Safer Woking Partnership / Surrey Safeguarding Adults Board

Joint Domestic Homicide Review and Safeguarding Adults Review

Into the death of Alice (pseudonym)

in May 2022

OVERVIEW REPORT

David Warren QPM, LLB, BA, Dip. NEBSS
Independent Domestic Homicide Review Chair and Author

Review Completed: 10 January 2024

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Personal statement written by Alice's Foster Mother

"My husband and I took *(Alice)* in when she was 14 years of age, she had had such a sad life before then. Both her mother and father were dead. Coming home from school one day when she was 10 years of age, she had discovered her father hanging, two weeks after the death of her mother who died in a car crash. Her father had left her a substantial amount of money in a Trust Fund to be run by her older half-sister, who was supposed to look after her. The sister was abusive and violent towards *(Alice)* and squandered all but 34 pence of her Trust Fund. Her sister was sent to prison for this and eventually *(Alice)* ended up with us. She was happy and became part of our family. She stayed until she was 18 years of age.

On her 18th birthday she went out with friends to celebrate, only to be raped by a man who was arrested for raping her and several other women. After that she was distraught and ran into many problems but whenever she needed help, she would come back to us.

She came to visit once with her partner, she was happy, free from drugs and expecting a baby. She had always wanted her own family and would have been a great Mum. It was not to be, as we were informed, she was in hospital after being severely beaten by her partner. That happened so many times, he would be sent to prison then reappear and it would just happen again and again.

The last time I saw her was a few weeks before she died. She looked amazing, her hair had been styled and she was cheerful and seemed positive, talking about coming to visit me. The only fear she voiced was about her ex-partner coming out of prison. It terrified her.

It still came as a great shock to learn that she had died. She always called me Mummy and her death has left a great hole in our lives. She has been let down by the system all her life. The many difficulties she had endured were tragic, yet she demonstrated the most incredible strength and resilience. In the end though, I think she just gave up, he was coming out from prison and nothing was going to change. She would have been an amazing mother, as she was a daughter to us. I miss her".

1. PREFACE

1.1. The Chair and Panel of this joint Domestic Homicide and Safeguarding Adults Review wish to express their deepest sympathy to Alice's (pseudonym) foster mother, her friends and all who have been affected by Alice's untimely death.

1.2. The Review is held in compliance with legislation and follows Statutory Guidance. Its purpose can be summarised as reviewing the actions of agencies to establish what lessons are to be learned from the case, about the way in which local professionals and organisations work individually and together to safeguard vulnerable individuals and to support victims of domestic abuse. To identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result. To apply these lessons to service responses including changes to policies and procedures as appropriate; and to identify improvements which could be made to community and organisational responses, to try to prevent future incidents. Actions taken to improve services as a result of this Review, will be part of Alice's legacy.

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

1.4. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Alice or Joe (pseudonym), entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Alice's death in a meaningful way and address with candour the issues that it has raised.

1.5. The Chair and Panel thank all who have contributed to the Review for their time, patience and cooperation.

2. INTRODUCTION

2.1. This report of the joint Review examines agency responses and support given to Alice (pseudonym), a resident of Woking, prior to the point of her death in May 2022.

2.2. In addition to agency and practitioner involvement, the Review also examines the past, to identify any relevant background or possible abuse before Alice's death; whether support was accessed within the community and whether there were any barriers to accessing support. By taking a holistic approach the Review seeks to identify appropriate solutions to make the future safer.

2.3. A summary of the circumstances that led to the Review being undertaken in this case:

2.3.1. Alice, who had a history of vulnerabilities through poor physical and mental health, alcohol and drug problems, had been the victim of violent domestic abuse over a number of years. She was found dead in May 2022, in a Surrey hotel room. Nearby her, were empty bottles of vodka, wine, cider together with empty packets of codeine and clonazepam. There was nothing to indicate anyone else had been present.

2.3.2. Alice had left several notes in the room, that talked about the voices in her head and how she 'could not take it anymore'. The Police, other agencies and her friends were aware that Alice was very concerned that Joe, (pseudonym) her ex-partner from whom she had suffered a long history of domestic abuse was being released from prison in July 2022.

2.4. The Review has considered all known contact/involvement agencies had with Alice and Joe during the period between April 2015 and Alice's death in May 2022, as well as contacts prior to that period which could be relevant to neglect, domestic abuse, violence, substance abuse or mental health issues.

2.5. The key purpose for undertaking this joint Review is to enable lessons to be learned where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each case, and most importantly, what needs to change to reduce the risk of such tragedies occurring in the future.

3. TIMESCALES

3.1. A decision to undertake a Domestic Homicide Review and Safeguarding Adults Review was taken by the Chairs of the Surrey Safeguarding Board and the Safer Woking Community Safety Partnership on 21 January 2023 and 31 January 2023 respectively. The Home Office was informed of this decision on the13 February 2023. The Independent DHR Chair was appointed on 27 February 2023 and the first meeting of the DHR Panel was held at the earliest opportunity on 20 April 2023.

3.2. Normally such Reviews, in accordance with National Guidance[1], would be completed within six months of the commencement of the Review. However, in this case, due to the long history of abuse and the significant number of agencies that had been in contact with Alice, the Home Office authorised additional time to allow agencies to conduct their Individual Management Reviews. For that reason, the second Panel meeting did not take place until 10 August 2023 and even then, some agencies were not in a position to present their reports.

3.3. A meeting was held with Practitioners who had been involved with Alice, on 13 September 2023, and further Panel meetings to consider the findings of the Review and the draft Overview Report were held on 10 October 2023 and on 23 November 2023. Alice's foster mother and friends were invited to the meeting on 23 November 2023 and after listening to them, amendments were made to recommendations and action plans. These were formally agreed at a final Panel meeting on 10 January 2024 when the review was concluded.

4. CONFIDENTIALITY

4.1. In accordance with Statutory Guidance, the findings of this Review are restricted to only participating Officers/Professionals, their Line Managers, Alice's foster mother, and

[1] The Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7) and The Care Act (2014) Guidance (14.162 and 14.63)

her close friends, until after this report has been approved for publication by the Home Office Quality Assurance Panel. In this case, on the advice of Children's Services, it has been deemed inappropriate to contact Alice's children who have been in care for several years. Joe has not responded to attempts to contact him. With the agreement of the Home Office a copy of the Overview Report has also been provided to the Surrey Coroner for his information only. The Surrey Police and Crime Commissioner and the Domestic Abuse Commissioner for England and Wales will, in due course, receive a copy of the report from Safer Woking Community Safety Partnership.

4.2. As recommended within the Guidance, to protect the identity of the deceased and her children, pseudonyms have been used throughout this report. The pseudonyms for the deceased and her ex-partner were chosen by the Review Panel. The deceased's foster mother confirmed that the pseudonym "Alice" is appropriate for her.

4.3. Alice who was born in South Africa was a white British national, she was aged 39 at the time of her death. Joe who is also a white British national was at that time aged 47. Their dates of birth and the date of Alice's death have been redacted from this report to protect their identities and for the privacy of Alice's children.

5. TERMS OF REFERENCE (As set out at commencement of the Review)

5.1. This joint Domestic Homicide Review and 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 of Safeguarding Adult Reviews (SARs) and for Domestic Homicide Reviews (DHRs).

5.2. The Review identifies agencies that had or should have had contact with Alice and/or her ex-partner Joe between 1 April 2015 (after the implementation of the Care Act 2014) and the date of Alice's death in May 2022, or any relevant contact relating to neglect, domestic abuse, violence, substance abuse or mental health prior to that period.

5.3. Agencies that have had contact with the deceased, Alice and/or her ex-partner, Joe were required to:

- 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 Reviews.

5.4. The Review Panel will consider:

5.4.1. Each agency's involvement with Alice and/or Joe, during the period set out in paragraph 5.2.

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

5.4.3. Whether COVID restrictions and/or her partner's interventions inhibited Alice's access to agencies.

5.4.4. Whether the impact of parenting restrictions including the removal of her children were fully understood by agencies.

5.4.5. 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.

5.4.6. Whether there were any other known safeguarding issues relating to Alice.

5.4.7. Whether there was any history of abusive behaviour towards the deceased and whether this was known to any agencies.

5.4.8. 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 Alice.

5.4.9. Whether agencies have appropriate policy and procedures to respond to needs of a vulnerable adult and to recommend and make changes as a result of the Review process.

5.4.10. Whether agencies have appropriate policy and procedures to respond to domestic abuse and to recommend and make changes as a result of the Review process.

5.4.11. Whether practices by agencies were sensitive to the ethnic, cultural, religious identity, gender and ages of the respective individuals.

5.4.12. Ascertain if any identified family or friends can be traced, who may wish to participate in the Review. If so, ascertain whether they were aware of any safeguarding concerns or abusive behaviour towards Alice.

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

5.6. 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.

5.7. The Review will also highlight good practice.

6. METHODOLOGY

6.1. The method for conducting this joint SAR and DHR is prescribed by Legislation and Home Office Guidance. As previously stated, upon receiving verbal notification of Alice's death from Surrey Police, a decision to undertake the joint Review was taken by the Chairs of the Surrey Safeguarding Adults Board and the Safer Woking Community Safety Partnership during consultation with Board and Partnership members. Although it was accepted that Alice had probably taken her own life, there were records to indicate that she had been a victim of domestic abuse and that she had been the subject of more than one Multi-Agency Risk Assessment Conference (MARAC).

6.2. Agencies in the Surrey area were instructed to search and secure details of any contact they may have had with Alice or Joe. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Alice's circumstances in the future. Each agency confirmed in their IMR report that records relating to relevant contacts had been secured. However Joe, who was in prison during the early months of this Review, declined the opportunity to engage with the Review and refused to sign a consent form, thereby restricting agencies from sharing his personal information.

6.3. The DHR Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating agencies and multi-agency forums including the Surrey Multi Agency Risk Assessment Conference (MARAC) and Woking's Community Harm and Risk Management Meeting (CHaRMM).
- Practitioners who had regular contacts with Alice
- Pathologist Report
- Surrey Coroner
- Statements from two of Alice's friends
- Discussions with Alice's foster mother and three of Alice's friends
- Discussions during Review Panel meetings

7. INVOLVEMENT OF FAMILY AND FRIENDS

7.1. Contact with Alice's family has not been possible for the Review. Both her parents are deceased, and the whereabouts of an elder half-sister is not known as Alice had no contact with her from the age of 12 when she was taken into care after allegedly suffering abuse from her.

7.2. All of Alice's four children have been in care and adopted for many years, therefore at the recommendation of Children and Family Services, they have not been contacted in any way by the Review.

7.3. The Review Chair has been in contact with Alice's foster mother who looked after Alice from the age of 14 to 18. She has provided information relating to Alice's early life which has been included in this Report. She has also provided contact details with two of Alice's friends - Anna (pseudonym) and Lena (pseudonym) who have also given information to the Review. Alice's foster mother was offered advocacy support from the charity AAFDA (Advocacy After Fatal Domestic Abuse) but declined.

7.4. Alice's foster mother and friends had contact with Alice in the weeks prior to her death, they confirm that at that time she had not been using any illegal substances for some time. They are in unison in the belief that Alice took heroin and cocaine only when Joe was out of prison, because of his influence, but also to dull the pain from his continuous assaults. Her foster mother wanted the Review to know that Alice had been very upset that although she had been promised extra security through the 'Sanctuary Scheme' nothing had

happened, yet her friend had her home secured even though she had been put on the list later than Alice. The Police knew she was frightened of what would happen when Joe was released from prison.

7.5. Her friends separately acknowledged that at times, Alice did not respond to the contacts from carers or other support workers, but that this was usually when Joe was about because he was a drug dealer and did not like outsiders or officials of any type visiting Alice's address whilst he was there.

7.6. A further friend of Alice contacted the Review and spoke about the effect of Joe's chaotic lifestyle and violence which he said, destroyed her, not just physically but also mentally. He confirmed that when Joe was in prison, Alice would stop using illicit drugs and would gradually regain some of her old confidence, until it neared the end of Joe's sentence, when she would become more and more terrified of what would happen upon his release.

7.7. Joe, Alice's ex-partner, has served a number of custodial sentences relating to domestic abuse, both on Alice and on his more recent partner. His Probation Officer notified him of the Review, but he declined to engage with the Review and there has been no further contact from him.

8. CONTRIBUTORS TO THE REVIEW

8.1. Whilst there is a statutory duty on bodies including the Police, Local Authority, Probation and Health bodies to engage in both a SAR and a DHR, other organisations can voluntarily participate; in this case the following twenty-seven organisations were contacted by the Review:

- **Alpha Extreme Services Limited:** This company had limited relevant contacts with Alice and an Individual Management Review (IMR) report was completed.

- **British Transport Police**: This Police Force had relevant contacts with Alice and Joe and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Byfleet United Charity:** This Charity had relevant contacts with Alice and a report was submitted.

- **Christians Against Poverty:** This Charity had relevant contacts with Alice and a report was provided.

- **Chit-Chat:** This Charity had relevant contacts with Alice and a report was provided.

- **CSH Surrey:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed by the Trust. A member of the Trust who is independent of any contact with Alice or Joe is a Review Panel member.

- **Goldtech Care Services Ltd:** This company had limited relevant contacts with Alice and an IMR was completed.

- **Mascot Community Hub:** This community association had relevant contacts with Alice. A report was provided setting out details of the professional and personal contacts and support provided.

- **Matrix SD&T Ltd:** This Company had relevant contacts with Alice and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Panel member.

- **New Vision Homes:** This Company, which had been the 'landlord' looking after the Woking Borough Council housing stock until 31 March 2022 when the partnership arrangement ceased, had relevant contacts with Alice and an IMR was completed. A member of Woking Borough Council Housing, who had previously worked for New Vision Homes is a Panel Member and IMR Author. She is independent of any contact with Alice or Joe.

- **Probation Service:** This Service had relevant contacts with Joe and an IMR has been completed. A member of this Service who is independent of any contact with Alice or Joe is a Review Panel member.

- **South East Ambulance Service NHS Trust:** This service had several contacts with Alice, limited to transferring her to hospital.

- **St Georges University Hospitals NHS:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed.

- **Surrey Adult Safeguarding Board:** The Surrey Adults Safeguarding Board Manager is a member of the Panel. She had no previous contacts with either Alice or Joe.

- **Surrey and Borders Partnership NHS Foundation Trust:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed by the Trust. A member of the Trust who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey County Council Adult Social Care:** This Department had relevant contacts with Alice and Joe. An IMR was completed. A senior member of this agency is a DHR Panel member.

- **Surrey County Council Children and Family Services, Together for Families:** This Department had relevant contacts with Alice and Joe in relation to their children. An IMR was completed. A senior member of this agency is a DHR Panel member.

- **Surrey Fire and Rescue Service:** This service had two contacts with Alice and a report was provided. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey Heartlands Integrated Care Board (ICB) for GPs:** This Board provided an IMR on behalf of the GP Practice where Alice was a patient. A member of the Partnership who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey Multi Agency Risk Assessment Conference (MARAC):** The Surrey MARAC Chair confirmed that Alice had been referred to a MARAC meeting and provided a report setting out her review of this referral. He had no previous involvement with Alice or Joe.

- **Surrey Police:** This Police Force had many relevant contacts with Alice and Joe and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Vaughan House:** This Charity for homeless people received a referral in respect of Alice but were unable to assist as they had no facilities suitable for a wheelchair user and no general accommodation had vacancies at the time.

- **Woking Borough Council:** The Council, as part of the Safer Woking Partnership had responsibility for Anti-Social Behaviour issues and therefore had relevant contacts relating to both Alice and Joe and an IMR was completed. A member of the Council is a Review Panel member.

- **Woking Borough Council Housing including Housing Solutions:** These Departments had relevant contacts with Alice and an IMR was completed. A member of Housing Solutions who is independent of any contact with Alice or Joe is a Review Panel member.

- **Women's Support Centre Surrey:** This organisation includes the charity, 'Catalyst'[2] that had relevant contacts with Alice and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **York Road Project:** This service had provided some non-relevant support to Alice prior to the dates of this review. Due to a reorganisation no records are available.

- **Your Sanctuary:** This domestic abuse support service has provided an IMR report in relation to Alice. A member of this Charity, who has had a limited supervisory role in relation to Alice's contact with the organisation is a Review Panel member.

8.2. Twenty-three of the agencies/multi-agency conference have completed Individual Management Reviews (IMRs) or reports.

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

8.4. Rethink Mental Illness (Surrey Support After Suicide Service) has attended Panel and Practitioner meetings to advise and support Panel Members, IMR Authors and Practitioners. The Service had no previous contacts with either Alice or Joe.

8.5. The Surrey Coroner has given the Review access to the report and statements provided to him for the purposes of the Inquest.

[2] Women's Support Centre Surrey were commissioned by Woking Borough Council (WBC) through Women in Prison until March 2021, then employed by WBC until 1 June 2023 when they were TUPEd to Catalyst.

9. REVIEW PANEL

9.1. The Review Panel consists of experienced, senior officers from relevant statutory and non-statutory agencies. The Woking Community Safety Manager discovered during the Review, that in 2019, that as the Chair of CHaRMM and CIAG she had a non-direct involvement in relation to Alice. None of the other Panel members had any previous involvement with Alice or Joe. Although it is clear in the statutory guidance for DHRs and was highlighted at the Review's first meeting, that Panel members should not also be IMR authors, due to the small number of personnel in two of the non-statutory organisations, the Review Chair agreed that their Panel members could also be their IMR authors. However, during the Review, due to staff changes and retirements of four Panel members, IMR authors who had a working knowledge of the case doubled up as Panel members for their organisations. All had no previous involvement with either Alice of Joe. The Home Office has been notified of this to ensure transparency.

9.2. Panel Members:

David Warren	Independent Chair
Michelle Baird	Review Administrator - Know More Limited
Paul Stanley	Detective Inspector Public Protection and Vulnerability British Transport Police
Natasha Coutts	Safeguarding Manager - Catalyst Support
Sarajane Poole	Interim Deputy Director of Quality & Deputy Chief Nurse CSH Hospital
Ian Grimwood	Director - Matrix SD&T Limited
Andy Pope	Statutory Reviews Lead - Surrey Police
Thomas Stevenson	Ass. Director | Quality | Practice & Performance Quality Assurance & Performance Div. Children, Families & Learning - Surrey County Council
Lynda Marsh	Deputy Head of Service - Surrey Probation
Memory Chingozho	Safeguarding Adults and Domestic Abuse Advanced Practitioner - Surrey and Borders Partnership NHS Foundation Trust (SaBP)
Sarah McDermott	Board Manager - Surrey Safeguarding Adults Board
Gareth Owen	Senior Manager (Countrywide Transition Team) Safeguarding Adults - Surrey County Council
Georgia Tame	MARAC Administrator/Domestic Homicide Review Coordinator - Surrey County Council
Phillip Stonebanks	Watch Commander - Surrey Fire and Rescue
Helen Milton	Designated Nurse, Safeguarding Adults - Surrey Heartlands Integrated Care Board (ICB) For GPs
Leanne Spiller	Women's Support Centre Manager - Women's Support Centre - Surrey
Camilla Edmiston	Community Safety Manager - Woking Borough Council

Catherine Butler	Housing Solutions Manager - Woking Borough Council
Gerri Summers	Residents Service Manager - Woking Borough Council
Louise Balmer	Adult Community Service Lead - Your Sanctuary
Cherisse Dealtry	Chief Executive - York Road Project

9.3. Expert advice regarding domestic abuse service delivery in Surrey has been provided to the Panel by Louise Balmer of Your Sanctuary, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Surrey. Expert advice on Safeguarding Adults, has been provided by Sarah McDermott of Surrey County Council. Specialist advice regarding self-harming and suicide has been provided to the Panel by Annabel Clarke of Surrey Support After Suicide Service. Julie Shaw, Senior Partnership and Programme Manager for Surrey Adults Matter for Public Health provided expert advice on the support that can be provided as part of the Surrey Adults Matter project.

9.4. The Review Panel met formally five times.

- 20 April 2023
- 10 August 2023
- 10 October 2023
- 23 November 2023
- 10 January 2024

There were additional meetings for: IMR
Authors on 17 May 2023
Practitioners on 13 September 2023

10. CHAIR OF THE REVIEW & AUTHOR OF THE OVERVIEW REPORT

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

10.2. He has no previous connection with the Surrey Safeguarding Adults Board or Safer Woking Partnership and is independent of all the agencies involved in the Review. He has had no previous dealings with Alice or Joe.

10.3. He has an extensive knowledge and experience working in the fields of safeguarding adults and children, domestic abuse and sexual violence at local, regional and national level. Between 2004 and 2011 he was the Home Office Criminal Justice Manager for the Government Office South West. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a founder member of both the South West Regional Safeguarding Children's Board and the Safeguarding Adults Board. He was also a member of a number of Central Government Committees, including those relating to the development of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

10.4. Since 2011 he has chaired numerous Statutory Reviews including Serious Case

Reviews, Safeguarding Adults Reviews, Mental Health Homicide Reviews, Drug Related Death Reviews and Domestic Homicide Reviews across the country. He has been a keynote speaker at several National Conferences on domestic and sexual abuse, most recently on the particular issues facing Domestic Homicide Reviews in cases relating to suspected suicides.

10.5. For a number of years, he carried out voluntary work as the Chair of a substance abuse Charity and has provided pro-bono legal work for a refuge and its residents.

11. PARALLEL REVIEWS

11.1. This Review is a combined Domestic Homicide Review and Safeguarding Adults Review. The Chairs of the Safer Woking Partnership and Surrey Safeguarding Board agreed to the Reviews being conducted together with the same Independent Chair and Panel.

11.2. Coroner's Inquest: The Review Panel thanks the Surrey Coroner for sharing the information and reports he has obtained for the purposes of the Inquest. The coroner made the decision to delay the Inquest until after the conclusion of this Review.

12. EQUALITY AND DIVERSITY

12.1. The Panel and the agencies taking part in this combined Review have been committed within the spirit of the Equality Act 2010 to an ethos of fairness, equality, openness and transparency. All nine protected characteristics in the Equality Act were considered and the Panel was satisfied that services provided, were generally appropriate. Alice's sex and disabilities were considered to be of particular relevance.

12.2. Ethnicity: There is no evidence to suggest that Alice or Joe being white British citizens[3] was ever an issue in the manner in which agencies delivered services to them.

12.3. Sex: The Panel, when considering Alice's vulnerability as a woman, was satisfied that all of the agencies, recognised and responded with empathy to her vulnerability. However, Alice's sex was a key issue with regards to the abuse she endured from Joe, her ex-partner.

12.4. Disability: Alice had many physical and mental health problems.

12.4.1. Physically, they included asthma and chronic obstructive pulmonary disease (COPD), which impacted on her breathing. She had 2 deep vein thromboses (DVTs) in 2007 and 2013, possibly due to her IV drug use. She was recorded as having epilepsy. From April 2015, Alice used a wheelchair due to pain and loss of sensation in her right leg, related to her history of IV drug use and when she was admitted to Hospital following an attempted suicide in October 2015, investigations concluded she had a 'right side lumbosacral plexopathy'.[4]

[3] Alice although a British Citizen was born in South Africa.

