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.

Reigate & Banstead Borough Council
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surrey safeguarding ADULTS BOARD

Reigate & Banstead Community Safety Partnership

DOMESTIC HOMICIDE/SAFEGUARDING ADULTS REVIEW

Into the death of Jane (Pseudonym)

In October 2021

EXECUTIVE SUMMARY

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

CONTENTS

1. THE REVIEW PROCESS

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

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

1.3 Jane who was 51 years of age at the date of her death was of White British origin.

1.4 The Inquest was concluded on the 28th March 2022, cause of death was suicide by hanging.

1.5 The Review process began when Reigate and Banstead Community Safety Partnership were notified by the Surrey Police of Jane's death on the 29th December 2021. It was noted that Jane was reported to have been a victim of domestic abuse and a decision was taken by the Chair of Reigate and Banstead Community Safety Partnership to undertake a combined Domestic Homicide Review/Safeguarding Adults Review on the 23rd February 2022.

1.6 The Home Office was informed of this decision on the 24th February 2022. The Review was delayed initially due to local restructuring which was protracted due to staff changes within the Community Safety Partnership and later by the death of the alleged perpetrator.

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

1.8 All agencies that had contact with Jane and John prior to the point of Jane's death were contacted and asked to confirm whether they had involvement with them. A total of twelve agencies were contacted.

2. CONTRIBUTORS TO THE REVIEW

2.1. The following organisations/Trusts were contacted by the Review:

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

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

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

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

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

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

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

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

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

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

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

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

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

3. THE REVIEW PANEL MEMBERS

3.1 The Review Panel consists of Senior Members, from statutory and non-statutory agencies who are able to identify lessons learned and to commit their organisations to setting and implementing action plans to address those

lessons. None of the Members of the Panel have had any contact direct or indirect with Jane and John.

3.2 The Panel Members:

Michelle Baird	Independent Chair / Author - Know More Limited
Georgia Tame	Domestic Homicide Review Co-Ordinator, Surrey County Council
Trevor Ford	Community Safety Officer - Reigate & Banstead Borough Council
Sarah McDermott	Safeguarding Manager - Surrey Adults Safeguarding Board
Andy Pope	Statutory Reviews Lead - Surrey Police
Helen Milton	Designated Nurse, Safeguarding Adults - Surrey Heartlands Integrated Care Board (ICB) for GPs
Ludmila Ibesaine	Safeguarding Adults & Domestic Abuse Lead - Surrey and Borders Partnership NHS Foundation Trust (SaBP)
Trevor Woolvet	Housing Needs Manager - Reigate & Banstead Borough Council
Vicky Abbott	Head of Safeguarding - Surrey & Sussex Healthcare NHS Trust
Tom Stevenson	Assistant Director Quality Practice and Performance Children Social Care - Surrey County Council
Clement Guerin	Head of Adult Safeguarding - Surrey County Council
Michelle Blunsom	CEO - East Surrey Domestic Abuse Services (ESDAS)
Richard Williamson	Tenancy Enforcement Team - Raven Housing Trust
Alison Hopkins	Deputy Head - Surrey and Sussex Probation Service

3.3 The Review panel met formally three times.

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

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

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

4.2 She has no connection with the Reigate & Banstead Community Safety Partnership or the Surrey Safeguarding Adults Board and is independent of

all the agencies involved in the Review. She has had no previous dealings with Jane or John.

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

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

4.5 In June 2022, she attended a two day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention.

5. TERMS OF REFERENCE

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

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

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

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts.
- Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews and Safeguarding Adults Review.[1]

  The Review Panel will consider:

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

[1] The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance 14.62 and 14.63

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

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

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

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

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

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

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

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

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

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

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

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

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

- The Review will also highlight good practice.

6. SUMMARY CHRONOLOGY

6.1 The synopsis of the case has been informed by chronologies of the contact agencies in Surrey had with Jane, John, Alex, Pat and Sam. All were of white British origin.

6.2 Jane and John had been in a relationship for close on 20 years, however, they separated a number of times during this period, the longest break being for eight years. Jane and John had two children, Alex and Pat. Sam was Jane's child from a previous relationship.

