and Gary assured health professionals that he would support Mary. This behaviour may indicate that Mary and Gary were trying to allay professional concerns and ultimately to reduce professional involvement. As a victim of CCB, she would have been aware that agency intervention could escalate Gary's behaviour. The children meant everything to Mary and therefore she would do everything possible to allay any concerns of professionals involved with the family. Disguised compliance could also be a way of Gary controlling professional involvement with the family.

- ***Accumulating risk – seeing the whole picture.***

During the last six months of Mary's life her risk of harm intensified, with escalating domestic abuse at the hands of Gary, substance misuse and increased mental health issues. When Ashley went to live with Dad and Frankie and Charlie were taken into care, Mary was trying to improve her parenting skills and was seeking help for her substance abuse. It appears that the police and children services did not recognise how vulnerable Mary was. Professionals were responding to each situation or new risk discretely, rather than assessing the new information within the context of the whole person or looking at the cumulative effects of all the incidents and information relating to Mary.

15.6 ***Whether there were any barriers experienced by Mary, the victim or her family friends in seeking support from professional service providers.***

15.6.1 Mary and her family had contact with many agencies over many years; as a teenager due to mental health and pregnancy and CSC; later in adult life, contact with health, CSC, police, ESDAS, housing, substance misuse services and other services from the local authority.

Despite all the involvement of different services, Mary still encountered barriers. In particular this included a lack of understanding around the impact of CCB and the trauma Mary was undoubtedly experiencing, which would have served as an isolating factor for her, as would the over focus on her behaviours instead of Gary's.

Women who experience domestic violence are 15 times more likely to use alcohol and 9 times more likely to use drugs than women that have not been abused.[50]

15.6.2 The co-existence of these issues presents additional barriers for service users and challenges for the services themselves.
Barriers can be internal or external; among internal barriers are perceptions of the stigma of domestic abuse, mental ill-health and substance abuse which can present obstacles to seeking help. Mary would miss appointments with services and services struggled to remain in contact with Mary.

Evidence indicates that Mary and Gary were seen by some agencies as living "a chaotic life". Police described the house on one visit as untidy, no bedding on the children's beds, no lightbulbs in certain rooms. Mary sometimes struggled to get the children to school. In reviewing the IMRs and in discussion with some professionals, either consciously or not, there were some moral judgements about Mary's way of living. which was seen in some cases as a lifestyle choice,-rather than as a result of living with abuse affecting her parenting capacity.

15.6.3 Mary did have several services that she could access but many agencies struggled to contact her directly. Mary's phone was often not on, perhaps not charged and at one stage was smashed by Gary. If messages were left Mary never responded. This may have been due to lack of credit (she was in significant debt) or possibly because she was trying to avoid messages from Gary. This practical barrier may possibly have impacted on Mary's ability to engage with services and may have delayed treatment that would have helped and supported her.

15.7 *Agencies that had no contact will investigate whether helpful support could have been provided and if so, why this was not accessed.*

15.7.1 Mary had contact with many services especially in the last three years of her life including specialist domestic abuse services, drug and alcohol services, some health services, children's social services, housing, family support and the police.

15.7.2 Although Mary received mental health support up until the end 2015, professionals involved with Mary, especially in 2017, were more concerned about her substance misuse, domestic abuse and the children's safety. The police in their IMR highlighted that a better understanding of Mary's mental health would have helped, by researching historical data about her. "Getting to know" victims better could have created a greater understanding of her needs especially relating to her mental health.

15.7.3 Mary experienced domestic abuse, substance abuse and mental health issues. A key message that has emerged from Serious Case Reviews is that practitioners need to gather and analyse more information; they must be encouraged to be curious and to

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[50] August 205 British Journal of Social work [(PDF) Domestic Violence and Substance Use: Tackling Complexity (researchgate.net)]

think critically and systematically[51]. Professionals should also be trauma-informed and help survivors to feel supported even when taking challenging action.

15.7.4 Although Mary had been referred to ASC, no interventions were put in place due to confusion over internal processes and communication between professionals in the MASH and the mental health support team i-Access. A key question remained unanswered in the assessment by both teams; there was no recognition that Mary had care and support needs herself (mental health and substance misuse concerns, domestic abuse), she was experiencing abuse and as a result was unable to protect herself.
If identified correctly, this would have generated an adult safeguarding decision-making process to be completed within 24 hours to identify whether there was a duty to make enquiries under S42 Care Act 2014[52].

15.7.5 This miscommunication was again repeated during a further referral into the ASC MASH team in July 2017, leading to another missed opportunity to investigate. The decision-making process by ACS MASH team and i-Access team would seem to indicate a lack of understanding of Mary's vulnerability and resulted in a lack of additional support being offered.

15.8 *Whether there were opportunities for agency intervention or support regarding known perpetrators of domestic abuse / coercive control which were missed.*

15.8.1 The review highlights that the police, ESDAS and CSC worked together to manage Gary as a high-risk DA perpetrator, with the aim of proactively addressing and preventing offending behaviour through the local Tasking and Coordination meetings. Gary's details were included on police borough and divisional briefing sites. This is an example of good practice, with agencies and practitioners working together to assess and to try to reduce the risks to Mary and the children.

15.8.2 Despite Gary being arrested for attempted rape and assault, it was difficult for the police to gain a charge. Mary originally wanted to pursue charges against Gary, but she often changed her mind. This may have been for several reasons:

i) Gary was continuing to supply drugs to Mary which she said confused her statements
ii) Gary was pressurising her to withdraw her evidence, through physical threats and verbal abuse. This fear of retribution through experiencing severe CCB would undoubtedly have played a part.
iii) Mary's mental health, including anxiety, may have impacted on her decisions. She did give a detailed ABE interview despite her fear.