[4] The lumbosacral (LS) plexus is a network of nerves formed by the anterior rami of the lumbar & sacral spinal cord. LS plexopathy is an injury to the nerves in the lumbar and/or sacral plexus.

12.4.2. Whilst practitioners from several agencies identified that neither of the two 'housing tenancies' she had were adequate to meet her needs as a wheelchair user; due to high cost of adapting her homes and the lack of purpose-built accommodation, this was never satisfactorily addressed.

12.4.3. Regarding Alice's **mental health:** she was diagnosed with bipolar disorder (2007) and later emotionally unstable personality disorder (EUPD). Medically she received timely treatment for anxiety and depression over a number of years, during which there were five identified incidents of self-harming before she took her own life.

12.4.4. It was suspected that the violent domestic abuse she suffered from Joe, increased her mental health difficulties and led to her attempts to take her own life. At the time of her death, the practitioners who worked with her and her friends, indicated she was extremely anxious regarding Joe's forthcoming release from prison.

12.4.5. Whilst generally Alice received appropriate care, on occasions this was inhibited due to her not always responding to appointments or answering the phone, these occasions were more common when Joe was with her, and she was using illicit substances. Those practitioners who had built up a rapport with her knew the best times to contact her were in the afternoons and when Joe was not present.

13. DISSEMINATION

13.1. Until this report has been approved for publication by the Home Office Quality Assurance Panel dissemination of the findings of this joint Domestic Homicide Review and Safeguarding Adults Review has been restricted. Each of the Panel members, the Chair and members of the Safer Woking Partnership, Surrey against Domestic Abuse and the Surrey Safeguarding Adults Board have received copies of this report. In accordance with Statutory Guidance[5], the findings of this Review have also been discussed with Alice's foster-mother who has read this report. She and Alice's two closest friends who have received copies of the Executive Summary of this Review. The Surrey Coroner[6] has been provided with a copy of this Overview Report with the Home Office consent, as he had adjourned the Inquest until the conclusion of this joint DHR and SAR. A copy will also be sent to the Surrey Police and Crime Commissioner and the Domestic Abuse Commissioner for England and Wales in due course.

14. BACKGROUND INFORMATION (THE FACTS)[7]

14.1. Alice had regularly consulted her GP with symptoms of feeling low and depression, which she attributed to various relationship issues. While she was given appropriate medication and was referred to mental health services, there were five occasions when she self-harmed and admitted to having suicidal thoughts.

14.2. On 2 July 2021, Joe went to Alice's home threatening to kill her and assaulted her.

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[5] Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. para 72 (Home Office. December 2016)

[6] Consent was granted by the Home Office for the Coroner to have a copy of this report on the basis he would not share it with interested parties.

[7] This section sets out the information required in Appendix Three of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016) [8] i-access is the Hospital substance abuse support service.

The Police were called and learnt that Joe had breached a restraining order by attending Alice's address multiple times, yet Alice initially would not fully engage due to fear of repercussions from Joe. However, after Joe had been arrested, she supported a prosecution. He was charged and later sentenced to a term of imprisonment.

14.3. Subsequently later in July 2021, Alice had been the subject of a MARAC meeting as a vulnerable person who had been a victim of high-risk domestic abuse from Joe. The meeting heard she had been the victim of several serious violent assaults and breaches of a restraining order that was still in place then and at the time of her death.

14.4. At the beginning of May 2022, Alice confided to her i-access[8] drug support worker that she felt anxious, as Joe, was to be released from prison in July 2022. She said she was 'feeling up and down' in mood. She confirmed that she had people around her, who could understand what she was going through and that the Police were aware. She confided that the overdose that she had taken in March 2022, was a result of her fear of Joe, but she would not disclose details. Alice was encouraged to continue to engage with the Community Mental Health Recovery Service (CMHRS) and to explain her feelings to them. She reported that she had the occasional drink and smoked cannabis. However, this was not something that she viewed as a problem. She denied any heroin use and stated that she would never go back to using that drug. Alice then requested that she be removed from 'recovery mode' as she was still abstinent from heroin and would work with CMHRS and her GP. The worker agreed, but informed Alice that should she require any support, to get in contact with the team. She thanked the Service for all the support she had received.

14.5. Later that month, Alice arrived at a Surrey Hotel having made a booking online for two days. She arrived alone and from the observations of staff, she was staying in the room alone.

14.6. She was last seen by staff the following evening, purchasing a bottle of wine and returning to her room.

14.7. The next day when she was due to leave the hotel, a hotel employee was sent to check on her as she had not booked out. He found her lying on the bed not breathing, nearby were empty bottles of vodka, wine and cider together with empty packets of codeine and clonazepam. Paramedics attended and declared her death after attempted resuscitation.

14.8. There were also several notes that Alice had left in the room, which described 'voices in her head and how she couldn't take it anymore'. A particularly poignant letter was to her foster mother who looked after her from the ages of 14 to 18:

"DEAR MUMMY, THANK YOU FOR EVERYTHING. THANK YOU FOR BEING MY MUMMY I'M SO SORRY THAT YOU GOT SOMEONE THAT WAS BROKEN. I CAN'T TAKE THE VOICES I CAN'T TAKE THE PARANOIA; I CAN'T TAKE THE PAIN. PLEASE DON'T CRY FOR ME MUMMY YOU DID EVERYTHING YOU COULD. I TRIED SO HARD BUT CAN'T DEAL WITH IT ALL NO MORE. PLEASE TAKE HEART THAT I WILL BE WITH GOD. NO MORE PAIN, VOICES, PARANOIA. I WILL BE WATCHING OVER

YOU MUMMY, I'M SO, SO, SO SORRY THAT I'M SO BROKEN."

14.9. The indications appeared to the Police Officers who attended, that Alice died through a self-induced overdose. The Police were aware that Alice had been very concerned that Joe was due to be released from prison after serving a 4-month sentence relating to stalking Lena, with whom he had also been in a relationship. He had threatened to firebomb her home, kill her and himself in the process. He had been in possession of a bladed article. Both Alice and Lena, were so fearful of him, that they had refused to support an investigation until they knew he had been arrested, and they were safe from him.

14.10. A forensic post-mortem was carried out and concluded that there was no evidence of third-party involvement. Whilst the Coroner's Inquest has not yet been held, the Pathologist report stated: "The finding of multiple drugs, many at a level that can be associated with fatalities, mean that death is most likely due to a combined effect of the drugs. In my opinion the cause of death was: Mixed Drug Toxicity".

15. CHRONOLOGY

15.1. The events described in this section explain the background history of Alice and Joe, prior to the timescales under Review as stated in the Terms of Reference. They have been collated from information from Alice's foster mother and the chronologies of agencies that had contact with Alice or Joe. It should be noted that the events took place prior to the introduction of both the Care Act 2014 and Serious Crime Act 2015, (this Act includes the offence of controlling and coercive behaviour).
15.2. Alice was according to her foster mother born in 1983 in South Africa. Her foster mother confirmed the background information that Alice had told her Probation Officer, her parents had drug addiction problems and that she moved to the United Kingdom with her father a British citizen when she was 5 years of age. Her mother remained in South Africa.

15.3. In about 1994 her mother was killed in a car accident in South Africa and two weeks later, on coming home from school Alice found her father, he had hung himself. Later Alice told a Probation Officer that her father was physically and emotionally abusive towards her. Her foster mother, however, told the Review he did care about her and left a substantial Trust Fund for her, which was 'squandered' by her older half-sister who Alice had initially moved in with. Due to physical abuse from her half-sister, Alice came to the attention of Children's Service and was taken into foster care; at that time there was only 34pence left in the Trust Fund.

15.4. Alice described to the Probation Officer, that her early foster care was negative, but she formed a good relationship later with her final foster carers' from the age of fourteen years of age and resided with them until she was eighteen. Alice remained in contact with her foster mother and when she died, she left a moving note for her, which her foster mother asked to be included in this report. (See para 14.8)

15.5. A Hampshire Children Services record states, Alice was placed in foster care 'having come from a troubled home, the specifics of which are unknown, and was already using drugs and alcohol at the age of 13/14 years old'.

15.6. It was at the age of 18 that she came to notice for offending. Alice described to a Probation Officer, a history of damaging and destructive personal relationships. She had been raped when she was 18 years of age and had married a previous partner who was

abusive to her, and who later received a life sentence for offences against other women. Alice was described in that Probation report as ‘a young woman who is vulnerable to exploitation’.

15.7. Alice was frequently homeless. After she met Joe who also had substance abuse (heroin and cocaine) problems, she found herself in another abusive relationship. As highlighted in section 12 of this report, Alice who was wheelchair bound, had a number of physical and mental health problems. The Police National Computer (PNC) had warning markers about Alice relating to self-harm and suicide attempts as well as physical ailments including hepatitis C.

15.8. Both Alice and Joe were well known to Surrey Police Officers. There are 174 occurrences recorded on the Surrey Police Niche crime recording system relating to Alice, and 364 occurrences relating to Joe. These included crime and non-crime incidents and intelligence reports.

15.9. Joe has served a number of custodial sentences relating to domestic abuse, both on Alice and on his more recent partner, Lena. The first recorded incidences were in June 2007 when Joe was arrested for two assaults, one on Alice and one on Alice’s new male friend who she had met whilst Joe was in prison for a robbery. In this case, Joe received a Community Order, a Supervision Requirement for 18 months with a 12-month drug rehabilitation requirement to complete an Offender Substance Abuse programme.

15.10. In September 2007, Guildford Community Mental Health Team (CMHT) received a report from a homeless support service that Alice was a vulnerable missing person. Notes at the time listed methadone prescription and epilepsy medication as risks. It was suspected Alice was staying at a squat, and Joe was named as her partner.

15.11. On 15 July 2008, Joe was arrested after a horrific attack on Alice causing injuries so severe that she was hospitalised in Intensive Care. He was given a four-year custodial sentence but served only 28 months in prison for this offence. One of their children who was 1 year of age was present during the sustained attack, in which she was rendered unconscious. Subsequently, her children were taken into care and later adopted. Alice had no further contact with them. Alice’s friends have told the Review that Alice was distraught at the length of Joe’s sentence and never regained confidence in the criminal justice system. In their view, it was for this reason she would often not report abuse from Joe to the Police.

15.12. In March 2009, the Police were called to an address after reports of an argument. Alice was found alone, emotional and there was drug paraphernalia in the premises. There was no other person present or named by Alice. However, later the same day, Police Officers returned to the premises because of concerns of males selling drugs outside of the property. Alice was reported as intoxicated and of having a 3-inch cut to her arm. Alice told the Officers that she had not slept for a week due to her heavy cocaine habit, which she said, was costing £70 a day. She appeared to the Officers very unhealthy and frail. It was suspected that she was dealing in drugs, although no drugs were found. Alice disclosed to Paramedics who were called, that she had Hepatitis C and was epileptic. Due to her physical condition, she was taken to Hospital. A form 39/24 vulnerable adult report was submitted.

15.13. Due to her parents' deaths, her half-sister's abuse, her own ill health, drug and alcohol problems, her children's safety, housing issues and the domestic abuse she was subjected to, Alice came to the attention of professionals from a wide range of service providers over a number of years. Twenty-three agencies that had contact with her, have participated in this Review. Because of the sheer volume of callers, there were occasions when she would not answer the phone or door to them. The practitioners she knew over a period of time, understood to call in the afternoons as she was a late riser. She was also more prone not to respond if Joe was with her. Nevertheless, there were many examples of agencies endeavouring to work together to help Alice. The following paragraphs give examples of that support.

15.14. On 23 January 2012, Alice was referred to i-access (a drug and alcohol support service) and was allocated to the team for a year. The i-access worker built a close rapport with her during this time and there were occasions when other agency staff, such as social workers and Occupational Therapists arranged joint visits through the i-access worker.

15.15. On 20 February 2012, a Police child at risk form was sent to CSH Surrey[8] after Alice had been found with Joe, sleeping rough within an industrial estate unit. Alice reported to the Police Officers that she was 9 weeks pregnant and homeless. At the time, it was evident to the Police that Alice was consuming alcohol and there was evidence of discarded drug paraphernalia near to her. This was described as "cooking pots and needle boxes." Alice admitted to the Officers that she had previously been a heroin user but stated that she had been clean for 3 weeks.

15.16. In March 2012, a Woking Borough Council Housing Floating Support and the Homeless Team noted that there could be potential for violence from Joe and recognised Alice's vulnerability. In May, Alice told the team that she had asked Joe to leave their room in temporary accommodation and in July 2012, a neighbour reported that there had been a big argument, and it sounded as though bottles and furniture were being thrown around. The Floating Support worker emailed Alice's Social Worker with this information. Alice was pregnant at the time. She was advised to approach a local authority in another area so that she would be safe from Joe. Whilst Alice did contact two other areas, the Woking Borough Council's Floating Support worker continued to visit and support her, suspecting that as her friends were in the area, she would not wish to be forced in to moving because of Joe's violence.

15.17. On 23 May 2012, Alice's Probation Officer who was concerned that Alice might resume her relationship with Joe as she was feeling low, contacted the 'Your Sanctuary Help Line' to access support for her. The Probation Officer explained that Alice had previously been the subject of a MARAC meeting, and when she lived in Guildford had engaged with South West Surrey Domestic Abuse Services (SWSDAS). An Outreach worker contacted Alice who was 4 months pregnant, however, Alice said she was not sure if she wanted any support.

15.18. On 25 May 2012, a follow up call was made by the Your Sanctuary Outreach Worker to Alice and offered an initial meeting with her. Whilst she said she would think about it, no further contact was received so the case was closed by Your Sanctuary on 6 July 2012, in accordance with their normal procedure and in line with their policy.

[8] CSH Surrey is an employee-owned, not-for-profit NHS community healthcare provider.

15.19. On 6 July 2012, during a targeted antenatal visit from a Health Visitor, Alice reported that she had a very difficult childhood and had several foster carers growing up. She said, she had two previous children removed into care and who were subsequently adopted. This was due to her drug misuse and involvement with her partner Joe, the father of her children, who was very violent towards her. At this visit Alice reported that Joe had not been violent towards her in recent times and was not living with her. However, she admitted that he visited her regularly to "support her", using her bathroom facilities and storing his clothes with her as he was then homeless. Joe who also had a history of drug misuse was on a Subutex programme at this time. Alice wanted to work with agencies to keep the baby.

15.20. Police returned to Joe and Alice's home on 7 July 2012, due to reports that a 'female was bleeding' and the flat was a mess; an ambulance was called. Alice's foot was bleeding due to a cut from glass from a previous incident. She was treated by the ambulance crew and was very vague about how it had happened but said that she had had an argument with Joe but claimed he had not assaulted her. She stated Joe had gone, and she did not want him back. She said they had split up 2 months previously but had been speaking recently, they had been in a relationship for 5 years. She admitted being pregnant and that Joe was the father of the unborn baby. Police completed a DASH risk assessment with Alice. Her reply to most of the questions was "no" however, the attending Officer was of the opinion that Alice was not being truthful about her relationship with Joe.

15.21. Alice told the Police about her 2 children who had been removed from her care. She said that approximately 3 years previously she had lost a child whilst pregnant through an assault by Joe. There was no record of this having been reported previously. She told the Officers that both her and Joe were using a heroin substitute Subutex, although Joe was still occasionally using heroin.

15.22. An antenatal case conference was arranged for 16 July 2012 and her expected date of delivery was 30 September 2012. The Police had raised concerns about the baby's safety and had submitted a child at risk form. They had on 2 separate occasions attended incidents due to domestic incidents occurring between Joe and Alice. Although both Joe and Alice denied domestic abuse, the Officers noted that the flat was very messy, and the television was broken with shattered glass on the floor. Alice appeared pregnant but claimed that she was just fat. Both Joe and Alice had stated they hated Police and refused to engage with them. Nevertheless, the unborn baby was subject to a child protection plan under the category of neglect and a legal planning meeting was to be arranged.

15.23. At that conference, Alice reported that she and Joe had separated, however Joe was seen at home by a Housing Officer on housing visits on two separate occasions. It was noted that Alice was reporting that she and Joe had separated, but both had been seen together regularly in Woking and had attended appointments together. Alice had missed an appointment with the i-access 'detox' service but told the conference Chair she wanted an opportunity to have the baby and would separate from Joe if necessary, and that she would like to go somewhere away from him. Alice's family support worker was concerned as Joe was very abusive and controlling. During the previous week Alice had not had a phone and had been using Joe's, this meant that he had been able to control who could make contact with her and who she could contact. The support worker disclosed that when she had picked Alice up, she had opened a can of beer and rolled a cigarette.

15.24. It was also recorded in the Conference minutes, that Alice had a history of self-harm and was thought to be at a high-risk of suicide. Probation noted that the safest course of action would be for Alice to be recalled to prison. Children's Social Care recommended that the baby should be removed at birth.

15.25. At the case conference, it was also noted that under the care of the hospital drug and alcohol team, Joe was not doing well with reducing his drug use and was using Diazepam and alcohol in addition to his prescribed drugs. Both he and Alice claimed that the domestic violence was due to Joe's post-traumatic stress disorder. However, following an assessment by a Consultant Psychiatrist, there was no evidence of Joe suffering from PTSD, and it was felt that he was using this as an excuse. Consequently, after the baby was born early on 5 September 2012, the baby was removed at birth into foster care and subsequently adopted.

15.26. In September 2012, Woking Housing records stated that detox would be too risky because of Alice's emotional health and pregnancy. She was receiving support from Women's Support Centre regarding her rent arrears.

15.27. On 15 November 2012, Probation recommended that Alice be returned to prison for breach of her licence relating to substance abuse, due to non-compliance. At the point of the recall, Police were informed that Alice was residing with Joe. They were both using heroin and Alice was in poor health due to deep vein thrombosis. Police were asked to execute an arrest warrant as soon as possible due to concerns about her being at risk of domestic abuse from Joe. It was also stated that Alice was at high risk of self-harm or suicide, due to recently having her newborn baby taken into care. The concern was also raised that she was at risk of drug overdose.

15.28. On 12 December 2012, Alice's licence period ended, and she was released from prison. A Probation risk assessment report stated that Alice described a history of damaging and destructive personal relationships. The report noted "There have been previous issues regarding self-harm and suicide whilst in prison (hanging, cutting herself, overdose of anti-depressants). She has previously been on an ACCT (*Assessment, Care in Custody & Teamwork*) document. She is taking medication for depression on a daily basis. Previously, she had suffered a head injury due to her epilepsy and has spent time in a psychiatric hospital. *(Alice)* is receiving no psychiatric treatment nor is there any pending. Emotional wellbeing is linked to a risk of serious harm to herself through previous self-harming/suicide and her injecting drug use. In addition, if *(Alice)* is not accessing support for her emotional difficulties, she is more likely to use alcohol and illicit substance as a means of coping. *(Alice)* has a complex history and has been the victim of significant abuse, which makes her particularly vulnerable and more likely to suffer with emotional wellbeing and mental health issues."

15.29. On 8 January 2013, Alice was arrested after she assaulted a female friend who she thought was 'trying it on' with Joe. During the arrest, Alice who had Hepatitis C, spat in the mouth of a female Police Officer. She was convicted and sentenced to a term of 22 months imprisonment.

15.30. In June 2013, it was reported to housing that the couple had split up and that Joe was threatening to kill Alice when she was released from prison.

15.31. From 3 November 2014 Joe and Alice were believed to be back living together in a Woking Borough Council property of which Joe was the tenant until he was later evicted for rent arrears.

15.32. On 7 March 2015, while dealing with Joe, who had overdosed on drugs and had been taken to hospital, (from where he prematurely discharged himself), Police Officers learned that Alice was alone at home and that her mobility was confined, in that she could only move around with assistance from a walking frame.

15.33. Officers visited Alice who stated she had enough basic food to get by, but that she had not received any money for the last three weeks. There was concern that both Alice and Joe had no money, and both were evidently suffering from the effect of drug abuse. The Officers submitted a 39/24 Adult at Risk form, outlining concerns for the welfare of both Alice and Joe. It was not clear from this, or earlier Police reports as to the cause of Alice's mobility difficulties, which appeared to be getting worse as she had moved from crutches to then using a walking frame. A later report indicates Alice suffers from thrombosis. The Officers rightly shared concerns with partner agencies through the submission of the 39/24 Adult at Risk form.

15.34. In March 2015, Adult Social Care Woking Locality (ASC) received a referral requesting an assessment for property adaptations. Alice was without fixed abode and Woking Borough Council had identified a property, but it was not suitable for a wheelchair which Alice was by then using. Alice who was then homeless, was placed in an intermittent series of short-term hotel accommodation whilst suitable accommodation was being sought.

16. OVERVIEW

16.1. This section summarises what information was known to the agencies and professionals involved in the Review about Alice or Joe within the period set in the Terms of Reference i.e. 1 April 2015 to the date of Alice's death in February 2022 which takes account of the implementation of the Care Act 2014.

16.2. Between April and October 2015, Surrey Adult Social Care (ASC) received several referrals from the Police and from members of the public concerned about Alice, who was homeless and sleeping rough. She had become homeless when Joe was evicted for rent arrears. By this time Alice was in a wheelchair as result of a right side lumbosacral plexopathy, she was therefore visibly vulnerable, and this led to the repeated complaints from members of the public.

16.3. ASC also received a contact in April 2015, from a hotel in Surrey reporting that Alice, who was in temporary accommodation there had hurt herself. Alice stated she could meet her own needs and did not need help that weekend. Later she was conveyed to hospital with unexplained swelling to the face. The Paramedics reported the presence of alcohol and syringes and confirmed that Alice had been told to leave her previous property by Joe. There was no evidence that this report was considered against Care Act 2014 s.42 criteria (Adults Safeguarding). However, later that month an ASC Occupational Therapist did attempt to complete a needs assessment, but Alice was not present at the arranged time.

16.4. Later in April 2015, the Police informed ASC that Joe had been admitted to hospital after a drug overdose as there were concerns of possible substance use, physical needs, financial difficulties, and availability of food.

16.5. In May 2015, Alice, because she was homeless contacted ASC stating she had been evicted after her partner Joe 'was sent to prison'. The record detailed that Alice had pain in her groin and was now permanently using a wheelchair. ASC concluded that no support was required at that time, however, Alice would benefit from Occupational Therapy assessment for equipment once she was appropriately housed. It was identified that Alice, the previous year, had received support from Mental Health Services and her needs were diagnosed as 'emotionally unstable personality disorder, depression and psychotic symptoms'. ASC confirmed with Woking Borough Council that their Housing Department were to offer temporary accommodation to Alice.