6.3 Jane's medical records show a very long and complex history of substance misuse and overdoses. Her first overdose (of paracetamol) was recorded in 1987 when she was 16. She was recorded as struggling with drug and alcohol misuse from 2001, undergoing detoxification programmes on several occasions. She had also been subjected to domestic abuse over a long period of time.

6.4 John had a history of significant drug use dating back to him being nine years old. He reported using Class A drugs from 1987 to 2004 when he began misusing alcohol. John reported having issues with his temper and felt angry about his childhood, experiencing a period in the care system when he was 15. He spent a number of years in foster homes, secure units, Young Offender Institutes and then adult prisons. He was also the victim of a significant assault in 2012 that resulted in a brain injury. Since this time, John reported experiencing depression and anxiety and hearing voices.

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

6.6 At the end of August 2017, Jane took an overdose of prescription medication. Jane was found by Sam who was 13 years of age at the time. It was believed Jane suffered a stroke as a result of her prolonged immobility.

6.7 Sam was made subject to three periods of Child Protection arrangements due to concerns of physical abuse, emotional abuse and neglect. Sam was removed from Jane's care on the 15th September 2017 after Public Law care proceedings were initiated and an Interim Care Order[2] was granted. Jane's level of distress and substance abuse escalated following Sam's removal.

6.8 In October 2017, John's Probation Officer raised concerns regarding John's lack of housing and whether a mental health capacity assessment could be completed. John was in prison at the time and Adult Social Care (ASC) contacted the ASC Prison Team to see if they could undertake an assessment. In November 2017, John was seen by the ASC Prison Team. It

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

was concluded that John did not have eligible care and support needs for ASC support, his primary need was for housing.

6.9 In August 2018, Jane was seen by Mental Health Liaison when she was admitted to the Emergency Department after being found in her shed, having taken an overdose of her prescribed medication and John's methadone.

6.10 On the 6th August 2019, Police were called by John. He was expressing concern that Jane had been feeling down and had recently taken an overdose. Police attended and forced entry and found Jane seated on a settee breathing, but unresponsive. There was an empty bottle of vodka, two empty packs of paracetamol and a can of lighter fuel lying close to her. Paramedics attended and Jane was taken to hospital.

i. Jane was admitted to the Intensive Care Unit for five days. Once she was deemed fit to move to a general ward, Jane self-discharged herself from hospital. A SCARF[3] and Vulnerable Adults at Risk notification (VAAR) were submitted by Police for Jane following her admission to hospital and shared with ASC Multi-Agency Safeguarding Hub (MASH) and Children Social Care. A Domestic Abuse Stalking and Harassment Risk Assessment (DASH) was completed and assessed the level of domestic abuse between Jane and John as medium risk[4].

6.11 On the 12th August 2019, a safeguarding concern was sent to ASC MASH by Raven Housing. Jane asked that her front and rear door locks were changed as John had her keys whilst she was in hospital. On the 15th August 2019, Jane reported to Police that whilst she had given John permission to access her home to collect some items for her, when she returned home she had discovered John had taken property without her permission. Jane subsequently arranged for the locks to be changed herself. ASC MASH obtained additional information from Surrey and Borders Partnership NHS Foundation Trust **(**SaBP) that suggested Jane had a diagnosis of Borderline Personality Disorder, agoraphobia leading to panic attacks and anxiety. It was noted that whilst criteria for Section 42 (S42)[5] was not met, Jane may benefit from a Section 9 assessment (S9)[6].

i. John was arrested on suspicion of Theft and his property searched and John denied the allegations. Jane later informed Police that some of the missing property was in fact intended to be given to John. Due to no recovered property, no witnesses and no other evidential opportunities, no further action was taken. A SCARF, VAAR and a DASH were completed and shared with ASC and Community Mental Health Recovery Service (CMHRS). The DASH assessed the level of domestic abuse between Jane and John as medium

[3] A SCARF is a Single Combined Assessment of Risk Form that enables officers and staff to raise concerns and observations in relation to the needs and vulnerability of individuals

[4] Medium risk: 'There are identifiable indicators of risk of serious harm. The offender has the potential to cause serious harm but is unlikely to do so unless there is a change in circumstances, for example, failure to take medication, loss of accommodation, relationship breakdown, drug, or alcohol misuse'.