This made it difficult for the police to have enough grounds to seek a charge. Research by the BBC in 2020[53] stated that over the past five years recorded rape had risen considerably to

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[51] Brandon. M, Bailey, S and Belderson, P (2010) Building on learning from serious case reviews. Department of education.
[52] s42 of the Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted
[53] Why are rape prosecutions falling? - BBC News

nearly 60,000 however the proportion making it to court had halved (2,100 compared to 3,050 in the previous 12 months). With the amount of evidence required for the CPS, including evidence from mobile phones and social media, it can make it challenging for the police, the prosecutor and more importantly the victim[54].

Research has also shown that it can be difficult to gain a charge for CCB as it is difficult to recognise and as such therefore difficult to gain enough evidence to prosecute[55]. Since the new offence of controlling or coercive behaviour came into force in December 2015 there have only been 235 successful convictions from 7034 arrests (up until July 2018).

15.9 *Identification of any training or awareness-raising workshops to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services*:

15.9.1 Since 2016, Surrey Police have embarked on an extensive DA training programme (DA Matters and Completing the DASH). Following recommendations from previous DHRs / SARs Children and Adult Social Care (along with many other professionals) have participated in a countywide Safeguarding programme run by the Safeguarding Boards, to ensure a common understanding of the characteristics of DA, the services available in the community and how to signpost and support not only the victim but also the family.

15.9.2 As already discussed, Primary Care staff have DA training as part of the Level Three Safeguarding programme. However, with detection rates of DA so low in Primary Care, it would seem further training and support is required. The implementation of IRIS[56] across Primary Care settings is essential. This would enable Primary Care staff to have the confidence to probe further and to better understand the relationship between mental health, substance abuse and domestic abuse. In Surrey there is a working group looking at establishing IDVAs in A&E settings and this review identifies that having a IDVA in A&E could have provided an opportunity for Mary to disclose about the DA she was experiencing, and the DHR/SAR Panel supports this initiative.

15.9.3 Professional Curiosity is nearly always mentioned in DHRs and in Mary's case the need for practitioners engaging with her and the family to ask questions, seek historical information and analyse reports in order to better understand Mary could have helped. This was especially true when the children were taken into police protection. Domestic Abuse and Safeguarding training should include tools to enable professionals to do this. 'Listening and understanding the voice of the child' was cited by health professionals as a training need.

15.9.4 There is no doubt that Ashley, Frankie and Charlie suffered, living in a home where domestic abuse and substance abuse occurred:

*i.*Ashley often had to care for younger siblings at an inappropriately young age.

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[54] BBC "why are rape prosecutions failing" 30 July 2020 www.bbc.com

[55] Evan Stark Coercive Control How men entrap women in Personal Life. 2008

[56] Identification and Referral to Improve Safety (IRIS): https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2825222/

*ii.*The children witnessed the physical and verbal abuse between Mary and Gary.
*iii.*The children's attendance at school and their physical and emotional wellbeing suffered.
*iv.*Evidence shows they were neglected and at risk.

The social worker who engaged with the children when in police protection, showed good practice in gaining the trust of the children. She gained valuable information which helped to build up a strong picture of family life and was able to identify the support that would be valuable to the children. However, no appropriate support for the parents was identified. It was also felt that if the information provided by the children had been shared with the police earlier, there would have been stronger evidence to establish a criminal case against Gary.
Providing other professionals with the skills and tools of 'listening to the voice of a child' could enable the whole family's needs to be better supported.

15.10 Whether professionals were aware of "confirmation bias" when reviewing Mary's and Gary's background to ensure scenarios were interpreted from a neutral standpoint.

15.10.1 Everyone has their own confirmation bias. Even for people who are open -minded and only observe the facts before coming to a conclusion, it is still likely that some bias will help shape the opinion. Professionals can also exhibit confirmation bias when they look for evidence that supports or confirms their pre-held view and ignores contrary information that challenges it. It occurs when professionals filter out potentially useful facts and opinions that don't coincide with their preconceived ideas.[57] Health professionals cite that Mary had a history of missed or cancelled appointments, that she repeatedly avoided engaging with mental health and drug services and this would appear to build up a picture that Mary was not trying to help herself or the children. Language used by the professionals included "Mary failed to engage" which would indicate it was Mary's choice as opposed to "Mary was unable to engage".

15.10.2 In **2017** the children's social worker was involved with Mary and the children struggled with contradictions about Mary's experience of domestic abuse. Mary had told the social worker about abuse in the relationships with the children's fathers. When the social worker spoke with them, the feedback indicated that Mary was violent and aggressive at the end of a relationship. These contradictions made it difficult for the social worker to understand Mary's motives. There was no consideration around Mary's well documented mental health issues. or whether Mary's violence was retaliatory, the impact of DA and trauma on her mental ill health and her parenting capacity. Dr Carlene Firmin states that professionals should consider the language used when describing a person's situation whether it be a child or adult (contextual safeguarding).[58]

15.11 ***What parental support was provided when the children were taken into care?***

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[57] Norfolk Adult Safeguarding Board https://www.norfolksafeguardingadultsboard.info/assets/NSAB-EVENTS/NSAB-MSPandProf-Curiosity-SlidesOCTOBER2018FINAL.pdf
[58] Contextual safeguarding: https://csnetwork.org.uk/about/what-is-contextual-safeguarding

15.11.1 There is no doubt that Mary loved her children, as evidenced in statements from family and friends. Mary informed health professionals that the children were her reason for living. Evidence suggests that Mary did struggle in her parenting role and did not always see that her substance abuse and the abusive relationship with Gary hindered her ability to look after the children appropriately.