16.6. At the beginning of June 2015, WBC Housing notified ASC that Alice could not access sheltered accommodation and that she had been found not to be eligible for social housing following a medical assessment. Alice had been given a deadline of 5 June 2015 to find somewhere to live. ASC completed an Occupational Therapy Assessment, with the conclusion that with the provision of equipment, Alice would be able to live independently if she was appropriately housed. Information recorded within and around the assessment included Alice's concerns about homelessness (with a suggestion that she would take her life by suicide if she had to live on the streets) and that her benefits had not restarted since she left prison the previous year. The following actions were agreed - 'Explore homeless shelters / refuges, Alice to liaise with a local community project, Citizens Advice Bureau and the Mascot Community Hub regarding advocacy, Alice to explore accommodation with a ground floor bedroom, SCC to fund the Bed & Breakfast accommodation and for Alice to seek support from Xchange" (a drug and alcohol drop-in service) with regards to her situation. It was also agreed that ASC would make a referral to the GP and liaise with Woking Borough Council Housing.'

16.7. The same month, ASC made a referral to the GP requesting urgent mental health support and made a professional challenge to Woking Borough Council Housing about the intentional homeless decision and Alice's right to housing. In the meantime, ASC agreed to extend funding of a Bed & Breakfast for Alice. ASC also engaged with the Housing Benefits Team and advised Alice of the steps required to apply for Housing Benefit. A referral was made to Vaughan House, a service for people that are homeless with substance use and / or mental health difficulties. Vaughan House did not have any vacancies nor the facilities for a wheelchair user.

16.8. Subsequently, after a referral by her GP to the Community Mental Health Recovery Service (CMHRS) for an urgent assessment as she had threatened to kill herself, Alice was triaged by the CMHRS and transferred to i-access for follow up. In an emergency, Alice was encouraged to contact the crisis line or present to the Local A&E to be supported with a triage by Psychiatric liaison.

16.9. Later in June 2015, ASC were notified that Joe was scheduled for release from prison. ASC discussed this with Alice, who was already aware. She stated that she did not feel threatened and that she thought that Joe would be unable to make contact as she had a new telephone number. She added that she did not want to have contact with him again because she wanted to 'stay clean'. This contact was not considered against s.42 Care Act criteria.

16.10. Shortly after Joe's release from prison, Alice saw him in town and spoke to him for about 30 minutes, before he collapsed, and an ambulance was called. Alice told ASC she

had a holdall with Joe's possessions in it, but neither the Police nor the Ambulance Service would take it from her. She reiterated that she did not want Joe back in her life again. ASC offered advice and guidance re: application for housing benefit and checked that she had sufficient food etc. Matrix Advocacy notified ASC that they were supporting Alice to appeal Woking BC Housing's homelessness decision. The Community Mental Health Recovery Service (CMHRS) informed ASC that Alice was on their caseload. However, they later discharged her as she failed to attend given appointments.

16.11. Towards the end of June 2015, Alice was taken to Hospital with pain. She told medical staff that she had started using heroin again when staying with friends. ASC were advised by the GP Practice that Alice was seen being pushed in her wheelchair by Joe. This information did not appear to have been considered against s.42 criteria.

16.12. In August 2015, one of Alice's friends received what they perceived as a suicide note from her and notified the Police, who located her in Woking. Alice said she had no intent to harm herself - the note that she had written was a thank you note to the friend. Alice discussed recent changes in methadone medication which was causing her difficulties. Police had read the note and did not think it gave cause for concern. Woking CMHT who were recorded as the Responsible Safeguarding Team, did not consider that this met the criteria for an Adults Safeguarding Enquiry.

16.13. ASC requested the GP Surgery to make a new referral to CMHRS. The GP Surgery advised that Alice had not attended a recent appointment with them. A member of the public who knew Alice reported to ASC that she was worried about Alice being homeless, having seizures and losing weight. ASC emailed CMHRS to check that they had received the referral and to advise that Alice was not open to ASC as they could not provide support until Alice was housed. In September 2015, ASC forwarded information to CMHRS that another member of the public had expressed their concerns that Alice was begging in the street. Later Alice was advised by ASC that they would pay for her Bed & Breakfast for 6 weeks only. Alice was told that she did not meet the criteria for Community Care Services, that her needs were related to housing and that Woking Housing had found her to be voluntarily homeless. This was challenged by both ASC in June 2015 and again by Matrix Advocacy in July 2015, after receiving the concerns from the Police and members of the Public. By defining Alice as intentionally homeless, the duty to house Alice as a priority case under S193 of the Housing Act 1996 did not apply.

16.14. In September 2015, CMHRS queried with ASC why Alice was not open to ASC. Subsequent notes indicate that a joint assessment could be the way forward. A report was later received, that Alice and Joe were staying in a multi-storey car park in Woking as the local homeless shelter was not wheelchair accessible.

16.15. There were two occasions during this period when Alice turned up at the local Hospital Emergency Department and became disruptive when told that she had been assessed not to have any medical needs. She was signposted to local shelters such as York Road and YMCA.

16.16. On the night of the second occasion this happened, she was found by the Police in the road, having soiled and wet herself. Joe had allegedly stormed off with her blankets. Alice was known to be an alcoholic and heroin user and was considered to be intentionally homeless. There was no indication that a Care Act 2014 referral was made.

16.17. On October 2015 Alice was seen by passengers waiting at Woking Railway Station wheeling her wheelchair on the platform, and as a train approached, Alice wheeled herself over the edge of the platform into the path of the train. She was stuck under the train but still alive. Ambulance and Fire and Rescue Service personnel were able to remove her onto the platform. She received head and hand injuries which were treated in hospital. In her possession at the time were a hypodermic needle and syringe. It was noted that Joe was with her at the time and that they were both of no-fixed abode. British Transport Police made her subject to a Suicide Prevention Plan (SPP).[9] Police were unable to trace any other family members at that time.

16.18. Two days after the incident, Joe turned up at the hospital and wanted to take Alice out to go to the Bank to withdraw his Benefit money. Alice attempted to get out of bed to go, until Security Staff were called, who were of the opinion that he had given Alice alcohol and may have been under the influence of alcohol himself. As Alice did not want him removed, he was allowed to remain in the Ward. Eventually Alice accepted she was not physically capable of leaving the hospital due to her injuries.

16.19. Subsequently CMHRS made a referral to ASC, reporting Alice's unmet care needs. ASC agreed to provide support, via the Reablement Service, when she was discharged from hospital. Alice's status for social housing was reviewed, and she was found to be eligible as a survivor of domestic abuse and was consequently allocated a ground floor flat by Woking Housing from 16 December 2015.

16.20. After Alice returned home from hospital on 16 December 2015, the CMHRS advanced clinical prescriber visited her to complete a medication review. Joe was present in the home and was identified as a 'carer' for Alice. However, he was never offered a carer's assessment. The Practitioner noted there had been no engagement by Joe. It was Alice who opened the door to relevant professionals.

16.21. On 29 December 2015, Police received a report from neighbours that they had seen a male (later identified as Joe) raise his right fist in the air and punch Alice, (who was in her wheelchair,) in the head. Joe then punched her knocking her out of the wheelchair, onto a sofa where he continued punching and kicking her before leaving the premises. When Police Officers attended initially Alice would not let them in, but they could see her in her wheelchair crying and holding her neck and head. After being persuaded to open the door to them. Alice initially refused to talk to the Officers saying, "Police don't help, they just make things worse". She said she did not have any faith in the Police as she was nearly killed by him in the past, and 'he only served a 2-year sentence for the attack' and he was now doing the same again and the Police would not be able to help her. Officers tried to persuade Alice to support the investigation as it would assist in achieving a conviction and safeguarding her. Alice said she felt unable to support a Police prosecution. The Officers offered to call an ambulance, but she declined.

16.22. Joe was nevertheless arrested shortly after on suspicion of causing Actual Bodily Harm. He was found in possession of a key to Alice's flat which was taken from him and given back to her. On CPS advice, Joe was released on bail with conditions set that he could not enter the street where Alice lived or contact her by any means, directly or indirectly.

[9] In 2016 British Transport Police updated SPPs which could not be communicated to other services to the national Police NICHE system to improve management and integration.

16.23. Although Alice had Home Care Services, she often refused to let them into the flat and her home was often found to be unkempt. Adult Social Care arranged for an Occupational Therapist to help Alice, as the property was not adapted to be suitable for a wheelchair user. However, this was not sustained as Alice did not respond when contacted. It is known that Joe had been staying, and he did not like officials visiting. On 13 January 2016 a Notice of Seeking Possession of the flat was served on Alice due to £385.91 arrears being owed. This would be standard practice. However, there were no notes on the system to show any other contact had been made to Alice or to services that were supporting her.

16.24. As a result of the assault on Alice on 29 December 2015, on 20 January 2016 Surrey Police made a high-risk referral to Your Sanctuary. The referral also highlighted that in 2008, Joe had been charged with grievous bodily harm (GBH)against Alice. Numerous telephone calls were made to Alice's mobile phone number over a period of several days but each time the call went to answer phone, in accord with a Your Sanctuary safety policy, no messages were left. On the 28 January the case was closed as Alice could not be reached.

16.25. The Police later returned to Alice's home following reports that Joe had stolen her methadone, possibly her bank card and that he had been staying with her on a daily basis. The Police found Alice heavily intoxicated, she told the Officers that she did not want to get Joe into trouble, rather to help him, so claimed that the recent report of Joe assaulting her was actually play fighting. The ASC records showed that i-access felt this incident met the criteria of s.42 Care Act, but there was no record of what subsequent enquiries took place.

16.26. On 2 February 2016, Alice was discussed at the Woking & Surrey Heath MARAC. Updates were provided by the agencies present. The Police Neighbourhood Specialist Officer and her MH worker were aware that the specific actions for the Police had been encompassed/completed within the Police investigation of 29 December 2015 and were being monitored by the Police Safer Neighbourhood Team.

16.27. During February 2016, it became apparent that both Adult Social Care and CMHRS were supporting Alice, and it was clarified that CMHRS would lead in managing care and support Alice. Over the following two months there were numerous reports of Alice refusing the support from carers. In March, an ASC Occupational Therapist attempted a review of equipment at Alice's home, but Alice once again advised that she was feeling unwell. The Occupational Therapist explained to her that the required major adaptations could not proceed without completing the review. Alice asked that the appointment be rescheduled, in writing, as her phone has been stolen. Again, it was suspected that Joe was regularly visiting /staying at her flat at the time. As on 13 March New Vision Homes (NVH) received a request to change her locks as she was vulnerable and has lost her front door keys following break-in by ex-partner. The Contract Manager at New Vision Homes authorised discretionary lock change.

16.28. In April, the Police attended following a report that Joe had forced his way into Alice's flat. Once inside, Joe had slapped Alice across the face. Alice refused to give the Police details of her care agency or others who were supporting her and refused advice to contact Women's Aid. The report stated that Alice wanted Joe to return to the flat, consequently a decision was made for 'No Further Action Under Safeguarding' by the Mental Health Substance Misuse Team.

16.29. The following month, on 5 May 2016, Adult Social Care received concerns from New Vision Homes that Alice's flat was being used as a 'drugs den', from the number of people entering and leaving. This information was shared with CMHRS. New Vision Homes sent Alice a letter stating that using and allowing others to use illegal drugs in the flat was a breach of her tenancy as this was unacceptable behaviour.

16.30. In June 2016, the Police notified Adult Social Care of their concerns that Alice's home was being used by young men for drug dealing. It was suspected that Joe who was staying in the flat, had allowed them to do so in return for drugs. Joe was convicted and received a custodial sentence. This information was also forwarded to CMHRS who were further notified that a Care Worker had found Alice with a black eye. Alice advised that she received this from falling. Surrey County Council Children's Services were notified as Alice was pregnant. On 15 June, support workers from Woking Borough Council and New Vision Homes made a joint visit to Alice, she would not let them in as she had not received the voicemail left for her. It was explained they wanted to help her maintain her tenancy. She asked them to rearrange a future visit as she was 30 weeks pregnant and thought the baby would be early.

16.31. There were numerous complaints to the Police (11 Intelligence reports) from Alice's neighbours and others, about anti-social behaviour and suspected drug activity. On 27 June, a communal internal door was damaged and although she was wheelchair bound as it was her flat, Alice was held responsible. She was served with an Acceptable Behaviour Contract. Partner agencies were engaged, and Alice was discussed at the Woking Community Incident Action Group (CIAG).

16.32. Information that Alice had given birth on 18 August 2016 was noted, and Social Services engaged to start procedure to remove baby from Alice's care.

16.33. Shortly after the birth of Alice's baby, the baby was removed from her care. Adult Social Services arranged for another round of involvement of an Occupational Therapist which resulted in a recommendation that Alice should be rehoused to a property more suitable for a wheelchair user. They also provided Home Care Services up until November 2017. The support provided was for 2 people to visit Alice for one hour per week to assist with cleaning, food shopping and laundry. However, engagement with the service was sporadic as on numerous occasions Alice would not be at home to let the staff in. The Home Care Service later pointed out that information had never been shared with them about Alice's drug habit or Joe's propensity to violence.

16.34. On 22 September 2016, following a proactive Police / partnership approach a drugs warrant was executed at Alice's address and Joe was arrested. At the time Alice was in bed in the bedroom of the property. During the search a bag containing £1500 cash was found in the living room, along with multiple cheap throw-away mobile phones. Cocaine and documentation relating to drug dealing were found. This was followed up by the Police arranging unannounced visits and Police patrols which ultimately reduced the number of complaints from neighbours. A 39/24 vulnerable adult report was completed and shared with partner agencies regarding Alice's situation**.** Joe was convicted of being concerned in the supply of controlled drugs and sentenced to a term of 20 months imprisonment.

16.35. In January 2017 ASC were notified by the Police that Joe was staying at the flat. They voiced concerns regarding the cleanliness and cluttered nature of the property, to the

extent that there was insufficient space to manoeuvre a wheelchair. The Officers found evidence of drug use in the form of a crack pipe and syringes. Bruises were observed on Alice's chest, but these were quickly covered up by her. Alice had told the Officers she was depressed and not in full receipt of benefits, although she had taken no action to resolve either issue. It was suspected that Alice was victim of domestic abuse but was unable to speak out. ASC Locality passed this information to CMHR**S.**

16.36. Over the following months, Alice repeatedly refused to let carers into her flat, but in April 2017, the Surrey County Council Emergency Duty Team (EDT) received contact from the care agency who advised that Alice had no food or money**.** EDT agreed for the carers to carry out shopping and for SCC to be billed for the food. This became a pattern, whereby Alice would not allow the carers in, but then there would be further incidents where she would ask for help as she had no food or money. In May CMHRS were notified.

16.37. In August 2017, ASC Occupational Therapists received a referral for the provision of a ramp, as Alice was having difficulties exiting and entering the flat. However, it was reported in November 2017, that the Occupational Therapist had been unable to contact Alice to complete this assessment. CMHRS arranged for the assessment visit to take place in December 2017, and this was completed with a recommendation made to Woking Borough Council Housing that Alice's current property was not suitable for her needs. ASC and WBC Housing liaised about how to support Alice in bidding for properties. It was however noted that Joe had been released from prison and has been seen leaving Alice's flat. The Social Worker commented that Alice had the mental capacity to make the decision to allow Joe into the flat, and this information was shared with Alice's i-access nurse.

16.38. A friend of Alice's contacted the Police reporting that Alice had told her she had been assaulted, that people were trying to manipulate her into selling drugs and as a result she had self-harmed. Alice was seen by Officers, and she denied anyone was trying to manipulate her into selling drugs and went on say she was currently adhering to her methadone programme. She explained that a female had slapped her face as she was upset about having her child taken away. Alice had told the woman that she related to, that as all her children had been taken away. She said she has since made up with the woman who she would not name. Alice added that the conversation about losing her children led to her cutting her arm with razor blades causing superficial lacerations. The Police Officer was concerned by numerous safeguarding issues, including her physical disability and mental health problems and the risk of her being open to manipulation/exploitation in the future. Consequently, he submitted a comprehensive 39/24 vulnerable adult referral, grading Alice as being at medium risk care/ support needs.

16.39. On 14 November 2017, a Social Worker contacted other agencies including New Vision Homes requesting that agencies involved with Alice should do so through her, as Alice was having difficulties retaining information relating to the number of professionals who were contacting her due to her mental health.

16.40. On 5 December 2017, Housing personnel called at Alice's home after reports that someone else was living there with her. On arrival, Joe opened the door to them, and it appeared that it was him that was staying there in breach of Alice's tenancy licence.

16.41. Three days later, on 8 December 2017, New Vision Homes were contacted by the Occupational Therapist stating that Alice would benefit from rehousing to a more suitable environment as soon as possible, as due to being a wheelchair user she struggled with accessing bathing facilities and the kitchen. A housing needs assessment was arranged.

16.42. In January 2018, Alice was referred to the Enabling Independence Team by her Care Coordinator, however she was not engaging with the worker who was meant to be supporting her with applying for her Personal Independence Payment (PIP). She was also enrolled with Outreach workers to support her with bidding for a new flat, however, she was not able to manage as each month she would be requesting a food voucher, and the care agency was reporting that she continued to refuse entry of the carers.

16.43. On 31 March 2018, Your Sanctuary received a referral from Surrey Police which detailed a high-risk domestic incident, whereby Alice had been beaten up by Joe at her home address. During the assault he had pulled her out of her wheelchair, kicking and punching her to her body and face. He also smashed her phone and trashed her flat. During the incident he had wheeled her round to the local shop, from which he was banned so that she could buy him alcohol. The incident had ended when Alice managed to crawl to a neighbouring property seeking help. Once again, a Your Sanctuary case worker endeavoured to contact Alice, but they were unable to do so, and the case was eventually closed by Your Sanctuary. Nevertheless, Your Sanctuary continued to try to contact Alice during April, and eventually on 5 May the Outreach worker spoke to Alice who stated her relationship with Joe was over and she would not take him back.

16.44. On 17 April 2018, New Vision Homes noted that Alice had still not been entering their bidding process for an adapted property to meet her disability needs and considered that this was probably due to her not having online facilities.

16.45. In April 2018, Joe was arrested for the assault on Alice and was remanded in custody. During the safeguarding work that followed, Alice disclosed that she had been in the relationship with Joe for 10 years, they had three children together. The children were no longer in Alice's care, and she has no contact with them. Joe had been jailed for 2 years in 2015 for a violent assault on her. He had more recently been sentenced to imprisonment for another offence and had been released on 24 November 2018 when he then moved in with Alice. She explained that things quickly became difficult as he returned to using Heroin and Crack Cocaine. Alice said he was very controlling and disrespectful. He would stop her visiting her friend by putting obstacles in the way, such as telling her that she needed to do his shopping before she left or telling her that they had already made other plans for the day when she was due to visit her friend. Alice also advised that Joe did not like her care workers visiting, he would tell her to "get rid of them"**.** Joe would remain in the lounge when care workers attended, which meant that the lounge had become untidy, and she was unable to ask care workers to support her with this. Alice was visually upset about the environment of the lounge. There were lots of beer bottles and cans lying around as well as needles scattered around. Alice stated he had been using her place as a "shooting shop," having various heroin users visit to use the property to inject drugs. Alice admitted that although she was a heroin user, she has not taken heroin for 2 months and has been providing fortnightly urine samples which have been clear of heroin. She was currently on 90ml of Methadone daily but also drank 2 to 3 cans of alcohol a day. Alice added that she was receiving regular support from i-access.

16.46. Alice went on to say that Joe had attacked her on 31 April 2018. He had wanted her sim card out of her phone, and she did not want to give it to him. Joe smashed her phone up and physically attacked her, punching her in the face several times and attempted to smother her face with a blanket. Alice said that Joe had hit her several times in the past. She admitted that she was more frightened this time as Joe had tried to smother her, she was scared that he would kill her. She remained fearful of him even though she was aware he would be unable to leave the prison. Alice was visually anxious and apprehensive, jumping at sounds from outside. She confided that the care workers were not visiting as often as they should and did not always like to do much when they attended. Her desired outcome was that Joe does not return to her property.

16.47. A multi-agency meeting was held on 24 April 2018. This was attended by ASC Locality, Woking BC Housing, i-access, GP Practice, CMHRS and the Care Agency. The meeting provided some clarity on the roles of the attending agencies; Alice's needs were no longer felt to relate primarily to mental health, so ASC Locality would lead on case-management and that Alice would remain open to i-access. It was agreed that Alice 'had capacity to make decisions regarding her own life, but she was just making unwise decisions'. Alice was not wanting the carers to support her at home. The plan was to complete a professionals meeting considering discharge from CMHRS.

16.48. On 8 May 2018, after neighbours complained to the Police of the numerous people calling at Alice's address at all times of day and night. A Community Harm and Risk Management Meeting (CHaRMM) was called regarding Alice, who although a victim of Domestic Abuse was at risk of losing her home due to anti-social behaviour and substance abuse at the premises.

16.49. A Specialist Neighbourhood Team Officer working with a Social Worker, made a visit and established that Alice was hiding in the flat and not answering the door through fear of letting in drug addicts who had been friend/associates of Joe, who was then in prison after the assault on her on 31 March 2018. The Specialist Neighbourhood Team Officer informed Alice that the primary need was to safeguard her and give her respite from the drug addicts attempting to take advantage of her vulnerability, and who were banging on her door at all times of day and night. A Social Worker carried out an assessment of Alice's living conditions as the property was in an appalling state.
Subsequently, New Vision Homes put a warning flag on the address, noting that Alice had a Police panic alarm and that the Police visited her daily.

16.50. At a second CHaRMM meeting, with representation from Woking Borough Council Housing, Adult Social Care, Police, Your Sanctuary and the care provider, it was noted that Joe remained out of prison on remand and Alice was not engaging with the Home Care Service. The Police had provided her with a mobile phone and a partial closure order was considered.

16.51. As a result of agreed actions at the CHaRMM, there were several further joint visits by the Police and Adult Social Care, and the hope was for her to be rehoused to a different area while Joe was not in contact. It was later decided that as Alice was engaging well with Adult Social Services, that the closure on the premises was no longer necessary and that there was no requirement for her to remain on CHaRMM. The Your Sanctuary Outreach worker attempted to contact Alice after the meeting but was unable to speak with her even after asking the MARAC team for alternative contact details, so their case was closed.

16.52. At the end of May 2018, Joe was sentenced to 4 months imprisonment, and a 5 year protection from harassment order, preventing contact with Alice would be in place on his release. An increased Police presence at Alice's home over the course of a ten-week period led to the number of visits being made by drug users diminish entirely.

16.53. In June 2018, it was found that Alice had no active housing application, as she had been unable to provide the identification information needed, and she was unable to get a copy of her birth certificate from South Africa. New Vision Homes notified Alice's Social Worker that as she was in a non-secure tenancy, she could not qualify for a high banding for a move, particularly as she did not wish to move out of the area to flee from Joe. A referral was made for an Occupational Therapist (OT) assessment for equipment to enable her to use the bathroom. By July however, ASC Locality updated CHaRRM that Alice was engaging well with Social Care, had not had any male visitors to her flat and was on the housing register for suitable properties. Alice was later offered a new tenancy in a bungalow.