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

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

risk. A MARAC[7] referral was also made, however as the incident was graded medium risk and not previously referred to MARAC, it did not meet the referral criteria. A referral for outreach domestic abuse support for Jane was made on the 5th October 2019, but Jane chose not to engage.

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

6.13 On the 17th March 2020, John reported to his CMHRS Support Worker that he was hearing voices instructing him to hurt himself or others. John stated that he could not control his anger and had thoughts of hurting others. John reported that he was feeling suicidal and that he had access to a gun[8]. John said he did not want to carry out the commands of the voices and felt his medication needed reviewing.

6.14 A medication review was completed on the 24th March 2020, it was not possible to complete a face-to-face assessment as COVID restrictions had been implemented. No safeguarding referral was completed in relation to John's disclosure that he could access a firearm nor was this reported to Police.

6.15 A MARAC referral was made by Sanctuary Support Living on the 27th April 2020. John showed bruising on his arm to staff and due to previous concerns around him being a domestic abuse perpetrator, together with the knowledge of his previous convictions, the referral was put in with Jane as the primary victim and John as the perpetrator.

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

6.16 A MARAC meeting was held on 21st May 2020. Records state that John was now staying with Jane at her address and that John had previously disclosed pushing Jane in the back during an argument in which Jane also assaulted him. ASC contacted Police that day to establish if there were any restrictions preventing John from visiting or staying at Jane's address, a response was received on the same day from Police advising there were no restrictions.

[7] Multi-Agency Risk Assessment Conference.

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

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

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

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

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

6.20 On the 12th November 2020, Jane spoke with her GP. She admitted to drinking two to three bottles of wine daily and reported that she was assaulted by her ex-partner three weeks earlier whilst sedated by drugs. Jane's GP encouraged Jane to report this to the Police. There was no mention of signposting to the SARC[9], RASASC[10] and Domestic Abuse Outreach services which should have been at least discussed with her.

6.21 Jane stated she was unintentionally losing weight and having difficulty swallowing. She was asked to attend a face-to-face appointment on the 16th November 2020, but did not attend. There was no further contact between Jane and the GP practice until February 2021. There was no reference to any safeguarding referrals or contact with support agencies following Jane's disclosure of assault. The GP records do not explicitly capture the nature of the assault (physical or sexual) or if the ex-partner she was referring to was John.

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

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

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

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

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

i. Whilst in custody, Jane was seen by the Criminal Justice Liaison and Diversion Services (CJLDS)[11] and a safeguarding concern was raised to ASC MASH following Jane's disclosures. Jane also reported drinking two bottles of wine a night. Jane was to be allocated to CJLDS Outreach.

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

6.25 On the 18th December 2020, a decision was made by ASC MASH for a S42 enquiry to be conducted. ASC called Jane, but there was no answer and a voicemail message was left asking her to call back. It was recorded on the 23rd December 2020 that the S42 enquiry was closed due to ongoing Police involvement and a protection plan that would be drawn up at a scheduled MARAC on 21st January 2021. It was recorded that ASC were unable to contact Jane or her family despite many attempts. In January 2021, CJLDS Outreach recorded that they had also been unable to contact Jane.

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

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

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

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

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

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

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

6.29 On the 25th March 2021, Jane sent a text message to Raven Housing stating she intended to kill herself if she was not rehoused. Staff at Raven Housing tried to contact Jane, but without success and a request was made to Police to conduct an urgent welfare check. Police contacted Jane by phone who was clearly in distress but declined any intervention by Police and was hostile to the prospect of Officers going to her house. The matter was passed to the South East Coast Ambulance Service (SECAmb), as it was a medical rather than a criminal issue. A safeguarding referral was made by Raven Housing and sent to SaBP MASH.

6.30 On the 14th April 2021, a letter was sent by SaBP MASH to Jane's GP regarding Jane's threats to kill herself. The letter stated, *"it is your [the GP's] decision whether you feel the need to take any action in response to this or*

not", rather than a clear request for support for Jane. No appointment was made for Jane with her GP following receipt of the letter.

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

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

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

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

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

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

iii. Given the documented history of domestic abuse perpetrated by John, Police acknowledge that taking Jane and John to Jane's accommodation would not usually be a preferred course of action, however Officers were left to manage a dynamic situation with few available options.

iv. The incident did not warrant arrest, John had no alternative accommodation, he had not been directly involved in the altercation and was presenting as

highly vulnerable. In addition, Jane was requesting that they be taken to her home address in order that she could care for him.