15.11.2 Mary was very vulnerable when the children were taken into care in September 2017. The children were taken into police protection from school and nursery, were allocated a social worker and placed in foster care. The social worker spoke with Mary and although initially agreeing to her children being Accommodated under Section 20 of the Children Act 1989,[59]she rescinded this a few days later and said she wanted to care for the children herself or for them to be placed with a family member.

15.11.3 Mary and her parents attended a Family Group Conference. They stated that they had found a house in Wiltshire large enough for everyone so Mary would have support in bringing up the children.
Frankie's father was not happy with this arrangement therefore it was not progressed.

15.11.4 There is evidence that Mary was desperate to have the children back. Whilst the children were in foster care, Mary reported that she had seen bruises on Charlie, and she told the head teacher that Frankie had sore private parts. Both the concerns were investigated and determined as unfounded. Mary also felt unable to cooperate with the police regarding further criminal charges relating to Gary unless the children were returned to her care.
Comments from professionals (ESDAS and Catalyst) indicate that Mary was focussed on regaining control of her life and proactive in seeking support so she could be reunited with her children. A friend said that a few days before Mary died, she had sounded positive and looked the best she had done for several years.

15 11.5 In late **November 2017** Gary was informed by the social worker that she would not be recommending that the children should be returned to Mary. Mary had not been informed at this at this stage and this was an inappropriate exchange of information. It is unclear whether Gary shared this information with Mary, however being in possession of such information would have undoubtedly reinforced his position of power over Mary.

15.11.6 Research identifies that there are several protective factors that can prevent a woman from taking her own life which includes motherhood and the strong maternal bond with children and other dependents.[60]
Mary was a very vulnerable women at the time her children were taken into care. She was experiencing the effects of drugs, alcohol and trauma associated with experiencing DA and this was well known to agencies involved with her. When care proceedings are initiated, a social worker will be under significant pressure to achieve all the evaluations

[59] Section 20 of the children act 1989 sets out how the local authority can provide accommodation for a child within their area if a child needs it, due to a child being lost/abandoned or there is no person with parental responsibility for that child.
[60] Women and Suicide Centre for Suicide Prevention www.suicideinfo.ca

required, especially if, as in Mary and the children's case, there are complex family structures, several potential carers and many multiple parenting assessments.

15.11.7 It is therefore not realistic to expect a social worker to support the parent as well and he / she relies on other agencies where there may be long waiting times. In Mary's case we are aware that it was difficult for her to receive counselling via ESDAS due to long waiting lists, although she was receiving outreach support. The focus was on the care of the children and the wrap around support that could have helped Mary was not apparent during the care proceeding process.

In some local Authorities e.g. Hertfordshire County Council Family Safeguarding Team, specialists' services have been developed to support children and parents. MARY was also under enormous pressure to do everything professionals asked of her in order to have her children back whilst believing that some professionals wanted her to fail.

15.11.8 CSC have implemented family focused model under the title of 'Family Safeguarding'. This 'whole system' approach aims to improve the quality of work undertaken with families (both parents and children) and focuses on meeting the needs of parents so they can meet the needs of their children. It utilised motivational interviewing. The model, implemented in April 2019, is based around a multi-agency approach including:

i. social workers and family workers
ii. domestic abuse practitioners (supporting the victim), domestic abuse officer (working with the perpetrator)
iii. recovery worker who works with adults around their alcohol / drugs use
iv. mental health practitioner who works with parents experiencing mental health difficulties
v. a clinical psychologist who works with parents to support their behaviour and parenting skills.

15.12 Consider whether Mary's welfare was promoted and protected through timely and effective assessment including risk assessment and response to the needs identified (this includes application of thresholds, information sharing, use of assessment tools and timely intervention).

15.12.1 Mary was involved with many agencies throughout her teenage and adult life. In her teenage years Mary was supported by her GP to access mental health services. CSC and the police were involved in several incidents at the same time, relating to inappropriate sexual relationships with older men which should have been identified as grooming and possible CSE. In addition, Mary's family reported they were not able to cope with her aggression although this is now disputed by the family.

15.12.2 From April 2014, when Mary became involved with Gary, agency involvement increased. Whilst Mary was pregnant with Charlie, she was found to be taking drugs which resulted in the police, health, and CSC all being involved. Charlie was born with cocaine identified in the system leading to a Child Protection Conference (CPC). This resulted in a contract being drawn up with Mary and Gary that they cease taking drugs

and that Mary be subject to drug testing through hair strand analysis. Gary was not included as this was part of Mary's Parenting Assessment.

15.12.3 From **September 2015-February 2017** there were several incidents relating to Mary, Gary and others resulting in the police, CSC, the local borough council (housing support) and the registered local landlord being more involved with Mary and the family. From information within the police and CSC IMRs the main concern during this period related to the children, their neglect, safety, living in a house where domestic abuse and substance abuse were a common occurrence. Although there was concern for Mary in relation to domestic abuse as identified by the police, Mary's mental health at that time was not considered an issue.

15.12.4 From **March 2017-November 2017** incidents between Mary and Gary increased. There was a referral to the MASH in late **March 2017** and following an assessment it was agreed that the Family Support Programme (FSP) would work with Mary and the family to address concerns. When she was unable to engage, it was agreed the threshold for the Children and Family Assessment was met and that a social worker be allocated to the family.
From **June 2017:** Mary was assessed as vulnerable by the police, with the DASH Risk evaluated as High and an outreach referral was completed (good practice).

15.12.5. Mary was deemed vulnerable by agencies and the Police, CSC and ESDAS worked as a strong partnership to provide a Refuge place in the midlands, with money and a safe mobile phone for Mary in order to keep her and the children safe. She did not stay long as she felt isolated and communicated with Gary.