16.54. On 21 September 2018, Probation notified the Police that Joe was to be released from prison on 24 September 2018, on Post-sentence Supervision which only afforded limited control and a maximum 14-day imprisonment for non-compliance. The Restraining Order from 2018 remained in existence. There was concern about potential harm to Alice and a MARAC referral was submitted. In preparation, consideration was given to adopting Joe under the Integrated Offender Management (IOM) scheme on the basis of reducing offending/crime reduction; however, Joe would not engage and held negative views towards the Police and Authority. The Police informed Alice of Joe's release date, and a warning marker was placed on her address**.**

16.55. Upon Joe's prison release he had no fixed abode. The concerns raised by Probation were, that despite the 5-year non-harassment order upon his release, his relationship may resume with Alice, with him using drug use as a way to control Alice.

16.56. A property in Old Woking was offered to Alice in October 2018, but an OT assessment found it was not suitable for a wheelchair user. By this time Alice was often staying with a friend who had a bathroom she could get into. The Police supported an emergency housing application on the basis of fleeing domestic abuse. This led to Alice being temporarily housed in a hotel, however, this led to difficulties in her being able to collect her methadone prescription.

16.57. On 6 November 2018, a MARAC meeting was held in respect of Alice. It was noted at the meeting that the Your Sanctuary Outreach worker had been unable to make contact with Alice, and the Police were trying to trace her to establish contact. Information's ascertained that Alice was temporarily staying at a hotel until a new property was ready for her. The Police suspected that although Joe was claiming to be sleeping in a Woking car park, he was in fact living in Alice's old flat. Although there was a restraining order in place on Joe till 2023, as Alice was known to be engaging with i-access for her drug use and Joe was a Class A drug user, it was believed they would be in contact.

16.58. In December 2018, Alice moved into a new property, a bungalow. An Occupational Therapist assessment had identified adaptations were needed, but it was determined these could be done after she moved in. It was noted by NVH that the property had a full refurbishment whilst empty but that the new kitchen was not a wheelchair accessible one.

It had a new wet floor shower room (with widened sliding door). The OT later submitted the following assessment: Provide chamfered timber ramps to the front and rear door thresholds suitable for wheelchair use. Remove the existing kitchen sink base unit and provide a wheelchair accessible sink unit. Supply and install window winders to the kitchen and bedroom windows. Widening the internal entrance hallway door to suit the resident's wheelchair. Carry out all the necessary making good associated with the works listed above.

16.59. On 6 January 2019, a neighbour informed the Police that on 27 December 2019, there were sounds of a disturbance coming from Alice's property. He and his partner went round and found Alice and Joe having a verbal argument. As they arrived, Joe ran to the kitchen and threw a small camping stove gas canister into the oven and switched it on, the suggestion being he wanted to blow the house up. The neighbour had removed the gas canister and secured it to prevent Joe doing it again. Two Officers attended and spoke with Alice. She denied any such incident had occurred. The Officers then spoke with the neighbour who told them that there were regular problems at the house, that he believed Joe knocked Alice about.

16.60. In January 2019, the Occupational Therapists and shortly afterwards the Woking Locality Team ended their involvement with Alice. NVH noted that Alice did not have a bank card and was having difficulty paying her rent. Christians Against Poverty were contacted and promptly assisted Alice with her payments.

16.61. On 7 February 2019, staff at i-access made a referral to MARAC, highlighting concerns about Alice and Joe. The concerns arose from the SCARF completed by Police relating to the incident reported on 6 January about Joe being back in contact with Alice.

16.62. In April 2019, one of Alice's friends contacted Adult Social Care to inform them that Alice was wheelchair bound and had not been able to access her GP Practice since she had been rehoused, therefore she could not get any of her medication. As she had moved out of the GP Surgery area, she needed to sign with a GP Practice somewhere closer, but as Alice did not have a driving licence or passport, she could not register anywhere. Arrangements were promptly made with the closest GP to her home to accept a utility bill as sufficient identification, but difficulties were experienced in contacting Alice to inform her of this.

16.63. The same month, Adult Social Care received a phone call from one of Alice's neighbours who had been helping her throughout the COVID crisis, but for the previous three weeks Alice had been saying that she did not have any money for groceries and had to rely on food banks. Arrangements were made, but a few weeks later a call was received by Adult Social Care from the Woking Family Centre to raise a concern about Alice, who was self-isolating on her own. She has been asking local COVID 19 volunteers to buy her large bottles of cider. On other occasions Alice had also been seen leaving the house to get alcohol herself when she was meant to be at home self-isolating.

16.64. On 3 March 2020 at the MARAC meeting, the following issues were noted, and actions arranged:

- There was a Protection and Harassment order against Joe.
- Welfare checks to be done by the Surrey Police Safety Neighbourhood Team (SNT).

- Alice was not supporting the Police at that time.
- MARAC would request an update from Probation.
- It was confirmed that Alice had been supplied with a Domestic Abuse kit.
- If Joe was arrested for any further offending, Your Sanctuary would try and support Alice.
- Alice was now a New Vision Home's tenant living in a partly adapted property.
- Both Alice and Joe were open to i-access.

16.65. In July 2020, Adult Social Care received a referral from i-access Drug and Alcohol Service that a visit had been made to Alice at her home, the house was bare and unkempt. There was no carpet on the floor and minimal furniture in the living room. Alice was also unkempt and did not show signs of maintaining personal hygiene. Alice had disclosed that her neighbour (who helped collect her medication and do shopping) had moved away and this has adversely affected her. With regard to the house, Alice stated that she was unable to afford to lay flooring in the house which was currently concrete flooring - which could cause significant harm if she was to fall. She also only has a small cabinet freezer and was unable to store much food in there. The garden which had several steps, and a platform was a safety risk with the wheelchair. The fence to the garden was also broken and therefore the property was not secure. The property required adapting for wheelchair access. Alice also disclosed that she not been receiving Disability Payment. An Occupational Therapist made several attempts to contact Alice, the Occupational Therapist sent a letter to Alice stating: "…tried to contact you recently without success. If you still require an assessment, could you contact us within 2 weeks. After this date we will close this case." As this was never conveyed to the i-access Drug and Alcohol Service Practitioner a reminder was sent in October 2020 to again ask for the help for Alice.

16.66. Similar further referrals were made during the following two months emphasising that Alice was alone, wheelchair bound and 'at risk of physical health (having a chest condition), and mental health deterioration and limited ability to seek assistance or help.' After the third referral a Social Worker arranged for a voluntary organisation to do a medicine collection and for a food bank to provide a food parcel. A referral to be made for an electric wheelchair.

16.67. The GP Practice had been copied into these referrals and noted the regular good communication from the i-access key worker. A result of which was the GP contacted Alice by phone, but in spite of all reasonable advice and safety netting being given, Alice declined an appointment/COVID test/medication for her chest symptoms. There was no reason to consider she did not have capacity to make these decisions.

16.68. On receiving a referral from ASC in January 2021, a manager from the Byfleet Unity Charity visited Alice at home. They agreed to arrange for a new fridge freezer, clothing and bedclothes. They advised her to contact Citizens Advice Bureau about getting her PIP restarted and dealing with £1750 utility debt. At the same period Adult Social Care commenced a S9 Care Act assessment (which was completed in March).

16.69. At about this time, Alice was reporting that she was experiencing continence difficulties, and this was a source of stress for her. ASC Locality referred Alice to the Reablement Service, but the Service did not feel that they were the correct service to support her, because they would not be able to accurately assess her due to her emotional

/ mental health needs. The Social Worker was advised to explore voluntary sector options to help with her debts and to consult with her GP.

16.70. On 5 February 2021, CSH Surrey received a referral to their continence service from Alice's GP. The reason for the referral was "Patient is wheelchair bound following a spinal injury, urinary incontinence at times, I would appreciate your review and provision of continence pads". A telephone consultation from the Continence Service was made due to Alice's overactive bladder and stress incontinence. A plan was agreed - refer to the pelvic physiotherapist, send some leaflets and samples of incontinence pants then to follow up in 3 months."

16.71. Later that month, both the ASC Locality team and NVH were contacted by a neighbour of Alice, who asked if her Social Worker could make contact with her to check on her welfare." Subsequently an ASC Locality Worker made contact with Alice via telephone and with a home visit. It was revealed that Alice was falling about 2 times per month and was also experiencing cognitive / memory problems.

16.72. On 29 March 2021, Alice was referred to CSH Surrey by the ASC Locality Team and the Community Nursing Team was asked to assess Alice's pressure sores. They attended Alice on 14 April with the physiotherapist and a plan was agreed with her, that the physiotherapist would speak to her Social Worker regarding the visit and to discuss:

- Provision of carers to help with washing and dressing
- Refer to Occupational Therapist (OT) for rails and chair raisers
- Refer for a pendant alarm and key safe

16.73. This meeting was followed up two days later on 16 April, when the Occupational Therapist visited Alice to complete the assessment. During this she was informed that the Wheelchair Service had confirmed she was on their waiting list for a new electric wheelchair which was estimated for June 2021. While an assessment was being completed, Alice briefly mentioned her history with suicide attempts, addiction, domestic abuse, etc, but said she was now in a better place mentally but generally frustrated. It was arranged for regular community nurse visits to check and dress her pressure sores. In the following weeks Alice reported being in significant pain and that her incontinence had got worse. She was given a bladder scan and advice regarding pads.

16.74. Following a home visit to Alice by the Independent Housing Support Service, a report was sent to Adult Social Care regarding the tearful state they found Alice in, after paying her bills she had no money left for food and had been sleeping on a sofa. She had told them that she was still awaiting the outcome of a wheelchair assessment two years previously for an electric wheelchair. They described the unsafe state of the garden and set out that they would organise a Careline and key safe to be fitted and would arrange for Refuse collection to collect her bin and put it back for her. They commented that Alice was easy to talk to and just needs some extra support. Her controlled medication needs to be picked up every Tuesday from Boots chemist so that will need to be incorporated into a care package. Alice had stopped taking methadone (in consultation with i-access) as a result of needing to increase dosage for epilepsy medication.

16.75. The Reablement Service, which was in contact with Alice once a day, contacted

Alice's Social Worker to explain that they could not collect Alice's medication so another service would need to do this. Alice reported that the work the reablement assistants were asking her to do, was increasing her pain levels. Due to Alice's history of drug misuse, her GP was very cautious about adding in more medication without specialist input but agreed to her increasing codeine and epilepsy medication as an interim measure until the Pain Clinic could see her.

16.76. A Reablement worker recorded "I am very concerned about Alice. She said to me that she is very close to doing something. She used her fingers to demonstrate how close it is. She was in tears. I want to believe that Alice was talking about ending her life. She said that she has been let down so many times. She also declined for me to contact her GP or paramedics. She reported that she has been kicked out of hospital before but did not explain why as she was crying. She is very low at the moment, and I am very concerned".

16.77. A Safeguarding referral was received by Adult Social Services from the Scope National Helpline. It was reported the Alice had rang them. "She called the national helpline because she was really struggling. She was not receiving the support that she needed from their support worker or carers. She was not able to eat properly due to her disability and access to the kitchen. Alice was in a lot of pain but not getting any help. She is struggling with a lot of things like benefits and debt. Her care needs should be reassessed. She is in a lot of pain but not receiving the support from the GP. I have referred to an advocacy service to see how they can" (document got cut off here).

16.78. "A Reablement review took place, and reported that (Alice) was in tears when expressing her pain and her frustration with how her case was being handled:

- She had not been able to see the GP for her pain.
- She was finding life 'very complicated and difficult'.
- Her Social Worker was leaving, and he could not tell her who was going to take up her case.
- She could not get through to anyone for help.
- She was scared for her life.
- She said she needed a key safe but could not afford that or Careline.
- She wanted help with shopping and cleaning and laundry because she was struggling.
- She could only move around in a wheelchair which she found difficult and that is why she slept on a sofa.

The report concluded that (Alice) needed help and recommended that she receives the help she needs urgently as she thinks she is struggling and there is no way out. She feels she is close to doing something to herself which might be to end her life.

16.79. As a result, on 14 April 2021 a face-to-face appointment took place at Alice's home with the Falls Physiotherapist (PT). An assessment was completed, and the following plan was agreed with Alice:

- The Falls Physiotherapist would consult with the Social Worker regarding the visit and to discuss provision of carers to help with washing and dressing
- Refer to the Occupational Therapist for rails and chair raisers

- Refer for a pendant alarm and key safe.

16.80. Two days later, on 16 April 2021, the Occupational Therapist visited Alice at her home and completed an assessment. During the assessment**,** Alice reported to be in a better place mentally but felt generally frustrated. The following day the Community Nurse saw Alice to check pressure areas and gave her advice as to how to manage vulnerable areas. There were no nursing needs identified, and Alice was discharged from the case load.

16.81. On 21 April 2021, Alice self-referred to the Women's Support Centre to join the SMART (Self-Management and Recovery Training), a group-based addiction recovery model designed to help people overcome addiction. A Tablet was purchased for her in order to support her to join virtual groups the Centre was providing. Alice was informed she could use this tablet for other purposes however, it was noted she did not attend any meeting and never opened the Tablet.

16.82. Later, on 5 May 2021 a Reablement worker reported: "(Alice) appeared asleep but unfortunately that was not the case. I saw that she had cut marks across the inside of her left arm. These were not at her wrist but up and down her arm (dried blood.) I managed to rouse her enough to find out that she had taken all of her pain medication/epilepsy medication. Every packet was empty. Called paramedics and until they arrived, I kept (Alice) awake. During that time, she explained that she was not trying to end her life. (Alice) wanted to stop the continuous, intolerable pain in her back. (Alice) did not want to go to hospital. Paramedics said that as she had capacity she did not have to comply. I mentioned that she might have an opportunity to talk to the pain management team there. Thankfully, she agreed to go with them."

16.83. Following the overdose, at a hospital Emergency Department, Alice denied having any suicidal ideation claiming the medication was taken for pain. After a discussion with the Psychiatry team, it was decided that as there was no suicidal ideation, there was no need for an assessment. It was noted that she was awaiting a Package of Care (POC) under the Reablement Team, and they were contacted to ensure the package of care restarted the next morning. She was also referred to i-access for follow up.

16.84. Subsequently Reablement added a second home care visit each day. A further record was made that Alice felt let down by a telephone pain management appointment, as the clinician did not have all her notes. Nothing could be done until he has them, and no interim pain relief was offered. Alice was feeling very low.

16.85. On 17 May 2021, Alice attended a hospital Emergency Department with back pain. She was examined but there were no new acute findings, pain management was undertaken, and she was referred to the Chronic Pain Team. However, on 1 June 2021 she failed to turn up to her appointment. She was later given two telephone appointments but again did not attend several planned face-to-face appointments.

16.86. A home care agency took over care delivery to Alice from Reablement. After their first visit they reported that Alice found the transition difficult as she had to explain her situation to the new carers. She told them about being hit by a train, that she suffered mental health problems and self-harmed. She was particularly concerned about answering the door for fear that it might be her ex-partner coming to hurt her.

16.87. On 1 July 2021 the NVH Housing Manager visited Alice with a member of staff from the social prescribing team as Alice was struggling. It was noted that she had no access to her garden and that an OT report had apparently been done but never received by NVH. It was arranged to find out what had happened to the assessment and in the meantime, to carry out some urgent repairs. Plaster was crumbling from walls around the radiator and Alice had stated that the floor got hot in the kitchen. Arrangements were made to have the problems checked and a burst pipe was found under the floor. That was promptly repaired but it took some months to re-plaster and fix the floor. The other identified issues identified by the OT together with a sanctuary safe room, were authorised by the NVH manager but were delayed due to the adaptation's contractor pulling out of the contract.

16.88. The Occupational Therapist made several attempts to see Alice during this period, but she declined the visits saying she was in too much pain, however she refused to attend the hospital or her GP. It was not until the 17 June that the Occupational Therapist was told by Alice that the equipment the Therapist had ordered for her had arrived. A discussion took place around further equipment needs and Alice agreed to have a profiling 'hospital' type bed, which the Occupational Therapist would order. Alice said she had been seen by the Pain Team and Mental Health Team and her medications had been adjusted. The Occupational Therapist noted that Alice sounded to be in better spirits. Subsequently the Occupational Therapist and the Continence Team continued to visit Alice at her home throughout June and July.

16.89. On 2 July 2021 Police attended at Alice's home after receiving information that Joe was visiting her. A neighbour who knew Joe well, confirmed that he was regularly visiting and staying over at Alice's address. The Officers completed a DASH, assessing Alice as being at high risk based on their observations and information known. It was decided that Joe was to be arrested for breaching the Restraining Order. Alice however was unsupportive, although this seemed to the Officers to be due to her fear of Joe and her concerns about repercussions. An Outreach referral was completed, and a SCARF/VAAR high risk was shared with partner agencies.

16.90. Surrey Police made a referral to Adult Social Care, requesting an assessment for Alice, as Joe had breached his restraining order multiple times by attending her address, and Alice had admitted that Joe had assaulted her on multiple occasions. The home care service also notified Adult Social Care that their care worker had reported Alice had a male visitor who had slept in the bedroom, while Alice slept on the sofa. Alice had refused personal care, as she wanted to sleep longer.

16.91. On 5 July 2021, a Police referral was also made to Your Sanctuary with the following summary of events being provided:

- This pair were in a 3-year relationship.
- There has been a long history of domestic abuse from Joe to Alice, including serious violent assaults, and she disclosed that she moved out of the area so he could not find her.
- There were concerns that Joe now knew where Alice lived and may be coercing her to let him stay there.
- Alice has a harassment order against Joe.
- Alice was a wheelchair user after she attempted to take her own life by jumping in front of a train.

- She also has a history of opiate misuse.
- She has limited mobility, and this impacted on her capability of protecting herself.
- Alice told Police that a couple of days previously Joe had turned up at her address soaking wet and crying.
- Joe's dog was soaking wet too, so Alice let them in. After drying himself and the dog had stayed and had a few drinks.
- Joe's mood changed and Alice threw him out as she felt stronger and would not put up with what she had previously. She did not wish to provide a statement to the Police.
- Alice was also wheelchair bound and has been subjected to numerous attacks from Joe whilst in her wheelchair.
- Alice could not defend herself, nor is she helping safeguard herself by letting him into her home address.

16.92. An i-access worker made a safeguarding referral that on 6 July 2021. Alice had disclosed that Joe, had turned up at her door with a dog about a week ago, wet from the rain, he had nowhere to go so she let him in, he was very angry. He 'switched on her' and she had retaliated. She then told him to leave her house. The Police attended her property, and she disclosed that Joe had been at her property. She was worried that he would find out as he had breached his restraining order. He has seen her key safe number, and he read it. The i-access worker explained that she would make a MARAC referral and arrange for the key safe number to be changed.

16.93. It was only after Joe had been arrested and was in Police custody on 12 July 2021, that Alice gave a statement to the Police. In the statement she referred to the incident in December 2019 which she had previously refused to speak to Police about, she confirmed that she and Joe had been arguing all day and that during the evening, he had grabbed her hair and punched her in the head several times.

16.94. On 17 July 2021, a high-risk referral, relating to Joe breaching a restraining order on numerous occasions by attending Alice's address was discussed at Woking and Surrey Heath MARAC. It was noted that Alice who is wheelchair bound, had been the victim of numerous attacks from Joe whilst in her wheelchair, but still permitted him to enter her home before asking him to leave and calling the Police. Joe was remanded in custody, but Alice declined to provide a Police statement/ The MARAC ensured that Adult Social Care linked with domestic abuse outreach, to encourage engagement and that health information was shared and documented on the MARAC Modus system. It was noted on the MARAC form that Alice had a brain injury and had carers who attended twice daily. She was deemed vulnerable, and it was suspected Joe was exploiting this.

16.95. On 21 July 202, Alice was taken to a Hospital Emergency Department after having been found unresponsive and short of breath by Carers. She was diagnosed with infective exacerbation of chronic obstructive pulmonary disease (COPD) and treated with nebulisers and antibiotics. She was admitted to hospital and discharged on 23 July 2021. A good social history was taken, and it was noted that her ex-partner, Joe, was in prison at the time. There was, therefore, no required changes to her social situation on discharge, as it was noted that she had once a day carer support.

16.96. On 3 August 2021, the Community Nursing Team visited Alice at her home and provided wound care to her right elbow and right ankle. The Team continued to provide home treatment every other day until 30 August 2021 when she was discharged. The

treatment (cleaning and dressing the wounds) recommenced bi-daily, throughout October and November 2021.

16.97. In September 2021, Surrey Police received a message from Alice which raised concerns for her welfare, as she stated she could not go on anymore and that her head was all over the place, and that she was nailing her own coffin. Shortly after a second message received, that she wanted to retract everything she had said about Joe and that nothing had happened. Police Officers attended her home address. She was upset and very stressed. She said that she was feeling very low as she was worried about going through with Police action in relation to Joe. She was scared that nothing much would happen, and that she would feel worse if he was to come out of prison and get to her again. It was explained the Police would support her. She was very scared but after a long chat, she provided a victim's statement. She said that she had no plans to self-harm, and if she felt that she wanted to, she would call 999 straight away and she would speak to her GP as she is not sleeping well. The Police contacted Your Sanctuary regarding their concerns about Alice. The Outreach worker contacted Alice and a request for the Sanctuary Scheme[10] was put through to Housing. Alice told the Outreach Worker that she was very scared of Joe and worried he would walk free from court on 9 September 2021. She was at first appreciative of the Sanctuary Scheme referral, but later reported she was being supported by the Police Domestic Abuse Worker and therefore did not require further support. ASC Locality considered this incident against s.2 of the Care Act criteria but decided this did not meet the threshold for a Safeguarding Adults Enquiry. The contact outcome stated that a referral to the GP / Mental Health Services was the appropriate action.

16.98. Surrey Fire and Rescue Service visited Alice and completed a full safety visit. It was noted that Alice 'is a wheelchair user who lives in a bungalow, but she cannot exit the bungalow in an emergency situation, when she does try and exit, she states the wheelchair tips and falls backward. She did explain she did have contact with Occupational Therapy and others who are helping with her situation, but it is concerning that she is not able to exit. Her home is also cluttered around her living areas, she would need assistance with clearing this and general house tidying, but her care staff will not assist her. The cooker also needs some attention, but once again she is unable to access this to clean. There is a reach pole in the property to assist her to close the windows, but she also struggles with this and doesn't find it easy to use. Fire alarms all tested, no gas in the property.'

16.99. In October 2021, there were numerous reports to ASC that Alice was not home when carers called. It was also recorded that Alice was not present for a planned assessment by ASC Locality Occupational Therapy. The following month, it was noted that Alice had a debt to Adult Social Care (ASC is means tested). Alice advised the Financial Assessments Team that she is still struggling to pay her utility bills.

16.100. Adult Social Care tried unsuccessfully to contact Alice by numerous telephone and visits to her home throughout January 2022, and it was not until early February that she was seen at her home. Alice admitted that she has been struggling with depression. She was currently not taking medication for this and she said this may be something she is

[10] A Sanctuary Scheme is a multi-agency victim centred initiative which aims to enable households at risk of violence to remain safely in their own homes by installing a 'Sanctuary' in the home and through the provision of support to the household.

interested in. Adult Social Care contacted Alice's GP to request a GP appointment to review her mental health.