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

6.34 On the 23rd September 2021, a MARAC meeting was held, actions agreed included for the Police Domestic Abuse Team to conduct a welfare visit to try and see Jane and encourage engagement with ESDAS. Police visited Jane on the 3rd October 2021 as agreed at MARAC. Jane said she was "*annoyed"* with all the visits and phone calls she was getting from Police and ESDAS. John was present at the address, Police report that he was lethargic and Jane stated she was looking after him. Jane asked that she have less contact from support services as it was starting to "*annoy her*".

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

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

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

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

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

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

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

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

7. KEY ISSUES AND CONCLUSIONS

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

7.2 The Review Panel commends the agencies that had contact with Jane, John and their children for the thoroughness and transparency of their reports.

7.3 Whilst all of the lessons identified will be addressed by the action plans set during this Review, many would not have had a significant bearing on the circumstances surrounding Jane's death. The Review Panel has however, recognised the following as being key issues, albeit some with the benefit of hindsight:

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

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

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

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

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

7.9 Domestic abuse has additional impacts on people with care and support needs. Perpetrators can use a victim's dependency to assert and maintain control. In particular, Jane's substance misuse and physical health needs may have made her feel increasingly dependent on John.

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

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

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

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

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

7.15 Evidence shows that removal of children has an '*immediate and enduring impact'* on women's lives. Women who have children removed from their care often have long-standing, entrenched and complex needs. In some cases, the removal of a child can lead to premature and preventable mortality (PAUSE, 2023)[12] and consideration should be given to the importance of agencies being more aware of the impact of child removal on women.

8. LESSONS TO BE LEARNED

8.1 The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the action plan template in Section 9 of this report.

Adult Social Care Surrey County Council (ASC)

8.2 There were instances where ASC did not meet their duties under the Care Act, including carrying out adult safeguarding enquiries under S42 and completing a S9 Care Act assessment of need for Jane. This was despite

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

there being indications that there was a risk of abuse or neglect, so an assessment should have taken place even if Jane had refused that assessment.

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

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

Children Social Care Surrey County Council

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

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

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

MARAC

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

8.9 It was identified by the MARAC Chair that no minutes were kept from any of the three meetings held. At that time, it was believed that this was not necessary, due to the information shared being available on MODUS[13] to all parties as were action plans. The MARAC Chair confirmed that other than information pertaining to attendees, there was little information to adduce in relation to the actual meetings. Minutes are now taken at all MARAC meetings.

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

Raven Housing Trust

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

Reigate & Banstead Borough Council Housing Team

8.11 The service had limited involvement with Jane and John. No learning was identified by the IMR Author.

Sanctuary Supported Living

8.12 This service had involvement with John and an IMR was completed. No learning was identified by the IMR Author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

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

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

Surrey and Sussex Healthcare NHS Trust (SaSH)

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

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

8.17 Since the timeframe of this review, better connections with the local domestic abuse services and mental health teams have been established. SaSH have a HIDVA[14] in post since May 2021 and during the past two years there is a raised awareness and visibility and empowered staff. The workforce is more familiar with the onward referral mechanisms and the support that is available, including MARAC. Of note is that funding for the HIDVA role is due to be withdrawn in March 2024, the need to continue this role is evident every day in the work undertaken and the outcomes for survivors.

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

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

Surrey Heartlands Integrated Care Board (ICB) For GPs

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

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

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

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

8.23 Jane's difficulties in engaging with services meant that she did not always receive the services and follow up appointments that she could have benefited from. Whilst it is difficult to draw any recommendations from this, practitioners need to be mindful of continuing to support engagement in those individuals who have difficulties doing so.

Surrey Police

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

9. RECOMMENDATIONS AND ACTION PLANS FROM THE REVIEW

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

Adult Social Care Surrey County Council

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

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

Children Social Care Surrey County Council (CSC)

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

MARAC

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

Raven Housing Trust

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

Surrey and Borders Partnership NHS Foundation Trust

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

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

Surrey and Sussex Healthcare NHS Trust

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

Surrey Heartlands Integrated Care Board (ICB) - For GPs

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

GLOSSARY

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