15.12.6. Mary highlighted in her ABE interview in **early August 2017** (as detailed in paragraph 13.37) that she felt very low. She went to stay with her parents, but the SIU (Safeguarding Investigation Unit) was so concerned with Mary's vulnerability and safeguarding that welfare checks were initiated.

15.12.7 Gary was identified as a High-Risk DA perpetrator in **August 2017** leading to a plan to proactively address and prevent offending behaviour through the local Tasking and Coordination meetings. The 4P[61] plan was completed including an intelligence profile relating to Gary and to increase welfare checks for Mary.

15.12.8 Mary and the children were referred by the police to ASC through the MASH in **July 2017**. The referral stated that Mary had "problems with drugs", she was suffering elements of coercive control and showed some vulnerability such as isolation and depression. The MASH team passed on the information to the *i*-Access Team who at that time were integrated with SaBPT and the ASC team working with substance misuse problems. The MASH worker noted that Mary was not open to SaBPT services but that the referral raised potential safeguarding concerns for Mary.

[61] Pursue, Prevent, Protect, Prepare

15.12.9 Contact records show that she was reported as a Safeguarding Adults Concern which was correct but a second question "Are safeguarding concerns indicated" was left unanswered. If this had been completed correctly, this would have created a workflow for Adult Safeguarding decision making.

15.12.10 A further referral to ASC took place in late **July 2017** which indicated an escalation in the DA she was experiencing, with a DASH rating now as High Risk. The ASC MASH team passed the work directly to the *i*-access team[62] on the expectation that they were actively involved with the case however they were not at that time. Also, the question "Are adult safeguarding concerns indicated?" was incorrectly recorded as a "No". A positive answer would have generated a S42 Care Act assessment.

15.12.11 ASC attended the MARAC in **August 2017** at which Mary was discussed. Information was shared, including that Gary had threatened to kill her, he had breached his bail conditions and that Mary was still taking drugs which was impacting on the children. It was not evident whether this information was discussed with the ASC team who may have been working with her.

15.12.12 In total, Mary was referred five times to ASC (**July 17-Nov17**) and on no occasion was a safeguarding concern identified. NHS Digital defines a safeguarding concern as a sign of suspected abuse or neglect that is reported to or identified by the Council. When ASC receive a safeguarding referral, they have a duty to decide whether the criteria in S42 Care Act 2014 has been met:

- Care and support needs
- Experiencing or at risk of abuse or neglect
- Unable to protect themselves from abuse or neglect because of their care needs.

The ASC decision not to hold an Adult Safeguarding Enquiry in response to concerns and whether Mary had experienced or been at risk of neglect or abuse.

15.12.13 ADASS[63] has a case study based on domestic abuse which outlines whether a safeguarding adult enquiry should proceed or not.[64]
In hindsight, safeguarding professionals agree there should have been an Adult Safeguarding enquiry because:

i. There is explicit and implicit evidence of coercion and control which could limit Mary's ability to protect herself.
ii. There was enough evidence that Mary was unable to protect herself.

In 2017 there may have been different views as to whether Mary had been a person with care and support needs for the purpose of S42 Care Act 2014 as there were some gaps in statutory guidance. The Surrey Safeguarding Adults Board revised its procedures in 2018 which now gives much clearer guidance.

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[62] *i*-Access https://www.surreydrugandalcohol.com/
[63] ADASS the Association of Directors of Adult Social Services in England
[64] ADASS/LGA "Framework for making decisions on the duty to carry out safeguarding enquiries" Appendix 3 www.Adass.org.uk

15.12.14 The sheer volume of referrals into the MASH in 2017 may also have hindered the support for Mary. The police and ASC worked to different definitions of vulnerability at that time, with the police assessing vulnerability as level of risk of harm, whereas ASC assessing their level of need and support. At the time of Mary's referral around 90% of the referrals were from the police and only 5% of those raised adult safeguarding concerns. In Mary's case, the referral was passed onto the locality team by email and not through the LAS system[65]. This email was not tracked and there is no evidence that it was acted on.

15.12.15 What is apparent is that ASC professionals were under pressure within the MASH which led to decisions not being made in a timely manner. Decision-making became confused with two different ASC teams working on the same case in isolation. The essential Safeguarding Enquiry under Section 42 Care Act was missed. It is also apparent that there was no thorough risk assessment of working with someone experiencing domestic abuse, including the lack of understanding of the potential impact of coercion and control.

16. LESSONS LEARNT

16.1 Better Support for parents involved in care proceedings.

Information provided by friends and agencies states that Mary loved her children, in her words "she would not do anything silly as the children were her life". Mary was distraught and angry when the children were taken into police protection. It is alleged that she went to collect the children from school and was then told by the police what had happened.
In the last couple of months of her life, Mary had been proactive in addressing her addiction and doing everything that was asked of her as part of the Child & Family Assessment including attending a parenting course and regular attendance at the Children's Centre.

16.1.1 Children are a protective factor for women and therefore when children are taken into care the protective factor is removed. Separation is a high-risk factor in relationships (Mary and Gary had supposedly separated at this time) and now Mary was separated from her children. This would have increased Mary's vulnerability, especially when it was known by professionals that she suffered anxiety, depression, substance abuse and domestic abuse. Although it is understood that a child social worker's primary role in such situations is to ensure the safety and wellbeing of the children, it is important that the welfare needs of a parent are also considered, especially if the parent is known to be as vulnerable as Mary was.
As the report has already detailed Mary should have been assessed under S42 Care Act 2014. If this had taken place, then additional support could have been available to Mary at this very difficult and high-risk time of separation.