16.101. On 25 January 2022, Alice had a telephone consultation with her GP Practice. She confirmed that she had stopped taking 'recreational' drugs. Her medication was reviewed as she was in a lot of pain and feeling depressed; but had no immediate thoughts of self-harm. It was noted that she had missed her appointment with Pain Management but agreed to make another appointment. The same day after the call, the GP wrote to Mental Health Services regarding medication changes. A letter was received back regarding this (recommending a trial of venlafaxine) but numerous attempts to contact Alice were unsuccessful.

16.102. The Occupational Therapist noted that contact had been made with New Vision Homes to chase up the adaptations in Alice's home. The repairs team advised that it required authorisation from a project manager, and that the project manager will be contacted to get an update on the adaptation. The therapist also called to chase up the application for an electric wheelchair but received no answer. The Police had made an assessment on the installation of some domestic abuse safety measures to Alice's home and were waiting for the Council to implement the work on the property.

16.103. On 28 February 2022, Alice attended a face-to-face Pain Management Clinic appointment. A letter was sent to her GP to review some medication to improve pain management at night to assist her sleeping. The possibility of steroid injections to improve her pain management was discussed with Alice, as a possible option for her.

16.104. Surrey Police contacted agencies working with Alice to give notice that Joe would be released from prison in the next few months, and that they wanted to inform professionals involved about the situation as Alice has a restraining order against Joe.

16.105. Adult Social Care had not been aware of the GP contact with Alice on 25 January, or about the correspondence between the GP and Mental Health Services, and as Alice had told the Social Worker she had not had any contact from the GP or Mental Health Services, ASC wrote again in March 2022 to the GP regarding Alice's mental health, stating it was declining and she was reporting having suicidal and self-harm thoughts and felt she needed a referral to the Mental Health Team.

16.106. On 21 March 2021, Alice was admitted to hospital following taking an overdose and having a cardiac arrest. A Psychiatric review was undertaken following a capacity assessment being completed and documented and Alice was discharged on 25 March 2021. A referral was made back to her GP for a community team referral, as Alice refused further testing for possible medical issues.

16.107. On 1 April 2022, Alice's health was reviewed by her GP in a telephone consultation. A paramedic home visit was arranged, and she was diagnosed with a lower respiratory tract infection and treated with a course of antibiotics. It was recommended that she should go to hospital, but she was adamant that she did not want to go because of a bad experience the previous time she was in hospital. She explained she had been abusive to staff due to the state she was in. She was reassured that staff would take no notice of that. She was struggling with her mental health and had previously had a cardiac arrest due to an overdose of medication and alcohol. She was referred urgently to the

mental health team for review, after previously declining their intervention when they had contacted her. Alice again declined support but stated she would phone 999 if she deteriorates.

16.108. In April 2022, Woking Borough Council responded to the Occupational Therapist's request for an update regarding the major adaptations to Alice's kitchen/bathroom/doors as she had been waiting almost ten months for these adaptations and would like to know how long she may have to wait. The OT was informed that New Vision Homes' contract had ended on 31 March 2022 and due to a backlog of adaptions, the work on Alice home had not been completed. Woking Borough Council were in the process of appointing a new major adaptations contractor with a view to starting works from May 2022 onwards.

16.109. Alice's allocated worker on the Adult Social Care team wrote to the Community Mental Health Recovery Services (CMHRS) stating that Alice 'had been seen by Psychiatry Liaison in hospital, following an admission regarding an overdose. Prior to this a request had been made several times to her GP to make a referral to CMHRS. Alice had confirmed that CMHRS had been trying to get hold of her, but she has not been answering your calls. She is very low and is not as engaging as she used to be. A risk assessment was being completed with Alice, but she is not engaging therefore the risk assessment will be completed without her input and will be sent to her in the post.' The Allocated worker asked that CMHRS arrange a home visit to Alice so that someone could keep in touch with her face to face. CMHRS responded by telephone that Alice was not open to their team, they had received a referral from the GP but had not been able to engage with her. However, having received the contact from the allocated worker they had endeavoured to see Alice but have been unsuccessful in reaching her. They suggested an urgent joint visit to Alice so they could complete an assessment with the support from Adult Social Care. They advised the assessment needed to be done urgently due to Alice's recent overdose and current suicidal thoughts. This was agreed and the worker contacted Alice to arrange the visit, and to inform her it would take place with a new allocated worker. Alice was also given an update regarding the adaptions to her home and that the worker was going to continue chasing up the electric wheelchair application and would be in touch regarding this.

16.110. Alice's foster mother and friends visited her about this time, and she appeared to them to be clean of drugs and happy. She had had her hair done and was dressed well. She spoke positively about her home and the help she had been having from a local charity. The only negative was her fear of Joe coming out of prison. She spoke of the sanctuary safe room scheme and hoped it would be installed prior to his release.

16.111. On 23 May 2022, i-access contacted Alice for a telephone consultation. It was recorded that she had been getting on well, she stated that she continued to receive support from the Byfleet United Charity. They are helping her with her garden and with getting furniture for her flat. When her mental health was discussed however, she reported being frustrated and paranoid. She felt something was not right in her head; she was hearing voices. The Psychiatrist are aware of this, and she had a home visit from a doctor the previous week. She had been encouraged to continue to engage with CMHRS as she was still under their care. She reported that she was not prescribed any medication at the moment but would call them. Alice added she was anxious as Joe her ex-partner would be released from prison in July 2022. The Police are aware of this. When discussing drug and alcohol use, she reported that she had the occasional drink and cannabis. However, this

was not something that she viewed as a problem. She denied any heroin use and stated that she would never go back to that. Alice then requested that she be removed from Recovery mode as she was still abstinent from heroin and would work with CMHRS and her GP. The Worker agreed but also informed her that should she require any support to get in touch. She said thank you to the Service for the support received.

16.112. On 25 May 2022, Alice's GP Practice telephoned and texted Alice to make a GP appointment for 30 May but received no response.

16.113. Later that month, Surrey Police found Alice deceased in a hotel room.
(See Section 14 of this Report.)

17. ANALYSIS

17.1. Agencies completing IMRs were asked to provide chronological accounts of their contacts with Alice prior to her death. In line with the Terms of Reference, the Review focused particularly on agencies' contacts from 1 April 2015 to the date of Alice's death, together with relevant information prior to that time. The recommendations to address lessons learnt are listed within the action plans in section 20 of this report. Where there was no involvement or insignificant involvement, agencies advised accordingly.

17.2. The Review Panel has checked that the key agencies taking part in this Review have Safeguarding and domestic abuse policies (either stand alone or as part of a wider Safeguarding policy) and is satisfied that those policies are fit for purpose.

17.3. Twenty-three organisations have provided Individual Management Reports (IMRs) or reports detailing their relevant contacts. The Review Panel has considered each carefully from the viewpoint of Alice to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Where they have not done so, the Panel has deliberated if all of the key lessons have been identified from the chronologies and that they are being properly addressed. Consequently, some agencies have added to their lessons learnt and reviewed their action plans during the course of this Review. Good practice has been acknowledged where appropriate. The Review also had the opportunity to listen to the experiences of the practitioners who supported Alice during the period being focussed on within this Review, and their responses and proposals are included in this section.

17.4. The following is a summary of each agency's report together with the Review Panel's opinion on the appropriateness of the agency's interventions.

17.5. Alpha Extreme Services Limited

17.5.1. The IMR Author informed the Review, that Alpha Extreme Services Limited were commissioned by the Woking Mental Health Team from August 2016 up until November 2017. The support provided was initially for one person to visit Alice for two hour per week to assist with cleaning, food shopping and laundry, however later when risks were identified this was changed to two people visiting for one hour a week.

17.5.2. Engagement was therefore minimal and on numerous occasions, the helpers were unable to gain entry to Alice's home as she would either not be in or would not open the door.

17.5.3. The IMR Author was satisfied that staff carried out their responsibilities in accord to good practice, however it was recommended that Commissioners should review their information sharing policies to ensure that helpers are informed of potential risks to themselves and to Alice when working in premises frequented by someone with a propensity to violence.

17.5.4. The Review Panel accepts that there were no significant lessons to learn or recommendations to make with regards this organisation's involvement with Alice but will recommend that commissioning services review their information sharing protocols to reflect on their duty of care to service providers.

17.6. British Transport Police

17.6.1. The IMR Author highlights that the British Transport Police had between 2011 and 2013 five contacts with Joe for alcohol related public order and theft offences, all of which were dealt with correctly through criminal procedures.

17.6.2. Involvement with Alice was limited to the one occasion on 14 October 2015, following her attempt to end her life, by wheeling her wheelchair into the path of a train as it came into a Railway Station.

17.6.3. The IMR Author was satisfied that appropriate safeguarding actions were carried out and that there was excellent liaison with other key agencies. Alice survived through the prompt aid rendered by the personnel from these agencies working in unison, and it was documented that there was care and support provided throughout the incident, prior to her being conveyed to hospital. All actions taken followed the British Transport Police processes of that time, and appropriate referrals were shown as having been made.

17.6.4. The IMR Author has however noted that policies and practices have evolved since 2015. Suicide Prevention Plans, a document which detailed all relevant safeguarding information regarding an individual, are no longer used. The Vulnerability Unit now manages individuals through NICHE, a case management system which has improved safeguarding responses within BTP.

17.6.5. The Panel is satisfied that there are no lessons or recommendations necessary from British Transport Police.

17.7. Byfleet Unity Charity

17.7.1. The Report writer confirmed that Alice had been referred to the Charity for support by a Social Worker in February 2021. The Charity contacted Alice and found her in a poor state, because of her incontinence problem, she was distressed as she had no underwear and needed more bedding. There was no floor covering to concrete floors in the bungalow she was living in nor did she have a fridge or freezer. Over following 15 months the Charity provided her with clothing, home furnishings including bedding and floor covering as well as paying for a cleaner for the house and for someone to keep the garden tidy. Neighbours had been complaining that the garden was overgrown but Alice had been unable to access it, as there were three steps from the premises into it.

17.7.2. The last contact Alice had with the Charity was on 18 May 2022, when the Charity's Grant Manager gave her a welfare 'home visit'. Alice expressed her thanks and satisfaction for all of the aid that had been provided. During that visit she gave the Manager a small gift as a token of her thanks for the help given. She opened up about the violence she had suffered from her ex-partner, Joe, in the past and saying how terrified she was of what would happen again on his release from prison in the near future. The Charity had never previously been aware of the domestic abuse Alice had been subjected to. It was only with the benefit of hindsight that the Manager suspected that Alice was saying her goodbyes as she had at that time, made up her mind to end her life. There were no lessons identified.

17.7.3. The Review Panel commends the Charity for the outstanding support provided to Alice.

17.8. Chit-Chat

17.8.1. This is a small business that was commissioned in early 2021 by Byfleet Unity Charity to provide a 'companionship' service for Alice. The owner of the business, explained that the service entailed visiting Alice once a week for two hours, chatting to her, cleaning her house, and doing shopping. Alice always appeared well adjusted and mentally well at that time. She seemed to enjoy the visits and was very communicative and engaging for the first 12 weeks of the service. There was never any indication that she was using illegal substances or drinking alcohol when the worker was with her and she never asked her to purchase alcohol. Unexpectedly after those 12 weeks, Alice disengaged, either being out or not answering the door when the worker called. This was reported back to Byfleet Unity Charity, and the contract was terminated. It was only many months later that the Owner learnt that Alice's ex-partner had reappeared about the time of her disengagement.

17.8.2. The Panel thanks the business for participating in the Review and accepts that there were no lessons to learn.

17.9. Christians Against Poverty:

17.9.1. The Charity confirmed it had been contacted by Woking Housing to help Alice who had accumulated significant rent arrears. Alice met with representatives from the Surrey section which not only paid off her arrears but assisted her in organising her finances so that the situation did not recur.

17.9.2. The Review Panel thanked the Charity for the help they gave Alice and acknowledged that there were no lessons to be learnt from their contacts with Alice.

17.10. CSH Surrey

17.10.1. The IMR Author highlighted that all of the information provided in the IMR was taken from Alice's electronic records from January 2012. Prior to this, records were paper and in storage. CSH have no records for Joe nor any information about any dependents or family. The last face-to-face contact with Alice by CSH services was 27 October 2021, the last contact with services was on the 9 November 2021.

17.10.2. The IMR Author noted there had been a discrepancy between agencies relating to the number of children that Alice had given birth to. The Hospital found evidence to confirm that Alice had given birth to 4 children - (2002), (2004), (2012) and (2016).

17.10.3. CSH Children's Services had limited involvement with Alice with the exception of a targeted antenatal visit whilst she was pregnant, and attendance at statutory child protection meetings including a strategy meeting and child protection conference. As none of the children were in Alice's care, she did not receive any further services from CSH children services.

17.10.4. CSH provided input from three services:

17.10.5. The Continence Team were involved due to her urinary incontinence, the referral states that "Patient is wheelchair bound following a spinal cord injury[11]." There does not appear to be any recorded conversation regarding this injury, how it occurred or how it impacted on her life; however, it is documented that on 29 July 2021 *(Alice)* disclosed that she was struggling with her incontinence, and it is having a huge impact on her quality of life. There are documented notes that *(Alice)* had a history of mental health issues and attempted suicide. These areas were not explored by the continence team.

17.10.6. The Rapid Response Team were involved due to Alice's frequent falls. The visiting Occupational Therapist (OT) completed a thorough initial assessment and during this assessment, Alice made comment to her history of suicide attempts, addiction, and domestic abuse. The OT did not explore Alice's history and how this was impacting on her life. It was recorded that she was at the time, in a better place but generally frustrated. The OT worked with Alice to improve her transfers and arranged delivery of equipment that was required. The OT called Alice on 30 April 2021, and she reported being in so much pain but declined to call 999. The IMR Author was of the opinion that the OT should have further asked / explored what support Alice had, and if she had any coping mechanisms to deal with her pain.

17.10.7. The Community Nursing Team were involved following a referral from Alice's care agency, requesting a review of a wound that had developed on her right ankle. There was no record that the community nursing team were aware of or had asked about any past medical history or history of attempted suicide / domestic abuse. Alice was initially compliant with her care, however out of the last 9 scheduled visits, Alice requested to reschedule 6 and on the final visit, the visiting nurse did not see Alice as she reported she was on the toilet and after waiting for 15 mins, the nurse had to leave. There were no reasons given why Alice requested a rescheduled visit, however it may have been due to disengaging with medical teams.

17.10.8. The IMR author highlighted that Alice's adverse childhood experiences, being a repeated victim of domestic abuse, drug and alcohol misuse, all would have impacted on her mental health and her ability to engage effectively with services. Adults who have experienced adverse childhood experience have an increased risk of mental health difficulties, violence and becoming a victim of violence as well as drug and alcohol misuse.

[11] Alice's GP Practice has confirmed that Alice used a wheelchair from 2015 due to pain and loss of sensation in her right leg, related to her history of IV drug use. But when she was admitted to St George's Hospital following her attempted suicide in October 2015, investigations concluded she had a right lumbosacral plexopathy. This represents an injury to the nerves of the lower back, resulting in back and/or leg pain, sensory changes, and weakness.

Women who suffer domestic abuse are three times more likely than their peers to try to take their own life**.** *(See also Section 18.1.3. of this report)*

17.10.9. The Review Panel thanks the IMR author for her thorough, honest and transparent report, and agrees that the key lessons that have been identified will be addressed by the recommendations made.

17.11. Goldtech Care Services Ltd

17.11.1. Goldtech were commissioned to provide home support for Alice from 7 March 2022 to 25 May 2022 with two calls a day (in the morning for 45 minutes and 30 minutes in the afternoon/evening) along with 3 hour a week for collecting her prescriptions, her shopping and taking her to the cash machine. (If she did not need the cash machine, one hour would be utilised for tidying and cleaning her house). The Report Author highlighted that if information regarding Alice's history had been shared by the commissioning service, it would have helped personnel offer a more appropriate level of safeguarding support for Alice and those working with her.

17.11.2. The Review Panel agrees with the identified lesson and that the commissioning service is addressing it in their action plan.

17.12. Mascot Community Hub

17.12.1. A report was received from the Hub manager that, in 2015 Alice attended the Hub on a number of occasions. She was perceived as being well adjusted and she soon became popular. Alice was walking with a crutch and still not in a wheelchair, nor did she appear to be using illicit drugs at that time.

17.12.2. When she first met Joe, she lived with him in a flat (with his name on the tenancy) for some time, before it became obvious that he was abusing her. The Hub staff gave her support initially, but suddenly she stopped going to the Hub.

17.12.3. Staff later learnt that Joe was evicted from his flat and Alice was made homeless. Outside the remit of the Hub, the Hub manager and his wife tried to help her get a place via Woking Council. She was given a temporary stay in a hotel and after that, she moved to other places in the Woking area. Joe was still in her life at that point, and it was a few months later that she attempted to take her life at a railway station. The Hub manager learnt that after Alice came out of hospital, she was provided with a Council flat and she did return to using the Hub again for a few times.

17.12.4. It was in this period (2016/17) that Joe badly assaulted her and was sent to prison. She was moved out of the area and no longer visited the Hub. The Hub manager was informed through mutual friends that she was safe but did not want anyone to know where she was, for fear that Joe would track her down when he came out of prison. Over the whole period the Hub manager and his wife tried to keep in touch with Alice, but she would lose/change phones and therefore change numbers so it was difficult to keeping contact.

17.12.5. The last occasion the Hub manager saw Alice was a few months before her death. On that occasion Alice was ‘chirpy’, she was talking about some decorating she wanted to do in her flat and her upcoming 40th birthday. She did however open up about being scared as Joe was soon due to come out of prison.

17.12.6. After this, Alice made no further contact with the Hub or her friends. there.

17.12.7. The Panel thanked the Hub manager for his information.

17.13. Matrix Service Development & Training Ltd

17.13.1. The IMR Author noted that Matrix acted on Alice’s behalf in July 2015 to challenge the decision by Woking Housing that she should be defined as intentionally homeless due to Joe’s eviction for rent arrears. In 2018 Alice was again referred by Adult Social Care to the Service and was allocated an Advocate, who with her permission contacted a Social Worker and found that the issue of concern had already been resolved to Alice’s satisfaction. The IMR Author noted that the Advocate worked under the instruction of the client (Alice) and was not making decisions or sharing information without permission. He was satisfied that policy was followed with emails and daily handover being completed, showing clear timescales from receipt to allocation. A Client Profile Sheet was completed, including interventions recorded.

17.13.2. Record keeping was scant, nevertheless the IMR Author found brief notes which indicated the Advocate raised concerns about Alice’s mobility, although it is not clear if the Advocate checked if the issues of concern around mobility were being addressed. The Advocate no longer works for the company, so it has not been possible to confirm if this was done.

17.13.3. The Panel thanks the IMR Author and is satisfied that the key lessons have been identified and addressed.

17.14. New Vision Homes

17.14.1. The IMR Author acknowledged that although the chronology that was provided is significant, there were not many occasions that Alice was seen by the team at New Vision Homes (NVH). The appointments for signing licenses and tenancies are standard practice and as the chronology indicated, there was good communication from Woking Borough Council to New Vision Homes around the support that was already in place for Alice. The visit with the Occupational Therapist from Adult Social Care and the Housing Manager was good practice and showed a commitment from all parties to ensure that support was provided.

17.14.2. The IMR Author noted that visits to Alice went well and in the most, communication was good between agencies at the beginning and middle of the tenancy, but later on, there seemed less communication, and this may have been due to ongoing support being in place from carers etc. and therefore there was no need for housing management input.

17.14.3. There was a delay in responding to the request for Sanctuary Scheme work and NVH could have done better in regard to its response time. However, there are now better

procedures in place, through Your Sanctuary, so that the work can be monitored and completed in a timely manner.

17.14.4. NVH no longer provides commissioned services in the Woking area. Since housing services came back to Woking BC, it has been recognised that whilst there are some policies and procedures in place, these are outdated and not relevant. As part of Woking Borough Council's Resident Services Service Improvement Plan all policies and procedures are being reviewed.

- Policy / procedures also need to include agency involvement and links, to ensure that a robust multi-agency approach is applied where required.
- Training needs to be provided to all staff in terms of domestic abuse / mental health.
- Weekly managers' meetings now also take place and mental health / vulnerable tenants / domestic abuse cases are discussed, with action plans being put in place.
- Multi-Disciplinary Team meetings now take place weekly, including members of Adult Social Care, Mental Health and other professionals around vulnerable tenants that have been identified (through a variety of methods, such as referrals from the Housing Team etc.) and are attended by the Housing Managers. This will ensure that a multiagency approach is put into practice and the appropriate actions are taken.
- Data needs to be accessible to the relevant teams and on this occasion, it was not. This is currently being addressed so that a full assessment can happen by the relevant Woking Borough Council staff and supportive measures can be put in place for the residents.

17.14.5. The Review Panel acknowledges that as NVH no longer provide commissioned services in Woking, that Woking Resident Services will implement an action plan to incorporate lessons identified by NVH.

17.15. Probation Service

17.15.1. The IMR Author noted in her analysis of the contacts Probation[12] had with Joe that:

- The assessment made in the pre-sentence report was clear and thorough. Points were made to be followed up on after sentence, to guide whoever the case was allocated to.
- There was no contact with Joe before release - good practice would have been to arrange a video-link to discuss his release plans and gain a sense of his attitude towards Alice. No safeguarding referrals were made in relation to Alice or Joe's new partner. It would have been helpful to find out more about Joe's new partner, as well as who was visiting him in prison and who he had been contacting.
- A focus on safeguarding, liaison with the police information sharing and pre-release work may have opened up opportunities for agencies to make contact with Alice, so that she was better informed about Joe's release from prison.

17.15.2. The Review Panel thanks the IMR Author for her perceptive analysis which form lessons that should be learnt by the Service. The Panel is satisfied that the recommendations proposed will, if actioned, address those lessons.

[12] It is noted that the Probation IMR covers Joe's contacts with both Surrey and Hampshire Probation. As lead service, Hampshire Probation will be responsible for the implementation of relevant recommendations.

17.16. St Georges University Hospitals NHS

17.16.1. The Report Author highlighted, that two days after Alice's admission into the hospital on 14 October 2015 in relation to the injuries she suffered after wheeling her wheelchair under a train as it arrived at a railway station, her 'partner' Joe attended at the ward and wanted to take Alice to the bank to withdraw his benefit money. Alice attempted to leave, but after security were called, she agreed to stay in the hospital.

17.16.2. The Hospital Safeguarding Lead confirmed that although there were worries about Joe being on the ward, as it was suspected he had given Alice alcohol, he could not be forcibly evicted unless Alice had requested it, unless his behaviour was deemed unacceptable. Advice was given regarding Alice's capacity to make decisions. Nevertheless, a request was made for the Mental Health team to review risk and 1:1 input. Joe voluntarily left and Alice was admitted to the Mental Health Hospital.

17.16.3. The IMR Author was satisfied that care was taken to follow the six principles of the Care Act to ensure Alice's safety.

17.16.4. The Review Panel acknowledges the tact of hospital staff in defusing the situation, when Joe having arrived on the ward expected Alice to leave with him to collect his benefit money, (two days after her admission). The are no lessons to learn although it is noted that legislation and procedures have changed since 2015 which may assist staff faced with such behaviour now and in the future.

17.17. Surrey County Council Adult Social Care (ASC)

17.17.1. Up until 2018, Adult Social Care Records did not clearly show how ASC were responding in partnership with other agencies, or exactly how Care Act duties were being implemented. It does appear, though that a compartmentalised view of needs was taken; with a pattern, up until 2018 at least, of case closure when a different agency was leading.

17.17.2. There was some evidence of good, holistic work by ASC that seemed accepting of Alice's difficulty in engaging. Notably, the Safeguarding Enquiry and Protection plan, that commenced in April 2018, appears to be a catalyst in supporting agencies to deliver secure accommodation, with care and support, taking steps to protect Alice from Joe, and providing some means for Alice to protect herself.

17.17.3. At other times, it does seem that Adult Social Care disengaged without clear rationale or recorded consideration of risks. The IMR author perceived that Alice's needs were seen as episodic rather than fluctuating but enduring, leading to an open and close approach.

17.17.4. There were opportunities between 2015 and the beginning of 2018, when it could have been legitimate, to initiate a s.42[13] Safeguarding Enquiry. This would have provided a framework and a process to identify clear accountabilities for all agencies to come together and could have supported the development of a clear shared, multi-disciplinary plan.

17.17.5. Statements, and decisions, were recorded by Adult Social Care regarding Care Act eligibility from 2015 but, up until the Adult Social Care Assessment in 2018, there was

[13] A section 42 Care Act 2014 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect.

no clear, recorded consideration of impairment against Care Act outcomes and, in turn wellbeing. These statements then, were not compliant with the Care Act.

17.17.6. In the records, there were numerous references to Alice having Mental Capacity to make the decisions that she was faced with. This, of course, may have been correct, and the Mental Capacity Act 2005 does lead with the presumption of capacity. However, it would not appear from the Adult Social Care records alone, that the fluctuating or potential long-term impact of substance use upon cognitive functioning were considered. Whilst a Social Worker would not have the training to assess such a question, it could have been considered and raised with clinical partners.

17.17.7. The Author also noted that Alice's re-engaging with Joe was, at times, considered as a free choice. Additional consideration of the recorded history might have prompted professionals to consider the presence / influence of coercion and control.

17.17.8. The Author expected to have seen a greater recorded management oversight. Surrey County Council has a policy for this.

17.17.9. The Review Panel agreed with this discerning analysis and accepts that the lessons identified by the IMR Author will be addressed by the recommendations and action plan he has proposed.

17.18. Surrey & Borders Partnership NHS Foundation Trust (SaBP)

17.18.1. This Trust is the leading provider of health and social care services for people of all ages with mental ill-health and learning disabilities in Surrey and North-East Hampshire and substance misuse services (provided by i-access) in Surrey.

17.18.2. Alice's contact with i-access was over a number of years with appropriate intervention being implemented. Alice was doing well when she was on her own when Joe was in custody. Alice was deemed to have capacity to make decisions but was often intoxicated when assessments took place: frequent alcohol and substances use contributed to her changed behaviour when carers or professionals were present to support. Her capacity fluctuated at times especially when she was using substances and domestic abuse also impacted on her mental health and her refusal of professional's support.

17.18.3. 'Understanding Trauma and Loneliness' - agencies involved with Alice had limited knowledge of her background and any other support networks she may have had. The IMR Author highlighted the importance of understanding a person's past, particularly any adverse childhood experiences and trauma. Loneliness is also an important component to consider as this can often present as complex in peoples' lives. Alice was living on her own and when she had her fourth child removed from her care at birth, this had a significant impact on her. Therefore, it is crucial for professionals involved to have as detailed history as possible. This will support with making informed choices about signposting, support and choosing the right engagement strategies. There is training available at SaBP on Understanding Trauma and Trauma Informed Care (TIC).

17.18.4. There was good communication between SaBP services and other professionals that were involved with Alice. With information being shared with Police, MASH, i-access,

CAMHS and Criminal Justice Liaison and Diversion. There was appropriate referral and actions within timescales with each referral.

17.18.5. However, staff did not consider or follow safeguarding procedures in relation to the concerns about domestic abuse (DA) and other potential risks of abuse, and there was no record of any discussions with ASC Safeguarding staff within the Trust as per procedures for integrated teams at the time.

17.18.6. The Panel thanks the IMR Author for her detailed IMR and accept the lessons learnt and recommendations to address them.

17.19. Surrey County Council Children's Services

17.19.1. The IMR Author confirmed that Alice had four children. The oldest two children did spend time in Alice's care and suffered neglect as a result of her dependency issues. All of Alice's children were removed due to her chaotic lifestyle and drug use. Children Services records note that her relationship with Joe was marred by serious domestic abuse, in addition to his own drug dependency. Neither parent was able to address the dependency issues and Joe continued to have anger and violence issues. Alice in turn minimised the extent and severity of the violence she was exposed to. Her youngest two children suffered withdrawal symptoms at birth, and both were removed at birth and subsequently adopted**.**

17.19.2. The Panel thanks the IMR Author for providing the background information and acknowledge that there are no lessons to be learnt for this Service.

17.20. Surrey Fire and Rescue Service

17.20.1. The Fire and Rescue Service had only two recorded contacts with Alice within the period being considered by this Review. The first was the assistance provided to British Transport Police and the other emergency services when Alice in her wheelchair, wheeled herself into the path of an approaching train at Woking Railway Station. The IMR Author is satisfied that the actions taken were prompt and in accord with policy and practice.

17.20.2. In September 2021 the Fire and Rescue Service carried out a full safety visit at Alice's home. It was noted that Alice was a wheelchair user who lived in a bungalow, she could not exit the bungalow in an emergency situation, when she does try to exit, her wheelchair tips and falls backward. She explained she does have contact with an OT and others who are helping with her situation, but the visiting Officer highlighted her concerns that Alice was not able to exit. The IMR Author noted that a thorough report was completed and submitted.

17.20.3. The Panel is satisfied that there are no lessons or recommendations for the Fire and Rescue Service to make.

17.21. Surrey Heartlands Integrated Care Board (ICB) for GPs

17.21.1. The IMR Author reported that her review of Alice's detailed records at a named medical practice shows robust attempts to contact and engage with her. Alice's documented non-use of voicemail on her mobile phone was fully acknowledged by both clinical and non-clinical staff, and when Alice did not answer her phone (which was

frequently the case), text messages were sent instead. These have proven advantageous in this Review, as they provide an objective record of what messages were sent and when. A missed phone call resulting in a voicemail may be recorded as “no reply, voicemail left”. The use of texts linked directly to the electronic GP record is now widespread.

17.21.2. There are several documented occasions when other key professionals involved in Alice’s care contacted the GP practice. Notably May 2020 (concerns she was no longer being supported by i-access), Spring 2021 (poor pain control and input from specialist pain management team) and early 2022 (deterioration in her mental health). Reviewing the records in detail, it is clear that on each occasion, the GP practice did take appropriate and timely action, and in many cases, there was an overlap between concerns being raised and action already being underway. Unfortunately, without Alice’s consent, details of referrals/medication changes etc. could not be shared with those raising concerns, and the challenges of reaching her by phone are noted throughout the IMR.

17.21.3. The IMR Author highlighted that the GMC guidance “Confidentiality; good practice in handling patient information” (2017, updated 2018) is clear that consent should be sought unless there is a compelling reason not to do so.

17.21.4. The Review Panel accepts the IMR Author’s identified good practice, lessons and recommendations.

17.22. Surrey Multi Agency Risk Assessment Conference (MARAC)

17.22.1. Alice had been the subject of five MARAC meetings between 2012 and 2022. The MARAC Chair highlighted the most recent, Alice was discussed at MARAC meetings on 3 March 2020 and on 27 July 2021, both related to domestic abuse she had suffered from Joe. The first referral was made by i-access Drug & Alcohol Service and the second by Surrey Police.

17.22.2. Both meetings were well attended, and the actions set which were monitored, were deemed appropriate.

17.22.3. Actions from the first meeting included a named Police Officer who Alice was familiar with, visiting her unannounced to check if there were any signs of Joe being at the property. Several visits were made and there was nothing to indicate that Joe was visiting the property. Alice was warned of the dangers of allowing Joe back. Adult Social Care flagged Alice’s record for domestic abuse from Joe and to make contact with Outreach Service if i-access makes a referral. Surrey Police checked with Probation if Joe was subject to any licence conditions. Joe had not been managed since 24 September 2018. However, there was a restraining order in place to prevent him contacting Alice.

17.22.4. Actions relating to the second MARAC meeting had actions for the Your Sanctuary Outreach worker, to liaise with the Adult Social Care worker to consider what joint work could be done to assist Alice. That was organised and was recorded by the MARAC as ‘ongoing’.

17.22.5. The MARAC Chair highlighted that since these two meetings, there have been a number of changes introduced to the MARAC process.

17.22.6. The administration and coordination of the Multi-Agency Risk Assessment Conference (MARAC) was previously undertaken solely by Surrey Police. Following a self-audit of the MARAC process and the identification of several gaps and risks within the current MARAC process, the MARAC administrator posts were created to provide safe best practice, consistency and stability in the coordination and administration of MARACs in Surrey. These posts are managed by the Domestic Abuse Programme Manager at SCC, which provides an independent oversight of the MARAC administration and process, and supports a stronger, more resilient partnership approach to MARACs in Surrey.

17.22.7. The MARAC administrators work closely with the Surrey Police MARAC coordinators, and both roles are complimenting each other. The MARAC administrators are addressing the identified gaps, better supporting the MARAC Chairs, representatives and process, and have become the key link for all MARACs across the County ensuring that high-risk victims of domestic abuse and their children are supported and kept safe with a multi-agency approach. This leads to a reduction in risk and repeat referrals into the MARAC process and all services including Children's Social Care, Health, and Surrey Police.

17.22.8. The MARAC Chair highlighted, that since the MARAC administrators have been in post there have been new processes implemented which are better supporting the MARAC referrals, information sharing and agency accountability:

- A new MARAC referral process has been designed which includes an online referral form and a secure ‘SharePoint' site where all documentation is stored.
- MARAC minutes are capturing the multi-agency discussions, risks identified, actions already in place, and actions agreed and assigned.
- MARAC actions are being recorded and tracked, and agencies are being chased and held to account ensuring that all agreed actions are completed.
- The MARAC GP process has been rolled out across Surrey, which informs GPs of cases where their patients are being discussed and enables them to feed relevant information into both the discussion and action planning.
- Quarterly MARAC reports are being produced. These reports provide information on all aspects of MARAC including referrals, agency attendance and action tracking. These reports are presented at both the MARAC Operational Group and MARAC Steering Group where any gaps, risks, issues and concerns can be addressed and escalated.

17.22.9. The Panel acknowledges, that the changes that have already been made have improved the work to the MARAC.

17.23. Surrey Police

17.23.1. The IMR Author’s analysis found there are 174 occurrences recorded on the Surrey Police Niche crime recording system relating to Alice, and 364 occurrences relating to Joe. This includes crime and non-crime incidents and intelligence reports.

17.23.2. It was identified that generally, there was a good Police response to incidents of domestic abuse from the first reported incident in 2008 to the last reported incident in June 2021. Officers demonstrated sound understanding of the challenges and dynamics in domestic abuse cases (practice and procedure over time), including associated risk factors

and an investigative mindset to secure evidence to charge Joe on several occasions for assaulting Alice.

17.23.3. Safeguarding Alice was at the forefront of the Police response to domestic abuse and neighbourhood / problem solving initiatives. Officers recognised Alice's vulnerabilities and susceptibility to exploitation. This was especially evident during times when Joe was serving prison sentences, and his drug user associates tried to take advantage of the fact that Alice was addicted to illicit drugs and was home alone.

17.23.4. Several Officers went above and beyond standard practice to gain Alice's trust, safeguard her, achieve some change and three convictions against Joe. Sadly, when Joe was released from prison, he returned to Alice despite the Restraining Order.

17.23.5. Generally, information sharing with partner agencies was good. There were a couple of occasions where referrals were not submitted, but overall information relating to Alice and Joe's vulnerabilities, level of risk and care need was appropriately shared. In Sep 2018, Probation Service notified Police of Joe's release date and made a MARAC referral. This was good practice.

17.23.6. There were some occasions where intelligence was recorded but not acted upon. In 2017, information that Alice had been seen with bruises on her chest was not followed up**.** Police had responded to a report of a domestic incident the day before, yet no injuries were disclosed / seen. This should have been explored. Intelligence recorded in 2019, indicated that Alice was being assaulted by Joe and bruises had been seen on her arms. The report also mentioned that there was a Restraining Order preventing Joe from contacting Alice. There was no further research completed. This was a missed opportunity which should have been followed up.

17.23.7. The Review Panel thanks the IMR Author for his detailed and transparent report. The Panel accepts that there was evidence of general good practice throughout the many contacts the Police had with both Alice and Joe, and that the IMR Author has identified several lessons which will or have already be addressed by Surrey Police.

17.24. Surrey Women's Support Centre

17.24.1. The IMR Author pointed out that the voluntary service offered Alice support through a Group Programme and provided her with a Tablet to help her engage with group sessions remotely if she was unable to attend in person. When it was reported that she was not engaging, Alice was contacted to ascertain what would help her to engage. Alice responded that she was suffering a lot from her back and not able to attend groups at that time. When asked if she was receiving any support, she confirmed that she was getting a new social worker and was still being supported by Woking Borough Council. She stated she had not even opened the tablet provided to her.

17.24.2. The IMR Author identified good practice by the service in providing the Tablet to assist Alice in engaging with group sessions she could attend in person but questioned if there was more that could have been done.

17.24.3. The Review Panel compliments the WSC for the efforts made to engage Alice and noted the enquiries to ascertain if she was receiving support. The Panel accepts the lessons identified by the IMR Author.

17.25. **Woking Borough Council**

17.25.1. The IMR Author explained that the Community Harm and Risk Management Meeting (CHaRMM) is a multi-agency problem solving group which supports victims and deals with problems of individuals or families in the Borough and meets on a monthly basis.

17.25.2. CHaRMM meetings discuss and agree action to reduce the negative impact that problem individuals and families have on Woking's communities through their antisocial behaviour. Using the expertise that exists on this multi-agency group, members share information on high-risk cases and incidents and put in place appropriate risk management plans to address the behaviour of the perpetrator and reduce the negative impact on victims.

17.25.3. The aims of the CHaRMM are to:

- Facilitate effective information sharing and case management, that enables appropriate action to increase the safety and well-being of victims and the wider community.
- Reduce repeat victimisation and implement risk management plans to prevent further harm.
- Address the antisocial or criminal behaviour of the perpetrator.
- To hold partner agencies to account for actions under their areas of responsibility.

17.25.4. The IMR Author pointed out that the Community Incident Action Group (CIAG) had a slightly different Terms of Reference, in that it was centred around offending behaviour. Therefore, once offending behaviour was addressed or no longer present, then they were discharged. In order to be referred to CIAG the nomination criteria were as follows:

- An individual who's antisocial behaviour poses a significant risk to public safety or is vulnerable.
- The behaviour is of a serious / persistent nature.
- There is reason to believe that referral to CIAG can reduce the risk.

17.25.5. Alice was referred once to CIAG and once to CHaRMM (once in 2016 under the meeting title of CIAG which became CHaRMM) and then again in 2018.

17.25.6. In May 2018, the referral was made by Surrey Police, following attending Alice's property after she had been violently assaulted by her partner, Joe. The attending Officer raised concerns regarding the condition of the property and the admission by Alice, confirmed by neighbours, that the property was being used at all times of the day and night by other drug addicts. Surrey Police felt at the time if possible, a partial closure would be a means to safeguard Alice in the short term.

17.25.7. The partial closure was explored, but there was not sufficient evidence at the time to make the application, and therefore it was never applied for. From a supportive perspective an Occupational Therapist report was requested, home visits were carried out and there was an action for the arranging of a deep clean at the property. Alice was discharged in July 2018 as she was engaging well with Adult Social Care. Due to being discharged, the action regarding the deep clean was not recorded as complete. The IMR

Author highlighted that there is also no record held by CHaRMM regarding the housing needs assessment being completed. Nevertheless, the IMR Author was satisfied that this case complied with policy relating to CHaRMM with risk assessments completed on referral by the referring agency.

17.25.8. The referral made to CIAG was also made by Police in June 2016. The referral made reference to Alice being a heroin user who had recently discovered she was 29 weeks pregnant**.** It also detailed that Joe was likely to be controlling Alice and allowing the premises to be used by others to deal drugs from the address. Other residents in the block had raised ASB concerns regarding the property to Police, as well as domestic incidents between Alice and Joe. Again, the IMR Author highlighted that the condition of the flat with drug paraphernalia was indicative that other persons were using the premises, as Alice was unlikely to have been able to move around the majority of the flat due to being in a wheelchair.

17.25.9. The referral was accepted with the view initially to close the property although consideration was also given to not making Alice homeless - this resulted in an Acceptable Behaviour Contract being issued, which was then monitored throughout the time she was discussed at CIAG. The CIAG also monitored her behaviour though the period of her child being born and the impact that having the child taken into care had on her. Another incident was noted in October 2016, whereby Alice had taken an overdose and was admitted to hospital. She was seen by the Psychiatric Liaison Team whereby she disclosed to them; the overdose was not a suicide attempt and that it was as a result of not sleeping well and she thought this would help. Work was carried out by Police to engage with neighbours to monitor the impact that Alice's behaviour was having on them, and it was recorded that from November 2016 onwards, that she did not come to Police attention at all, and no complaints are recorded with housing either. She was eventually discharged from CIAG in January 2017. At the time of discharge, although it was still noted the condition of the property was poor, she was stating she was engaging with i-access and Catalyst (alcohol and drug support). It was less clear around whether she was allowing carers into the property, although Alice said she was. It is accepted though that she had stopped granting access a couple of weeks prior to discharge. Throughout the 6 month period that Alice was on CIAG, it was recorded that her engagements was sporadic at best, despite constant offers of support being made wherever possible. The IMR Author confirmed that the case complied with policy relating to CIAG and that the minutes from both CHaRMM and CIAG have been retained by the IMR Author.

17.25.10. The Review Panel acknowledges that neither the CHaRMM or CIAG had the authority to direct the actions of participating agencies. The Panel accepts the IMR Author's identified lessons and recommendations made.

17.26. Woking Borough Council Housing

17.26.1. The IMR Author discovered notes on the Housing Register which had not been transferred to the new IT Housing system, which related to Alice, being placed on occasions into bed and breakfast and temporary accommodation prior to November 2015. There were no records found of the contacts from ASC or Matrix Advocacy to appeal a decision relating to Alice being assessed as intentionally homeless. However, in November/December 2015, whilst Alice was in hospital after attempting to take her own life, there were contacts between the hospital discharge staff, mental health team and

housing to ensure that Alice would not be homeless when she left the hospital. Although temporary accommodation had been identified for her, it was not ready to let, so Alice had to spend a night in Bed and Breakfast accommodation which New Vision Homes had tried to avoid but was necessary as the housing team had no control over when repairs would be finished and a property ready to let.

17.26.2. The IMR Author reviewed the Housing Register and Allocations documents and found that a lack of suitable accommodation meant there was a year-long wait for a move from temporary accommodation to a suitably adapted home for a wheelchair user.

17.26.3. It was noted that although Alice had support from various agencies, closer working from housing might have made a difference to timescales but would still have been subject to suitable accommodation becoming available.

17.26.4. The need for a more suitable home for Alice was identified following an Adult Social Care assessment, as the bathroom and kitchen had become increasingly inaccessible to Alice. Ideally, the property should have been inspected by an OT before Alice moved in, and this now happens when properties are considered for people with mobility challenges.

17.26.5. As a result of Alice's action in wheeling herself in her wheelchair under a train, which ended with her admittance to hospital, the Options Team has undergone resilience/counselling training around applicants vulnerable to self-harming and the impact it has on housing professionals.

17.26.6. The Review Panel acknowledges the lessons identified and that actions are being taken to address them.

17.27. Your Sanctuary (YS)

17.27.1. The IMR Author highlighted that whilst YS had referrals from the Police and Probation services from as early as 2012 in respect of Alice, she was reluctant to engage directly. In May 2012, she told an Outreach worker that she was not sure if she wanted support and when offered an initial meeting, she said she would get back to her which she never did. This followed on over the years with referrals being made but with Alice not responding. The IMR Author highlighted the persistence with contact attempts when calls went unanswered, stating this was reasonable, proportionate and in line with policy. It demonstrates a willingness to try and engage, and multiple requests were made for alternative contact methods through other professionals involved with Alice.

17.27.2. Any information received by Your Sanctuary relevant to neglect, domestic abuse, violence, controlling behaviour, self-harm or other mental health issues was received from other agencies via referrals or at MARACs, not directly from Alice as there was limited involvement or discussion with Outreach staff at her request. Whilst information was not known or held specifically by YS, a history of mental health problems and self-harm was known to the multi-agency forum, as there is documented reports within the MARAC minutes that Alice had previously tried to end her life. As YS was not directly able to engage with her, this was never directly discussed with her by Outreach staff. This is true for safeguarding issues and abuse Alice suffered from Joe, it was known collectively, but

YS had no active involvement with Alice to be able to support her directly in such areas of need.

17.27.3. Your Sanctuary now manages the sanctuary safe room scheme to ensure work is completed in a timely fashion.

17.27.4. The Review Panel acknowledges the efforts made to engage with Alice and agrees with the lessons identified by the IMR author and the recommendations made.

17.28. Practitioners Event

17.28.1. The event was held with only the Review Chair and Safeguarding Lead present to ensure that the practitioners who came from both statutory and non-statutory organisations, felt safe to express their views openly.

17.28.2. The Purpose of the event was:

- To gain a better understanding about the purpose of this combined SAR/DHR review.
- To consider their involvement.
- To share their experiences.
- To consider Lessons identified.
- To contribute to improving service delivery for vulnerable adults/ victims of domestic abuse.

17.28.3. There were 23 practitioners present and all had the opportunity to speak.

The main themes were:

- Engagement with Alice could at times be difficult. What worked well was continuity. The practitioners who worked with her regularly, built a bond - she did not need to explain her history or problems repeatedly to them. They knew the best times to contact her. Gradually practitioners learnt to visit her together in a cross-agency approach. What did not work was constant change of personnel, practitioners contacting her in the morning, or when Joe was on the premises. (He would tell her not to answer the door and would not let cleaners go into the living room).

- The number of agencies involved in trying to address her diverse needs often swamped her and did not work well. There was little coordination other than the informal joint working of practitioners arranging to visit her together. It was pointed out that Surrey Adults Matters (part of the national Making Every Adult Matter {MEAM} initiative) was introduced in April 2020 yet was never involved. Not many of the practitioners knew about it or its aim of being able to coordinate service delivery to those with multi complex needs.