The DHR / SAR Panel felt that this early learning was so important that the Independent Chair presented a briefing paper to the Children and Adult Safeguarding Partnerships

[65] Liquidlogic Adults' Social Care System https://www.liquidlogic.co.uk/adults/las/

in October 2019 highlighting the consideration of support-needs for parents when children are removed during care proceedings.

The DHR / SAR Panel acknowledges that over the past two years there have been significant structural changes within CSC, which in the future, will be able to address the welfare and support needs of the whole family.

Surrey Police has updated their Public Protection Policy (including the removal of children from their parent(s) to closer align it to the Police Protection and Approved Professional Practice that is published by The College of Policing.

16.2 Professional Curiosity and understanding the need to know the victim better.

16.2.1 The review identifies that there were complex issues in Mary's life starting in her teenage years. She had mental health issues in her early adolescence with her anxiety and depression worsening whilst with Gary (comments from friends). There were incidents of previous domestic abuse in her relationships prior to Gary, both as victim and perpetrator but the domestic abuse increased once in her relationship with Gary. Her substance misuse appears to have commenced during her relationship with Gary either as a controlling or a coping mechanism.

16.2.2 Analysis of IMRs highlights that if agencies had researched historical incidents, a pattern of domestic abuse, mental health and substance abuse could have been established which would have given agencies a better understanding of Mary's needs.

For example, the police and CSC concentrated on the issue of domestic abuse and substance abuse whilst health focused on Mary's mental health. Health services were not included in the MARAC and could have provided valuable information to create a more complete picture of Mary's vulnerabilities and the support she needed. Domestic abuse and Safeguarding training need to equip professionals with the tools to be curious and build up a complete picture of an individual so the most suitable support can be provided.

16.2.3 Norfolk Safeguarding Adult Board has produced a Guidance document about Professional Curiosity; what it is, the barriers and how a professional can be professionally curious.[66] Such a guidance document would be helpful to many agencies including organisations with less experience of dealing with a complex number of issues as in Mary's case e.g. Catalyst, Children's centres, GPs.

16.3 Access to services and lack of engagement

16.3.1 Mary was involved with several services but professionals from all agencies had difficulty engaging with and contacting her. It is likely that there were a multitude of reasons and this would have been compounded by Mary's mental health issues, domestic abuse, controlling behaviour by Gary and substance misuse.

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[66] https://www.norfolksafeguardingadultsboard.info/assets/UPLOADS/NSAB-Professional-Curiosity-Partnership-VersionAPR2020FINAL04.pdf

Mary and Gary missed several appointments, especially with health and there was little evidence of professionals challenging their lack of engagement and their possible avoidance behaviour. Mary may also have been prevented from engaging by Gary as part of his increasing CCB. Whilst it is recognised that there needs to be a degree of personal motivation to engage with services, there can be a tendency for too much onus on the service user to take responsibility for this. When an individual is suffering from mental health issues, domestic abuse and substance misuse, as Mary was, the effort to go to appointments, return phone calls and communicate can be too much. Gary may also have prevented her calling as he had previously smashed her phone. Professionals do need to review how to improve engagement processes with people who are deemed 'difficult to engage with'.

16.4 Information Sharing

16.4.1 The numerous agencies involved with Mary led to a confused approach to information sharing.

i. Mary and Gary were referred twice to the MARAC but there appears to have been confused information sharing between representatives who attend the MARAC and the practitioners who were working directly with Mary. This was highlighted by both CSC and ASC within their IMRs. Communication procedures between same-agency professionals need to be reviewed although since the review commenced improvements have been made.

ii. Surrey Police (who co-ordinate the MARAC) now recommend that confidential sharing with other agencies takes place when assessing intelligence which impacts on the safeguarding of children. They also recommend that incidents that are linked to the same individuals or domestic situation are allocated to one Investigating Officer. This will ensure single oversight of all reported incidents and help inform risk management strategies.

iii. The GP appears not to have been updated with the MARAC outcome and although Mary had not been in contact with her doctor for some time, this meant that there was not an opportunity to review her mental health support.

iv. Catalyst, who were providing support to Mary around her substance misuse issues had a key role in her life at the time of the MARAC. Similarly, no information from MARAC was shared; with their involvement there may have been an opportunity to review all the support that Mary was receiving and identify any gaps.

A process should be found to ensure information is shared with GPs and other non-statutory agencies to enable a safe coordination of services to take place.

16.5 Lack of understanding by professionals of coercive controlling behaviour.

Despite controlling and coercive behaviour being embedded in domestic abuse legislation, it still appears that it is the least understood aspect of the overall domestic abuse and safeguarding legislation. All professionals need to think wider and seek to explore individuals with greater curiosity. Most police have a good knowledge of CCB and the tools to identify

such behaviour (via DA matters training). However not all the professionals dealing with Mary had the confidence to identify coercion and control as a risk factor in Mary's life.
A friend said that Gary was isolating Mary, he wanted to control her, he gave her drugs when she wanted to get clean and he bribed her with expensive gifts. These are all classic indicators of coercive controlling behaviour.

16.6 Domestic Abuse as both Victim and Perpetrator

16.6.1 Assessing a victim who is also a perpetrator of violence is not always straightforward and care is needed to access underlying factors. Evidence indicates that Mary suffered from mental health issues early in her life and had potentially been groomed by older men into sexual relationships as a child she was unable to give consent. Her parents sometimes struggled to cope with Mary's behaviour.

In her later relationships, there were examples of Mary being both a victim and using violence towards Gary in retaliation. Mary's aggressive behaviour arose after relationships finished and she was vulnerable and low.

16.6.2 Mary and Gary commenced a relationship and the incidence of abuse towards Mary grew, often fuelled by drugs and alcohol. Evidence suggests that Mary had not been significantly involved with drugs and alcohol prior to this relationship. Gary was known to supply and take drugs. He used drugs to control Mary, especially when she was trying to give up, by posting supplies through the letterbox. To gain a fuller picture, Surrey Police has recommended that an experienced investigator reviews the historical as well as current Police involvement with the individuals, to inform risk management.

16.6.3 It is not clear whether Mary's drinking was a response to the psychological, physical and verbal abuse she was experiencing. Alcohol and drugs are frequently used to self-medicate, to block out thoughts and to cope with feelings from abuse.[67]
Some professionals may not have considered her drinking as a coping mechanism but more of a lifestyle choice. It is important that professionals understand the complex behaviours of a victim.
A victim (who on some occasions has been labelled a perpetrator) can indicate the use of retaliatory violence which highlight a victim's sense of despair and feelings of helplessness.

16.7 ASC Assessment Process

16.7.1 ASC has identified that Mary should have been made a subject of a safeguarding enquiry. The response to the concerns raised by two referrals for Mary (5 July 2017 and 21 July 2017) were not considered for an adult safeguarding enquiry until three weeks later, whereas this should have been completed within 48 hours. Due to such a long delay, there was a conflation between decisions on

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[67] Using drugs and alcohol to cope with abuse www.domesticshelters.org Feb 2016.

whether there ought to be an adult safeguarding enquiry and whether Mary had experienced or been at risk of abuse or neglect, with evidence showing clearly, she was.

16.7.2 In 2017, the MASH was overwhelmed with referrals from the police who used different criteria to assess vulnerability to ASC (risk of harm rather than level of need). This resulted in 90% of MASH referrals coming from the police of which only 5% were adult safeguarding concerns. This led to only a basic check on Mary in the MASH before her referral was passed to the ASC locality team despite the *i*-Access team being involved with Mary.

16.7.3 Since 2018, there has been several changes which have improved the safeguarding assessment process:

i. *Support for those making decisions about whether an adult safeguarding concern should lead to a S42 Care Act Enquiry. This includes clarity about "care and support needs" and includes needs arising from substance misuse which would have related to Mary.*

ii. *Improving ASC response to adult safeguarding concerns relating to domestic abuse.*

iii. *Improving the functioning of the MASH, which has resulted in non-adult safeguarding referrals being managed in different ways. This leaves the MASH to focus on adult safeguarding to ensure decisions are made in a timely and correct* way.

16.8 Impact on children living with domestic abuse.

16.8.1 Although the TOR did not identify the children as a key line of enquiry, this review has given a detailed insight into the life of a child living with domestic abuse, substance abuse and with a parent with mental health issues which may help professional when dealing with families with complex issues and needs. Although the children were not interviewed directly for this review, information from family and friends and the IMRs has given an insight into the experience of Ashley, Frankie and Charlie.

Ashley became a carer for the younger siblings, changing nappies, getting them ready for school and feeding them. Frankie displayed behaviours possible resulting from what was witnessed between Mary and Gary, for example inappropriate knowledge of sexual behaviour.

16.8.2 It is well documented within the report how concerned professionals were about the children and their neglect. However, there is a danger that if neglect is used as a category for a Child Protection Plan where domestic abuse is also a factor, that the emotional harm to the child of witnessing and coping with domestic abuse is lost.

Research shows that domestic violence has a devastating impact on children and young people which can last into adulthood. Symptoms can include:

- Becoming anxious or depressed
- Having nightmares / flashbacks
- Having physical symptoms e.g. wetting the bed, tummy ache
- Possibly becoming aggressive [68]

Examples within the report identify that Frankie was taking knives and hiding them under the pillow. The Foster carer stated that it took a while for Frankie and Charlie to sleep in their own beds and Frankie displayed some aggressive behaviour.

16.8.3 It is important that professionals working with families understand the impact on children of living with domestic abuse and have the tools to identify behaviours, listen and interpret the voice of the child to enable the whole family's needs to be better supported. As a result, Surrey Police has recommended that all police staff involved in the investigation of incidents of domestic abuse ensure that accounts are obtained from the children involved/witnessing incidents with the appropriate expert advice and assistance.

16.9 Post Review Learning

The updated DHR Statutory Guidance (December 2016) advises that a DHR should be undertaken where it would appear someone has died unexpectedly in circumstances where there are concerns about domestic abuse, including controlling coercive behaviour. The process is about learning and not blame. However, some families struggle to understand why a DHR is required as there was no homicide[69]. In the only telephone conversation with Mary's mother, she said the family were struggling to understand why such a review was taking place, as they did not see Mary's death related to domestic abuse.

17.0 CONCLUSIONS

17.1 Mary's death was unexpected. Mary said to professionals that although she had felt suicidal at times, she would not do anything as her children were her protective factor. Mary was devastated when Frankie and Charlie were taken into care, especially as she was seeking help for substance abuse, attending the Children's Centre and was "doing what professionals asked".

17.2 The review has highlighted the tragic cost of domestic abuse including coercive control, mental health issues and substance abuse. The numerous agencies involved with Mary did not always consider the 'bigger picture' of all the issues she was experiencing; if this had been recognised, then Mary may have had more support especially during time when the children were taken into care. As a result, Surrey Police have reinforced that an experienced investigator reviews the historical as well as current Police involvement with the individuals, to inform risk management.

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[68] Women's Aid -The impact of domestic abuse on children and young people: https://www.womensaid.org.uk/the-survivors-handbook/children-and-domestic-abuse/

[69] Homicide the killing of one person by another -Oxford Dictionary of English

17.3 Health agencies were not given information about Mary and what she was experiencing in 2017. Sharing information from the MARAC with the GP and mental health services could have enabled a better picture of Mary's support needs during the period when she was very vulnerable.