- **Criminal Justice:** Although she had a good rapport with two Police Officers, in general, she was wary of supporting police prosecutions of Joe because of the short length of his prison sentences. She felt that the punishments did not reflect the seriousness of his assaults on her. Joe would turn up after prison release and inevitably assault her again and again.

- Alice being in a wheelchair and homeless when she attempted to take her own life by pushing her wheelchair in front of a train in 2015. It was questioned if the housing laws were different then, but this was not an issue, it was because she had been categorised as 'intentionally' homeless as she had been evicted with Joe for his rent arrears. It was pointed out by a practitioner and confirmed later that this would not happen now with the introduction of the Rough Sleepers initiative.

- Length of time it took to get actions completed. Although an OT tried to arrange for Alice to have an electric wheelchair in 2018 and later informed her she would have one in 2021, it had never arrived before her death. She was placed on the Sanctuary Scheme by the Police in anticipation that the work would be completed prior to Joe being released from prison. She could not understand why it was not done, when another of Joe's victims went on the scheme after her and the work was completed whilst hers never started. Practitioners pointed out the procedures had been radically changed since her death. The Scheme was now managed centrally by Your Sanctuary which had its own contractor and work is always promptly completed.

- **Lack of information sharing:** Practitioners from small businesses and charities providing cleaning services highlighted that they were never informed about the domestic abuse or drugs, syringes and other paraphernalia at the premises and this put them and Alice at risk. Others pointed out that because they worked for non-statutory organisations, they were never invited to MARACs etc. No-one was aware of the Surrey Information Governance Handbook. It appeared she was never asked if she minded the carers being informed of her situation. When she warned them herself, they had to work in twos and this reduced their hours from 2 to 1 hour a week, which was not satisfactory. Several Practitioners voiced their view that being restricted by her lack of mobility she was intensely lonely.

- Other good practice included the professional curiosity and persistence of the Surrey and Borders Partnership NHS Foundation Trust's Rapid Response team. The Team contacted her by telephone, but she was not keen to engage, and she hung up. Recognising she was vulnerable; they followed up this telephone call with a visit to her home - knocking for a long time before she opened the door. She stated she did not want help from the mental health service and would not let them inside. The team then contacted New Vision Homes and arranged for a joint visit and an assessment with Social Care. Subsequently with people present whom she knew, she agreed mental health input and saw a consultant. The proposal of the Practitioners is to remind practitioners if they are engaging an individual with complex needs, who is initially reluctant to engage, find another agency she does engage with and find out how they did it and if they can assist with a joint contact.

18. KEY ISSUES AND CONCLUSIONS

18.1. KEY ISSUES

18.1.1. Domestic Violence and Alice's fear of Joe

18.1.2. In November 2014 Alice told her Probation Officer that her father had been physically and emotionally abusive towards her when she was a child. At 18 she was raped. It was recorded by her Probation Officer that Alice had described a history of

damaging and destructive personal relationships. She had married a previous partner who was abusive to her and who received a life sentence for offences against other women. The Officer concluded that Alice presented as a young woman who was vulnerable to exploitation.

18.1.3. From the very commencement of their relationship, Alice had suffered physical and mental abuse from Joe for many years, yet because of her fear of him, she still allowed him into her home when he turned up, in spite of the court order restraining him from contacting her. The Review has alluded to a number of the vicious assaults he inflicted upon her, including whilst she was in her wheelchair when she would not or could not do his bidding. The assaults summarised are too savage to be detailed in this report and it is perhaps not surprising that she bore a lasting sense of injustice that his prison sentences did not always reflect the injuries she suffered and had to live with. The Police although hampered on occasions, by her reluctance through fear to support proposed actions against him, nevertheless, took positive action against Joe when they had evidence to do so. Although this is a matter for the Coroner's Inquest, the fear of Joe's pending release from prison appears to have been a major factor in Alice's decision to take her own life. Her friends and foster mother who were with her not long before her death, have separately recounted, that although she was unhappy about the inadequacies of her living accommodation and the lack of action in addressing her needs, particularly the absence of any work on the promised sanctuary scheme safe room; it was that fear of Joe coming out of prison which terrified her.

18.1.4. Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment.[14]

18.1.5. There is other significant independent research that indicates that intimate partner violence is a common health care issue. Long-term illness or disability were more likely to be victims of recent domestic abuse (within the last year) than those without one; to a ratio of 15.9% compared with 5.9%.) One in four women who have died by suicide had been the victim of physical violence, one in five had suffered psychological violence and one in six had been sexually assaulted.

18.1.6. A further research document stated: "These (anxiety) issues can make the abusive situation even worse, as the partner or ex-partner may make use of a diagnosis" (for example, telling them they are useless or ordering them to carry out menial tasks). It was stated in the above research that; "It can also be difficult for professionals to see beyond mental health issues and to recognise that an abusive relationship may be at the heart of the problems".[15]

18.1.7. In an article for NSPA Suicide Prevention Blog by Tim Woodhouse, Kent and Medway STP Suicide Prevention Programme Manager, one victim of domestic abuse tried to explain the links between domestic abuse (DA) and suicide in the following manner: **"I**

[14] CTC (2014), Website of the US Centres for Disease Control and Prevention, National Centre for Injury Prevention and Control, Division of Violence Prevention

[15] http://www.healthtalk.org/peoples-experiences/domestic-violence-abuse/womens- experiences-domestic-violenceand-abuse/impact-domestic-violence-and-abuse-womens- mental-health#ixzz5GbWdgJtL [17] COPD -Chronic obstructive pulmonary disease

knew that he was going to kill me, so it wasn't a matter of choosing to die, just who was going to do it." These are words Alice could have uttered.

18.2. Substance Abuse

18.2.1. Alice and Joe both had/have chaotic lifestyles, both used/use illegal drugs and were/are alcohol dependent. Joe has a long list of convictions for drink and drug related assaults and anti-social behaviour. Alice's parents were allegedly involved in the sale and use of illicit substances when Alice was born, and her foster mother has told the Review that she had been using heroin prior to her coming to live with her family when she was only 14 years of age. Alice was drug free by the time she came out of care at the age of 18. However, after being raped at 18 years of age, she went through a difficult time and is believed to have returned to using heroin and cocaine as well as cannabis. Other than during her pregnancies, she continued to use illegal drugs while Joe was with her; either because of his influence or as a coping mechanism against the violent assaults she suffered at his hand. Whenever Joe was in prison, she worked hard to be drug free. On her own, she said she had an on/off reliance on alcohol, with reports of her asking neighbours or carers to purchase alcohol for her when she was housebound during the period of Covid restrictions.

18.3. Physical and Mental Problems

18.3.1. Alice was wheelchair bound and suffered from a number of life-defining physical and psychiatric disabilities including Hepatitis C, COPD[17], Epilepsy, Thrombosis in right leg, Incontinence and Bi-polar. The anxieties and depression she suffered were aggravated by her life experiences of; finding her father after he had taken his own life by hanging when she was about 10 years of age, being raped on her 18th birthday, living in fear of the recurring violence from Joe, her poverty and inadequate accommodation.

18.3.2. Being bereaved by suicide as a child, placed Alice at an even higher risk of self-harming. A wide range of studies (e.g. Guldin et al., 2015; Rostila et al., 2014; Wilcox et al., 2010) have observed that people who are bereaved as a result of suicide are themselves at increased risk of taking their own life. In light of this, Guldin et al. (2015) undertook a register-based study of 7,302,033 Scandinavians born between 1968-2008.

They found that if a child had lost a parent due to an unnatural cause, the risk of the child attempting suicide was twice as high as that of a non-bereaved child. The study further discovered that children who had lost a parent to suicide had an 82% higher risk of attempting suicide compared to children who had lost a parent in an accident.

18.3.3. Women with severe mental illness are up to five times more likely than the general population to be victims of sexual assault and two to three times more likely to suffer domestic violence.[16] The study, found that 40% of women surveyed with severe mental illness had suffered rape or attempted rape in adulthood, of whom 53% had attempted suicide as a result.

[16] *Psychological Medicine* 2023 research led by UCL and King's College London funded by the Medical Research Council and the Big Lottery.

18.4. Homelessness

18.4.1. At one stage both Alice and Joe were homeless. Adult Social Care received notice of this from members of the public concerned that a woman in a wheelchair was having to live on the streets. As she had been deemed to be intentionally homeless and therefore not eligible for care and support, ASC and Matrix Service Development & Training Ltd. appealed this decision, however it was only after Alice attempted to take her own life by pushing her wheelchair in front of a train, that the decision was rescinded, and a flat was found for her.

18.5. Inappropriate equipment and accommodation

18.5.1. Practitioners from several agencies identified problems in her living conditions. She could not easily get in or out of either the flat or bungalow she had been provided, because of poor wheelchair access. She had difficulty getting to a bath, she had to sleep on a sofa for long periods, kitchen equipment included sink and work services which were too high for her to use from her wheelchair.

18.5.2. Several times from 2018 until the time of her death in 2022 it was advocated that she should be given an electric wheelchair, due to the state of her manual one - nothing happened.

18.5.3. In September 2021, Surrey Fire and Rescue Service carried out a safety inspection of her bungalow, reporting that the premises had not been adapted for someone in a wheelchair and highlighted the risks Alice faced with access and egress to/from the building. Little happened, other than the wooden ramp at the front of the premises being adjusted. There were only steps at the rear of the premises which she could not use. The internal doors were taken out to create a wide enough gap for her wheelchair access. These were well intentioned make-do solutions, but Alice needed accommodation that was fit for someone in a wheelchair. These issues were regularly brought to the attention of the correct agencies by practitioners, yet her housing needs were never properly addressed due to the high cost of adapting the accommodation she had and the lack of purpose-built wheelchair accommodation being available in the area she wanted to live.

18.6. CONCLUSIONS

Considered within the context of the six principles of the Care Act 2014 ie. Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

18.6.1. Alice had to manage an incredibly challenging range of needs and adverse circumstances, over a number of years; recurring, and persistent difficulties that included childhood upheaval and abuse, unsettled accommodation, homelessness, ill-adapted accommodation, ongoing financial difficulties, lack of food, security, physical impairment, mental health challenges, cycles of addiction - recovery and relapse, chronic, unbearable pain and having 4 children removed from her care. Throughout, there were numerous incidents of physical and emotional abuse from Joe.

18.6.2. The range, persistence, complexity, and interrelated nature of these difficulties necessitated Alice receiving support from a range of agencies. The Review identified 23 different organisations that had contacts with her between 2015 and 2022. Their visits,

telephone calls and letters were rarely coordinated and on occasions resulted in her being swamped with well-meaning practitioners trying to contact her. It is perhaps not surprising that on occasions she became frustrated and just did not respond to them. This was particularly so when there was a rapid turnover of personnel or if Joe was on the scene. Gradually the practitioners themselves realised this, and organised joint contacts with her at times which suited her best. It did not help that although Occupational Therapists and other practitioners identified her essential needs, to her it appeared that there was little resulting action. Individual agencies have told the Review that there was no overall ownership or co-ordination.

18.6.3. Until 2020 one agency could only request another organisation to act on a recommendation to take a particular cause of action and partnerships such as MARACs, CHaRMM, CIAG could only coordinate not direct. Yet in January 2020 Surrey Adults Matter (SAM)[17] was launched with a Strategic Steering Group attended by senior leaders from Public Health, Adult Social Care; Housing; Probation Service; Community Safety and Surrey Police among others and also from the charity and voluntary sector.

18.6.4. In spite of this, Alice was never referred to SAM and agencies during the Review never mentioned its existence nor that in 2021 Surrey also became a Changing Futures Area which allowed the creation of an alliance of trauma Informed outreach workers to compliment the multi-agency strand of their multiple disadvantage work.

18.6.5. The Review found that during the first few years after the implementation of the Care Act 2014, there appeared to be a little evidence of a working knowledge of Care Act 2014 responsibilities, although informally practitioners (as has been mentioned above) did share information well with others for the benefit of Alice. Care Act referrals improved considerably after people became more familiar with the legislation and the Review acknowledges the diversity of the agencies making appropriate Safeguarding referrals from 2018 onwards.

18.6.6. The review noted many examples of good practice and in particular the Panel highlights the small Byfleet Unity Charity which, when informed of Alice's situation, promptly spent thousands of pounds of the charity's scant budget to cloth her, provide clean bedding, kitchen equipment including a fridge/freezer, laminate flooring for her concrete floor garden care and a companionship cleaning service.

18.6.7. The Review concludes that whilst practitioners from the different professions, recognised her vulnerabilities and correctly reported that her basic needs[18] were not being met, other than the above-mentioned Charity, no one Agency or Partnership took ownership of expeditiously actioning those needs. The Review Panel is nevertheless satisfied that the lessons from Alice's horrendous experiences will be addressed, if the recommendations agreed during this combined Review are properly implemented. That will be Alice's legacy.

[17] SAM's aim is to 'design and deliver better coordinated services for people facing multiple disadvantage, facilitating a shift to crisis prevention for those with complex needs who are often hard to reach'. The intention being 'to look at how things are operating at individual, system and service level, with a view to improving outcomes.'

[18] Maslow described the human basic needs as: Psychological needs - The needs for survival ie. Food, shelter, water etc. Safety needs: These include our need for personal, emotional and financial security as well as physical wellbeing.

18.6.8. The Review Chair and Panel acknowledge that the scope of the review has been limited by Joe's decision not to engage with the Review.

19. LESSONS LEARNT

19.1. The following summarises the lessons agencies have drawn from this Review together with those identified by practitioners and the Review Panel during their deliberations. The recommendations made to address these lessons are set out in the Action Plan template in Section 20 of this Report.

19.2. CSH Surrey

19.2.1. Domestic abuse routine enquiry and history taking were not embedded in the initial assessment. Despite Alice disclosing that she has been a victim of domestic abuse, had suffered from drug addiction and suicidal attempts, there was no further enquiry to understand the impact this had had and was currently having on Alice. It was not known if she was still drug taking, was experiencing domestic abuse from a new partner or her previous partner or what her current mental health was. Her physical health needs and her disclosure about her lived experiences all indicated that she was a vulnerable adult with safeguarding needs. Further explorative conversations following her disclosure may have engaged Alice and enabled her to share further information. Alice was discussed at MARAC in July 2021 due to Joe repeatedly breaking the restraining order and attending Alice's home, if domestic abuse had been explored with her by practitioners who were providing services prior to this, earlier intervention would have been possible.

19.2.2. There appears to have been little professional curiosity, particularly around rescheduled visits and the comment regarding the adverse effect of incontinence to her quality of life. There is no evidence of practitioners exploring with Alice why she refused some visits or rebooked them and how she could be supported to engage more with the service. There is no understanding of what her daily lived experience was or of the impact of her history which she disclosed to clinicians and the understandable impact that this would have on her mental health and current health. It is not known if Alice had a wider support network or any family, what her day-to-day life was like or what other support services she had. Had this been undertaken she may have felt comfortable to disclose that she had given birth to 4 children who had been removed from her care and the subsequent impact this would have on her and an understanding of her increased vulnerability, especially her mental health. There is no evidence of a holistic assessment of Alice's life and needs.

19.2.3. Good practice was identified, practitioners were responsive to Alice's requests and clinical needs, making appropriate changes as required to try to improve her quality of life. Practitioners offered further visits / alternative dates when Alice declined to engage, to try to ensure she received the help she needed, reassuring her when she became distressed, and signposted to her GP for an assessment of her pain. CSH Wound Assessment and Management guidelines and Bladder Scanning and Assessment of Residual Urine Policy were in place and were followed. Community Continence Assessment and Reassessment Policy were also in place at the time of intervention and were followed. Level 3 adult safeguarding training which is delivered face-to-face includes how to ask explorative questions about relationships, how to respond and access support, to listen and understand the client's lived experiences.

19.3. Goldtech Care Services Ltd

19.3.1. Information sharing could have been better, as personnel working with Alice were totally unaware of her history of mental health difficulties, domestic abuse or self-harming. If they had known they could have been more vigilant and been able to structure support more appropriately. (This is being addressed by the commissioning agency.)

19.4. Matrix Service Development & Training Ltd

19.4.1. Recording systems at the time (2017) were an extension of an existing pdf system that existed for ward-based interactions as the primary work was IMHA. These only allowed short entries and although these could be extended to the next available section, the compartmentalised nature discouraged this. The introduction of new word templates that allow unlimited system entries. This allows for more detailed information to be recorded than the PDF system in use 2017.

19.4.2. Prompts around safeguarding concerns had been omitted on latest case notes systems.

19.5. New Vision Homes

19.5.1. The delay in responding to the request for Sanctuary works, NVH could have been better in regard to its response time. However, there are now better procedures in place and a Repairs Team inbox, so that the whole team can monitor and progress these kinds of works and ensure that they are completed in a timely manner.

19.5.2. Level of the response, to the requests made by Occupational Therapists, the Fire & Rescue Service and other Agencies practitioners, for Alice's flat, then bungalow to be adapted to meet her needs as a wheelchair user, was not given sufficient priority.

19.5.3. Whilst attempts were made to communicate with Alice this was inhibited due to her difficulties as a wheelchair user being able to attend meetings and as she often did not have/or would not answer a mobile phone. Other methods of communication could have been explored.

19.5.4. As New Vision Homes no longer exists, there are no improvements to discuss regarding the service they would provide. However, as the service is back in- house, it has been recognised there is a need for updated policies and procedures. This is being undertaken as part of a service improvement plan for the housing service within Woking Borough Council.

19.6. Probation Service

19.6.1. The assessment made in the pre-sentence report was clear and thorough. Points were made to be followed up on after sentence to guide whoever the case was allocated to.

19.6.2. Lack of pre-release work, change of Officers when staff move on, evidences the need for handovers to be conducted and recorded and show management oversight. Given Joe's history of violent offending, there should have been consideration of a referral

to MAPPA and the decision making in relation to this recorded on NDelius. There are other missed opportunities in relation to referrals for Joe - for example, he could have been considered for the IOM scheme. IOM is the joint and intensive management of offenders by Police, Probation and other partner agencies (including local authorities, drug and alcohol support services, mental health services, accommodation providers and voluntary sector organisations). Joe could also have been considered for MATAC (multi-agency tasking and coordination), a proactive method of identifying and tacking the most harmful domestic abuse perpetrators, which commenced in July 2021.

19.6.3. There was no contact with Joe before release - good practice would have been to arrange a video-link to discuss his release plans and gain a sense of his attitude towards Alice. No safeguarding referrals were made in relation to Alice or Joe's new partner. It would have been helpful to find out more about Joe's new partner as well as who was visiting him in prison and who he had been contacting.

19.6.4. A focus on safeguarding, liaison with the Police information sharing and prerelease work may have opened up opportunities for agencies to make contact with Alice so that she was better informed about Joe's release from prison.

19.7. Surrey County Council Adult Social Services

19.7.1. From an Adult Social Care practice perspective, given the timespan of this chronology, some of the learning identified has already been learned. However, the Author views the outstanding learning points as follows:

19.7.2. Understanding and implementation of Care Act 2014 s.9 duties to assess and s.13 Eligibility Criteria - the chronology has shown that eligibility decisions may have been made without reference to the outcomes and wellbeing considerations required by the Care Act. Whilst practice has undoubtedly moved on within the organisation since the Care Act was implemented, and any new legislation invariably brings a natural learning period for workers and organisations alike, this chronology does show the adverse outcomes that can occur if this is not understood.

19.7.3. Understanding and implementing of Care Act 2014 Safeguarding Adults Criteria and Threshold. The chronology showed that there were opportunities when the Surrey Adults Safeguarding Procedures might have applied but were not considered - doing so could have strengthened the multi-agency network, working in a more co-operative, preventative way and, potentially, raising cognisance amongst the whole network of concerns regarding coercion and control.

19.7.4. Understanding of fluctuating needs, in relation to Care Act Assessments.

19.7.5. Awareness and understanding of fluctuating mental capacity, in relation to Mental Capacity Act 2005. The chronology showed numerous instances where capacity was believed / assumed, and this assumption appears to have persisted regardless of how Alice was presenting. There were reasons, by way of mental health, substance use and coercion / control where a disturbance of the mind or brain could have been reasonably considered to be affecting ability to make choices (even if only temporarily).

19.7.6. Awareness of coercion and control, what it is, how it looks and multi-agency best practice; the chronology did not reveal any persistent consideration of this area of practice.

19.7.7. There is no indication that Alice was ever asked if carers, employed at her home by other agencies could be warned of the inherent risks of harm from drugs, syringes, other paraphernalia or of the dangers if Joe was at or arrived at the premises whilst they were present.

19.7.8. Agencies appeared to have been confused about their duty of care to staff and/or the client by sharing information without consent, due to their belief that to do this may contravene Data Protection Legislation.

19.7.9. Data sharing agreements as recommended in the Surrey Multi-Agency Information Sharing Protocol, did not appear to have been in place with those non-statutory commissioned services employing carers in Alice's home.

19.7.10. There was a lack of knowledge regarding the 'Surrey Data Sharing Handbook' amongst the professionals involved with Alice between 2015-2022.

19.8. Surrey & Borders Partnership NHS Foundation Trust (SaBP)

19.8.1. Re **Information sharing**: Prior to the s75 NHS Act 2006 agreement ending in November 2019, both the CMHRS and i-access were integrated health and social care teams. Therefore, any safeguarding concerns should have been discussed with ASC staff within the teams and/or the ASC Safeguarding Advisors and Managers that covered the CMHRS and i-access at the time. They would have then decided if further enquiries were required under s42 Care Act 2014.

19.8.2. Post s75 agreement, all teams now report safeguarding concerns to MASH in line with all other Trust services. In addition, domestic abuse forms a significant part of the Trust safeguarding adults training and DASH training has been provided on an ad hoc basis in partnership with Domestic Abuse Outreach services in the Trust. MARAC and DASH are discussed as part of safeguarding training as well as coercion and control.

19.8.3. There is currently good practice as domestic abuse is now part of the safeguarding adult's policy, and a workforce domestic abuse policy is in place. The Trust's intranet includes a specific page on domestic abuse which provides a range of information, including domestic abuse services contact details. Domestic abuse is an integral part of the Trusts safeguarding adults training and learning from Domestic Homicide Reviews and Safeguarding Adults Reviews are shared through governance arrangements.

- Domestic abuse and Domestic Abuse Stalking and Harassment (DASH) training to be further embedded across the Trust.
- Audit of safeguarding adult enquiries in relation to domestic abuse across directorates with a specific focus on the routine enquiry.
- All people supported by SaBP services can be seen without their partners.

19.8.4. Although there is good evidence of recording and comprehensive assessment with the teams, there are gaps of information sharing when Alice was known to a variety of professionals. The teams would stop involvement but follow up by a care coordinator was not arranged.

19.8.5. There were also opportunities to speak to Alice on her own when she would attend i-access service for prescription collection without Joe. Discussions to address domestic abuse were missed, particularly when two different workers saw her black eye but did not believe the explanation that she gave. Staff noted that Alice and Joe appeared to have a volatile relationship but did not attempt to speak to Alice separately from Joe.