17.4 Although Mary was seen as a victim by some agencies, there is evidence in the IMRs to indicate that professionals were judgemental about Mary, Gary and what was perceived as their "lifestyle choices" and which indicated "professional bias". Professionals used the words "did not engage" "missed appointments" and did not explore the reasons behind this behaviour. Professionals may need to have difficult conversations with victims, but they should ensure that that this is done through a compassionate, supportive and non-judgemental approach.

17.5 When an abusive relationship is breaking down, there is an increased risk of serious harm. Although some professionals are more aware of such risks through training and experience, this review also highlights the risks relating to separation of a mother from her children. Feedback from friends highlights that Mary loved her children and wanted them back. There is evidence to indicate that Gary used the separation from himself and the children to control and coerce Mary. During the time that care proceedings were taking place, professionals focused on the children and the domestic abuse that Mary was experiencing. The high risk of separating Mary from her children was not identified and the support she needed during this period was not considered.

17.6 When Mary was referred to ASC as an adult safeguarding concern, a decision should have been made as to whether the criteria in S42 Care Act 2914 had been met (which they were). She should therefore have been subject of a safeguarding enquiry, and support could have been made available for her. This may have helped her through the period of increased experiences of domestic abuse and separation from her children.

17.7 It is imperative that agencies work together to ensure that they understand fully the issues a person in experiencing and to understand what has happened in the past. This will enable professionals to "know the victim" better in order to provide the essential support that they may need.

18.0 RECOMMENDATIONS

The CSP submits a quarterly monitoring report to the Surrey DHR Oversight Group. The report is compiled from updates from each of the agencies with responsibility for recommendations, who are required to provide evidence of progress. Progress is also discussed and at the quarterly CSP meetings.

1. TRAINING LOCAL

Recommendation One
Professionals must understand the increased risk when children are removed, especially when a parent is experiencing domestic abuse, has other risks and has increased vulnerability. Support for the parent should be provided both before the children are removed and afterwards. Individual agencies to ensure their staff are trained understand and support the parent, including the management of risk. This will be scrutinised by the SSAB and SSCP, giving assurance to the SAB / SCP that the agencies have implemented this training.
Ownership: Individual agencies (Police, ASC & CSC)

Recommendation Two
The Surrey Children Services Academy (SCSA), SSCP and SSAB will develop a training programme and guidance information on Professional Curiosity which will be available to all agencies including the charity, community and faith sectors. Agencies to review improved understanding of professional curiosity in supervision.
Ownership: SCSA, SSCP and SSAB

Recommendation Three
The Children Service Academy (SCSA), SSCP and SSAB will ensure that staff working with vulnerable adults, children and families have an in depth understanding through DA training including coercive controlling behaviour, the trauma impact of CCB, the increased risks including stalking, grooming of family members and professionals, retaliatory violence / resistance and an understanding of the links between substance abuse, mental health issues and domestic abuse. Through training, those professionals working in adult social care must have the tools to understand the needs of a victim suffering from domestic abuse, substance abuse and mental health issues.
Ownership: SCSA, ASC, SSCP and SSAB

Recommendation Four
DASH training to be available to all agencies when assessing risk.
Ownership: Police, ASC and SCSA

Recommendation Five
ASC professionals to ensure (through Safeguarding Training and supervision) that the importance of timeliness in decision making is emphasised following receipt of a safeguarding enquiry referral.
Ownership: ASC

Recommendation Six

Learning from this DHR to be disseminated via a workshop organised by RBBC/SSAB and the Independent Chair.
Ownership: RBBC and SSAB

2. INFORMATION SHARING / REFERRAL PROCESS

Recommendation Seven
The MARAC process to be reviewed to ensure that information regarding relevant risks for a service user is passed safely and promptly to any involved service, including Primary Care e.g. GPs. Thia was also a recommendation in the Coroner's report from the Inquest October 20.
Ownership: Surrey Domestic Abuse Management Board (DAMB)

3. ASSESSMENT

REFERRAL PROCESS

Recommendation Eight
SSAB and SSCP to produce safeguarding referral guidance (adult and children) for organisations whose sole purpose is not safeguarding e.g. housing associations, drug and alcohol services, and to raise awareness of its availability.
Ownership: ASC MASH and Children C-SPA.

4. NATIONAL

Recommendation Nine
RBBC CSP to highlight the need for the Home Office to consider updating the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016 to include specific guidance where a person may have taken their own life**.**
Ownership: RBBC CSP

Recommendation Ten
RBBC CSP to request that the Home Office promotes the Domestic Abuse Housing Association Accreditation principles as best practice for housing associations[70].
Ownership: R&B CSP

SERVICE SPECIFIC RECOMMENDATIONS

POLICE (original documents numbering in brackets)

P-Recommendation 1(2): It is recommended that all police officers and police staff involved in the response to / investigation of incidents of domestic abuse ensure that accounts are obtained from the children involved/witnessing incidents with the appropriate expert advice and assistance.

[70] www.daalliance.or.uk

P-Recommendation 2 (3): It is recommended that once incidents of DA have been referred to the Safeguarding Investigation Unit, an experienced investigator reviews the historical as well as current Police involvement with the individuals. This will help inform investigative and risk management strategies.

P-Recommendation 3 (4): It is recommended that where possible, incidents that are linked (same individuals, same domestic situation) are allocated to one investigating OIC. This will ensure single oversight of all reported incidents and help inform risk management strategies.

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APPENDIX ONE
DHR / SAR PANEL MEMBERS

ORGANISATION	ROLE	NAMED OFFICER
Surrey Police	DCI East Surrey	Debbie Crouch
	Statutory Reviews Lead	Andy Pope
Surrey Safeguarding Adult Board (SSAB)	SSAB Chair	Sarah McDermott
	Surrey Safeguarding Adults Board Administrator	Dena Kirkpatrick
Adult Social Care (ASC)	Senior Manager	Teri Cranmer
Surrey Wide CCG	Designated Nurse Safeguarding Adults	Helen Blunden
Children Social Care	Assistant Director SE Quadrant	Sam Bushby
Primary Care	Designated GP for Safeguarding Children & Adults	Tara Jones
Raven Housing Trust	Tenancy Enforcement & Housing Choice Manager	Sue Young
ESDAS	Director of Operations	Miatta Marke
RBBC	Partnerships Team lead	Clare Mittelstadt
ESCSP	Community Safety Officer	Amanda Bird
Independent	Independent Chair	Liz Borthwick
Independent	Independent Co-ordinator	Debbie Stitt
SABPT	SGA & DA Lead	Debra Cole

APPENDIX TWO

TERMS OF REFERENCE
DOMESTIC HOMICIDE REVIEW and SAFEGUARDING ADULT REVIEW
Updated February 2020 *(vrs 6)*– MARY

1. This is a joint Domestic Homicide Review (DHR) and a Safeguarding Adult Review (SAR)

2. *The Domestic Homicide Review (DHR)* is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

3. *The Safeguarding Adult Review (SAR)* is being conducted in accordance with the Care Act 2014 which states that Safeguarding Adult Boards (SABs) must arrange a Safeguarding Adult Review (SAR) 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 together more effectively to protect the adult.

4. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

5. *Parallel investigations*: The following were investigated separately to this Review:
i) Children's Services; complaint from father
ii) Police; criminal trial for breach of Non-Molestation Order and driving offence
iii) IOPC; in response to officer conduct
iv) Mary's father complaint to the IOPC about Police conduct.

6. The DHR will strictly follow the East Surrey Community Safety Partnership (ES CSP) DHR protocol, which is based on Home Office guidance[71]

7. *The statutory purpose of the DHR is to*:

a) Establish what lessons can learned from Mary's unexpected death regarding how the local professionals and organisations worked individually and together to safeguard the victims of domestic abuse.

b) Identify clearly what those lessons are, both within and between agencies, how they will be acted on, and what will change as a result through a detailed Action Plan.

c) Apply these lessons to service responses including changes to policies and procedures as appropriate.

d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

[71] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

8. The statutory purpose of the SAR is to:

a) To direct the Safeguarding Adults Board (SAB) to review the circumstances where 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.
b) Identify and promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. This will include useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
c) Explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

9. The agreed timeframe for information to be secured and reviewed is **date of birth of the first child** unless there have been significant events prior to this. *Significant events will include engagement due to mental health and other noteworthy medical issues, domestic abuse, other wellbeing issues etc.*

10. The DHR / SAR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SAR, IPCC referral, internal agency disciplinaries) may use information from the DHR process to support their investigations.

11. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:

a) Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and perpetrator.

b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator[72]

c) To consider whether opportunities were missed for professionals to routinely enquire about domestic abuse, coercive, controlling and stalking behaviour which should have led to a referral to a domestic abuse support service.

d) To review whether there was adequate 'professional curiosity' during engagement with Mary

d) Whether there were any barriers experienced by Mary or her family / friends / colleagues in seeking support from professional service providers.

e) Agencies that had no contact will investigate whether helpful support could have been provided and if so, why this was not accessed.

[72] e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

f) Whether there were opportunities for agency intervention or support regarding any known perpetrators of domestic abuse / coercive control which were missed.

e) Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.

f) Whether professionals were aware of ‘confirmation bias when reviewing an individual’s background?

h) What parental support was provided when the children were taken into care?

i) Whether Mary’s welfare was promoted and protected through timely and effective assessment including risk assessment and response to the needs identified (this includes application of thresholds, information sharing, use of assessment tools and timely intervention).

12. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the Chair of ES CSP.

13. These Terms of Reference may be varied by the DHR Panel as new information emerges.

APPENDIX THREE

GLOSSARY OF ABBREVIATIONS AND TERMS USED IN THIS REPORT

ABBVTN	FULL NAME
AAFDA	Advocacy after Fatal Domestic Abuse
ABE	Achieving Best Evidence interview used by the police, often videoed
ASC	Surrey Adult Social Care
CAADA	Co-ordinated action against domestic abuse. Risk assessment tool
CAMHS	Child & Adolescent Mental Health Service
C&F	Child and Family
CFHS	Children & Family Health, Surrey
CCB	Coercive Controlling Behaviour
CCG	Clinical Commissioning Group
CFH	Child & Family Health
CSC	Children's Social Care Surrey
CSCA	Surrey Children's Services Academy
CSH	Central Surrey Health
DAMB	Surrey Domestic Abuse Management Board
DASH	Domestic Abuse Stalking and Honour-based Violence Safeguarding Risk assessment
ESCSP	East Surrey Community Safety Partnership (CSP) - now reverted to the standalone Reigate and Banstead CSP
IMR	Individual Management Review
IO	Police Investigating Officer
IOPC	Independent Office for Police Conduct
FSP	Family Support programme
MARAC	Multi-Agency Risk Assessment Conference
MARF	Multi-Agency Referral Form
MASH	Multi Agency Safeguarding Hub (now C-SPA)
OIC	Officer in Charge
PACE Interview	Interview carried out under caution under the Police and Criminal Evidence Act
Police	Surrey Police
RBBC	Reigate & Banstead Borough Council
SDAC	Surrey Drug & Alcohol Care
SECAMB	South East Coast Ambulance Service
SIU	Surrey Police Safeguarding Investigation Unit
SSAB	Surrey Safeguarding Adults Board
SSCP	Surrey Safeguarding Children Partnership