19.8.6. There is good information sharing when the new Care coordinator was allocated and would arrange the professionals' meetings effectively so that relevant professionals would support with different tasks. However, there were times where there were inconsistencies with mental health and substance misuse services outcomes. The dual diagnosis policy was not utilised effectively. At present the Use of the Triangle of care is being implement in the Trust with regular training and discussion in team meeting to ensure effective practice.

19.9. Surrey Heartlands Integrated Care Board (ICB) for GPs.

19.9.1. There was good inter-service working**.** The GP contributed to the initial child protection conference for Alice's unborn baby in the summer of 2016, and subsequently provided a medical report for her Family Court solicitor.

19.9.2. No information was received by the GP practice regarding any MARAC attendances; this would have been the case at the time, but as a result of an earlier Surrey DHR, a GP/MARAC information sharing process was agreed at the end of 2021. Following a pilot in the first half of 2022, this process was rolled out countywide from September 2022. Surrey GPs are now contacted in advance of the MARAC, asking them to share any relevant information, and informing them that their patient is due to be discussed and is hence a victim of high-risk domestic abuse. Training of clinical and non-clinical staff has supported this development, and there are very good levels of returns from Surrey GP practices, and improvements in DA clinical record keeping. (See Appendix D: Surrey GPs and MARAC Information Sharing Guide**)**

19.9.3. Good practice: Reviewing the detailed records for the 3 years that Alice was registered at her last medical practice, shows robust attempts to contact and engage with her. Alice's documented non-use of voicemail on her mobile phone was fully acknowledged by both clinical and non-clinical staff, and when Alice did not answer her phone (which was frequently the case), text messages were sent instead. These have proven advantageous in this Review, as they provide an objective record of what messages were sent and when. A missed phone call resulting in a voicemail may be recorded as "no reply, voicemail left". The use of texts linked directly to the electronic GP record is now widespread.

19.10. Surrey Multi Agency Risk Assessment Conference (MARAC)

19.10.1. Whilst the MARAC Chair was satisfied that the MARAC meetings in respect of Alice were well attended and that the actions set and delivered were appropriate, it was pointed out the MARAC process in Surrey has continued to develop with a number of administrative changes having been implemented which are better supporting the MARAC referrals, information sharing and agency accountability.

19.11. Surrey Police

19.11.1. There were some occasions where intelligence was recorded but not acted upon. In 2017 information that Alice had been seen with bruises on her chest was not followed up. Police had responded to a report of a domestic incident the day before, yet no injuries were disclosed / seen. This should have been explored.

19.11.2. Intelligence recorded in 2019, indicated that Alice was being assaulted by Joe and bruises had been seen on her arms. The report also mentioned that there was a Restraining Order preventing Joe from contacting Alice. There was no further research completed. This was a missed opportunity which should have been followed up.

19.11.3. There has been a lack of basic training for Officers/Staff in connection with the submission of intelligence, and this has contributed to issues regarding reports being submitted when there is no requirement and reports not being submitted when they ought to be.

19.11.4. In this case, the Officer submitting the report graded the intelligence as low risk based on the fact that the information was provided by a member of the public. This was an incorrect assessment and may well have been due to lack of training and appreciation of enhanced risk levels relating to domestic abuse.

19.11.5. There were a few occasions where breaches of the Restraining Order could have been pursued / investigated more robustly by police.

19.11.6. In high-risk DA cases consideration should be given to a multi-agency enforcement strategy, especially where a victim is open to different agencies. This could be agreed at MARAC.

19.12. Surrey Women's Support Centre

19.12.1. Good Practice: Women's Support Centre (WSC) provided Alice with a laptop in an attempt to enable her to engage with substance misuse support.

19.12.2. WSC was told in May 2021 that Alice had not opened the tablet box, but it was unclear what further support was provided or what encouragement was offered at this time.

19.12.3. Documentation could have been more detailed as it is unclear what, if any encouragement was given to Alice when her non-engagement with the SMART group and with WSC as a whole became known.

19.12.4. **Subsequent to WSC initial involvement with Alice it has introduced a dedicated domestic abuse service and employs a DA worker who is a qualified IDVA.**

19.13. Woking Borough Council

19.13.1. The criteria for which Alice was referred to both the CIAG and ChaRMM Partnership meetings had been met on both occasions and therefore was suitable for

discharge at that time. However, this happened when there were still outstanding actions, albeit not necessarily relevant to the original referral. Once discharged from CIAG/CHaRMM there was then no oversight on whether the actions were completed.

19.13.2. At the time of the CIAG involvement, there was no IT that would support onward monitoring being used at Woking Borough Council, (This is no longer the case). The use of the information sharing platform, 'Ecins', allows for an individual to be discharged from the meeting, however the outstanding actions would then still be monitored. If an action is then incomplete in the agreed timescale after discharge, then it can be addressed under AOB as part of the CHaRMM to ensure update/outcome is provided.

19.14. Woking Borough Council Housing

19.14.1. A particular lesson learnt is to ensure that vulnerable people are bidding for suitable, settled homes regularly so that their housing needs can be met as soon as possible.

19.14.2. Although Alice had support from various agencies, closer working from housing might have made a difference to timescales but would still have been subject to a suitable property becoming available.

19.14.3. The need for a more suitable home for Alice was identified following an Adult Social Care assessment as the bathroom and kitchen had become increasingly inaccessible to Alice.

19.14.4. There are no records of representations being made by ASC and Matrix Service Development & Training Ltd in June and July 2015 relating to Alice sleeping in a public carpark as unfortunately, there are no homelessness notes for the time period as they were input into a different IT system which is no longer in use. The notes on the relevant system were input retrospectively by the IMR author as they had previously been in the email inbox of a member of the Options Team. The IMR Author took immediate action by informing all staff that notes must be input in a timely manner into the correct IT system in accord with policy.

19.15. Your Sanctuary

19.15.1. Good Practice: Persistence with contact attempts when calls went unanswered. This was reasonable, proportionate and in line with policy. It demonstrated a willingness to try and engage and multiple requests were made for alternative contact methods through other professionals involved with Alice.

19.15.2. Learning: For follow up actions from a MARAC or any other Professional meeting to be clearly documented and recorded on the Client Case Notes, positive or negative.

19.15.3. Inter-agency responses identified as a potential missed opportunity when YS did not appear to have actioned contact with Alice's Adult Social Care Worker. Otherwise, there is evidence of good practice in terms of Professionals meetings being attended as well as MARACs, despite having little input to offer due to lack of contact between Alice and YS.

19.15.4. As it had been hard to engage with Alice from the first contact in 2012, an opportunity where she was willing to speak, expressing her genuine fear and asking for support could have been optimised so as to learn more about her needs and situation. However, it is noted that at that time, Alice preferred to speak to a Police DA Worker, with whom she had established a rapport. This may have been why further exploration and risk assessment was not completed, because Alice was likely to have done so with the Police DA case worker.

19.16. Cross Agencies & Practitioners

19.16.1. There was a lack of knowledge of the Surrey Multi-Agency Information Sharing Protocol amongst practitioners, several of whom were working at Alice's home without having been warned of the risks to either themselves or Alice.

19.16.2. There was no formal co-ordination of the many practitioners who needed to have contact with Alice; this resulted in Alice becoming confused by the many different agencies contacting her. It was practitioners themselves who identified the problem and informally arranged joint visits at times suitable to Alice. There was a lack of knowledge regarding the Surrey Adults Matter programme.

19.16.3. Some non-statutory organisations working with Alice were never invited to multiagency forums meeting to discuss her care.

19.16.4. Escalation to a senior level is the option that all professionals should consider where there are concerns that an adult's safety and wellbeing is compromised, and the current action of other agencies does not support the adult.

20. RECOMMENDATIONS

20.1. The DHR Panel's up to date action plan, at the time of concluding the review is set out in Appendix A of this report.

20.2. National Recommendation

20.2.1. In this joint Review the Review Chair and Safeguarding Lead met with 17 practitioners who had worked with Alice in relation to her diverse and complex needs health (physical and mental), housing, drugs/alcohol, children being taken into care, in addition to violent domestic abuse over number of years. The meeting allowed those practitioners who came from both statutory and non-statutory organisations, to express their views openly in a safe environment. After being reminded of the confidentiality of the Review, the practitioners gave key information that had not previously come to light in the IMRs, and which now features in the lessons and recommendations of this Review. It is the view of the Review Panel that the participation of the practitioners has added immensely to the quality of the Review's findings, and they therefore recommend that the Home Office team currently drafting the new statutory guidance for the conduct of DHRs consider adding such engagement with practitioners as good practice.

20.3. Cross Agency Recommendations

20.3.1. To reduce the risk of individuals with severe multiple needs falling through gaps between services or being faced with a plethora of service providers, participating agencies should utilise the Surrey Adults Matter (SAM) programme to work together in a more coordinated way with the client at the heart of the process with a view to improve outcomes. This would enable joined-up support to individuals with multiple needs and reduce the number of professionals individually contacting them.

20.3.2. Agencies have a duty of care to staff and commissioned services, who are expected to carry out work in environments/situations where there is a high risk of serious harm. It is therefore recommended that such agencies participating in this review, should rely on legitimate interests as the sole lawful basis for collecting and sharing the relevant information that would need to be given to the front-line workers. This will always need to be clearly documented, to allow the consent to share to be a valid reason basis for sharing.

20.3.3. Participating agencies working with members of the public should ensure that front line professionals understand the Surrey Gold Standard Coercive and controlling behaviour framework so as to enable them to identify and deal appropriately with people who may be experiencing controlling or coercive behaviour (CCB) https://www.healthysurrey.org.uk/domestic-abuse/professionals/surrey-gold-standardcoercive-and controlling-behaviour-framework

20.3.4. All agencies involved with this review should ensure that they have an escalation policy to assist staff to know pathways for escalation. All agencies should be aware and utilise as appropriate, the Surrey Safeguarding Adults Board Inter–Agency Escalation Policy and Procedure - Resolution of professional disagreements and oversight of risk in work relating to safeguarding adults.

20.4. Agency Recommendations

20.4.1. CSH Surrey

a) Clinicians to have access to regular and ad hoc safeguarding supervision.

b) The introduction and use of a holistic tool would enable practitioners to complete a robust assessment of a client's needs and how to address them whilst also further safeguard any vulnerable adults. In the community health children services a family health needs assessment is used and could be adapted to support this.

20.4.2. Probation

a) To improve the quality of pre-release work in custody cases to ensure effective risk management and safeguarding

b) Probation staff to be aware of their responsibilities under the Care Act where there are safeguarding concerns.

20.4.3. Surrey County Council Adult Social Care

a) In relation to cross agency information sharing appertaining to the safety of front-line workers, agencies going forward, need to actively seek the individual/data subjects' consent where there is the potential high risk to others and staff working on the case. If the individual is able to give consent at the earliest opportunity, this opens up the gateway to share the relevant detail on this matter with appropriate parties who could be affected. This will always need to be clearly documented, to allow the consent to share to be a valid reason basis for sharing. If individuals do not give consent, then a best interest decision in line with the Health and Social Care (Safety and Quality) Act 2015, will need to be considered as the potential risk to others, who maybe directly affected if not to share, is just as important as the risk to the data subject if we were to share information.

b) ASC workforce will be supported to understand and implement Care Act 2014 s.9 duties to assess and s.13 Eligibility Criteria.

c) ASC workforce will be supported to be confident in understanding and implementing implement of Care Act 2014 Safeguarding Adults Criteria.

d) ASC workforce will be supported to be confident in understanding and considering fluctuating needs, in relation to Care Act Assessments.

e) ASC workforce will be confident in understanding and considering fluctuating Mental Capacity, in relation to Mental Capacity Act 2005.

f) To ensure that ASC workforce understand all aspects of coercion and control and what multi-agency best practice is in place in this area.

g) ASC Workforce supported to be confident in assessing risk and recording assessment / risk management.

20.4.4. Surrey Integrated Care Board (for GP Practice)

a) 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.

b) That Level 3 update sessions in 2023 include high-risk DA and response.

c) That Information sharing processes are established between Surrey GPs and MARAC.

20.4.5. Surrey Police

a) Bespoke training to improve the quality of intelligence report submissions should be provided to all public facing officers and staff.

20.4.6. Surrey Public Health

a) Increase awareness amongst the Public and practitioners of the links between domestic abuse and suicide, as this can be hidden by a perfunctory classification such as 'deceased suffered from depression or mental health problems.

20.4.7. Surrey Support After Suicide Service

a) Drive awareness among frontline professionals of Suicide bereavement as significant risk factor for suicide. Include suicide bereavement as a potential risk factor when assessing for suicide risk.

20.4.8. Woking Borough Council - Safer Woking Partnership

a) To better use the available information sharing platform Ecins (Data System) to ensure that all actions are completed. To ensure that all actions have a visible audit trail from assigning to closing.

b) Encourage wider use of 'Ecins'[19] amongst partners to ensure all those that attend the CHaRMM are able to access and update cases and can be accountable for assigned actions.

c) Introduce into the ToR for CHaRMM that under AOB all outstanding actions that have expired in time to complete, to be addressed on all cases discharged to CHaRMM. The agenda can then provide in advance of the meeting those actions and who they were assigned to so that they can come prepared to answer.

20.4.9. Woking Borough Council Housing (Incorporating recommendations from New Vision Homes)

a) To review all current policies and procedures that are relatable to domestic abuse and mental health.

b) Initial domestic abuse training to be delivered by an external provider. To have regular training provided on an ongoing basis.

c) Mental health training to provide in line with the mental health protocol. To continue training in line with any relevant legislation.

d) To update data information via a bolt on to the existing system within WBC.

e) For a member of the Resident Services team to attend MARAC when a tenant is on agenda meetings alongside Woking Borough Council's Housing Team.
This should be a manager from Housing options and resident services accompanied by Housing Options Officer as a training opportunity.

f) To ensure that there is a process in place so that vulnerable people who need to move into suitable, settled homes are monitored regularly so that their housing needs can be met as soon as possible.

g) The Rough Sleeper Team to work with other support agencies and other organisations to assist vulnerable people to access a suitable property as they become available.

[19] Collaborative case management system

h) That properties are inspected by an Occupational Therapist (OT) before a tenant moves in to ensure the needs of people with mobility challenges can be addressed at the property where possible before the new tenant moves in.

i) All case notes to be input in a timely manner.

j) Homelessness Policies and procedures to be reviewed/updated.

20.4.10. Women Support Centre - Surrey (WSC)

a) To improve record keeping through the completion of training and skills workshops around case notes and what to include.

b) To ensure all avenues are explored by personnel to encourage client engagement and retention.

c) To ensure all key WSC personnel have a sound working knowledge of the Mental Capacity Act and how/when it should be utilised to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

20.4.11. Your Sanctuary

a) A management review/dip sample of MARAC actions being documented on client case notes and follow up records being made to include outcomes and whether MARAC/MODUS has been updated.

b) For follow actions for MARAC or any other professional meeting to be clearly documented and recorded on the client case notes.

c) A need has been identified for a more consistent approach to MARAC and record keeping.

APPENDIX A: Action Plan

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
It is the view of the Review Panel that the participation of practitioners has added immensely to the quality of the Review's findings, and they therefore recommend that the Home Office team currently drafting the new Statutory Guidance for the conduct of DHRs consider adding into the new guidance, such engagement with practitioners as good practice.	National	Home Office team currently drafting the new statutory guidance for the conduct of DHRs consider adding into the new guidance, such engagement with practitioners as good practice. Surrey Community Safety Partnerships to comment on this when the new draft guidance comes out for consultation.	Home Office and Woking Community Safety Partnership	Publication of new Statutory Guidance.	September 2024	**Outstanding** Consulting Practitioners enhances the quality of information available to DHRs and therefore improves Review findings and actions.
To reduce the risk of individuals with severe multiple needs falling through gaps between services or being faced with a plethora of service providers, participating agencies should utilise the Surrey Adults Matter (SAM) programme to work together in a more coordinated way with the client at the heart of the process with a view to improve outcomes.This would enable joined-up support to individuals with multiple needs and reduce the number of professionals individually contacting them.	Local Cross Agencies	Countywide partnership communications piece to be disseminated in early 2024 by Public Health MD team, regarding a new referral pathway for clients with Multiple Disadvantage. Awareness of SAM approach to be included in this piece of work. Participating Agencies should ensure the practitioners and supervisors are aware of SAM and the Team around the Person process.	Surrey Adults Matter, Surrey CSP, Surrey SAB, Surrey LA Departments/ Surrey Emergency Services & NHS are already included as partners working closely with the SAM process and	Surrey wide organisations including LA, NHS & Emergency Services are already embedded and committed to multi - agency working protocol with the involvement of SAM. There is a need for continual awareness raising at least annually, to capture new staff across the wider workforce to ensure all staff in all partnerships know when and how to refer to SAM	September 2024	**Completed** The purpose is to provide a coordinated approach to ensure that the multiple needs identified by Practitioners are promptly actioned by agencies through the SAM programme.

			have representation on the relevant governance board.			

Agencies have a duty of care to staff and commissioned services, who are expected to carry out work in environments/situations where there is a high risk of serious harm. It is s therefore recommended that such agencies participating in this review, should rely on legitimate interests as the sole lawful basis for collecting and sharing the relevant information that would need to be given to the front-line workers. This will always need to be clearly documented, to allow the consent to share to be a valid reason basis for sharing.	Local Cross Agencies	On the advice of the ICO If relying upon legitimate interests, this information can be shared with the front line staff without consent. However Agencies need to be transparent that this may be shared with them if appropriate and necessary (as to inform the data subjects).The Agency would be able to justify this lawful basis, as there is an overriding interest to protect the workers going into these environments, and this information can be shared regardless of whether the data subjects want it to.	Individual Participating Agencies / Woking CSP Surrey SAB	Agree with Agency data protection leads. Brief Supervisors of procedure Ensure personnel /commissioned service providers are informed of potential risks in carrying out their duties.	September 2024	**Ongoing** The outcome of this recommendation is that agencies and commissioned service providers address their duty of care to practitioners working in potentially dangerous environments.

Participating agencies working with members of the public should ensure that front line professionals understand the Surrey Gold Standard Coercive and controlling behaviour framework so as to enable them to identify and deal appropriately with people who may be experiencing controlling or coercive behaviour (CCB).https://www.healthysurrey.org.uk/domestic-abuse/professionals/surrey-goldstandard-coercive-and controlling-behaviour-framework	Local Cross Agencies	The DA Executive to recommend this to partnership agencies.	The DA Executive supported by Your Sanctuary	Dissemination of training.	Ongoing	**Completed** To ensure that practitioners have a professional understanding of CCB.
All agencies involved with this review should ensure that they have an escalation policy to assist staff to know pathways for escalation. All agencies should be aware and utilise as appropriate, the Surrey Safeguarding Adults Board Inter– Agency Escalation Policy and Procedure - Resolution of professional disagreements and oversight of risk in work relating to safeguarding adults.	Local / all participating agencies	Participating agencies to remind operational personnel and their supervisors of the importance of upward referrals for advice and support when working on complex multiple needs cases.	All agencies participating in this Review together with agencies represented on Surrey SAB and/or Surrey based CSPs	Team discussions to be arranged.	April 2024	**Ongoing** The intended outcome of this recommendation is to ensure appropriate management support is given to practitioners dealing with multiple needs cases.

Clinicians to have access to regular and ad hoc safeguarding supervision.	Local	To formalise the safeguarding supervision offer for clinical Adult services. Develop regular drop-in safeguarding supervision groups for clinicians. Develop a safeguarding supervision template, that becomes part of the patients notes. Advertise the ad hoc offer via staff app.	CSH Surrey	Records of ad hoc supervision. Records from drop in group supervision. Call log to evidence any increase in calls for advice. Clinician feedback on supervision sessions and effects to practice – Microsoft form.	January 2024	**Completed** To improve agencies / individual practitioners safeguarding service delivery.
The introduction and use of a holistic tool would enable practitioners to complete a robust assessment of a client's needs and how to address them whilst also further safeguard any vulnerable adults. In the community health children services a family health needs assessment is used and could be adapted to support this.	Local	Develop DA template on electronic record system (EMIS), to be used across all Adult services. Monitor and audit the use of the template and its effectiveness. Embed the DA template across all Adult services.	CSH Surrey	Develop and launch a DA template within adult services. Include being built into the electronic record system, the flagging of records. Audit the quality of completed DA templates. Triangulate the completion of DA template and the use of ad hoc supervision.	Working date of January 2024 August 2024	**Completed** The intended outcome is to enable the completion of a robust assessment of a client's needs and how to address them.
Probation staff to be aware of their responsibilities under the Care Act where there are safeguarding concerns.	Regional	Themes to promote locally, in teams/team meetings/training events etc. (to be decided by PDU). Staff to be aware of the need to make referrals to MARAC and/or Adult Social Care in cases where there is evidence of domestic abuse and/or safeguarding concerns and why this is	Probation (Hampshire Probation Delivery Unit)	Training packs relating to: a) domestic abuse including function of multi-agency forums and b) Safeguarding and duties under the Care Act.	Ongoing	**Ongoing** Intended outcome, to improve Probation staff understanding of their Care Act responsibilities.

		important in effective release planning.				

To improve the quality of prerelease work in custody cases to ensure effective risk management and safeguarding.	Regional	Themes to promote locally, either in teams/team meetings/training events etc (to be decided by PDU). Timely contact with prisoner and prison prior to release Liaison with local police and referrals to local safeguarding services for cases that don't meet victim liaison service eligibility effective management oversight prior to release to help identify any concerns and actions needed. Importance of accessing and reading all court documents, including the PSR and following up on any points raised. Consideration of referral to MAPPA category 3 as routine discussion for high-risk domestic abuse cases that do not meet the standard category.	Probation (Hampshire Probation Delivery Unit)	Training delivery sessions organised and timetabled.	1 July 2024	**Completed** To improve risk management and safeguarding awareness and delivery.
In relation to cross agency information sharing appertaining to the safety of front-line workers, agencies going forward, need to actively seek the individual/data subjects' consent where there is the potential high risk to others and staff working on the case. If the individual is able to give consent at the	Local	ASC Information Governance Team therefore recommends the Information Governance Handbook that gives staff direct guidance in this area is made more accessible, the detail following this matter is now being uploaded to the platform know as Tri-x with Surrey County Council.	ASC Information Governance Team	This document should be considered as a core policy and guidance platform which should be achieved not later than the 1 November 2023.	1 November 2023	**Completed** The outcome of This recommendation is to ensure front line practitioners/ commissioned services are aware of potential dangers when

earliest opportunity, this opens up the gateway to share the relevant detail on this matter with appropriate parties who could be affected. This will always need to be clearly documented, to allow the consent to share to be a valid reason basis for sharing. If individuals do not give consent then a best interest decision in line with the Health and Social Care (Safety and Quality) Act 2015, will need to be considered as the potential risk to others, who maybe directly affected if not to share, is just as important as the risk to the data subject if we were to share information.						working in with a service user.

ASC workforce will be supported to understand and implement Care Act 2014 s.9 duties to assess and s.13 Eligibility Criteria.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	21 August 2023	**Completed** The training will ensure ASC Workforce have an improved understanding of their Care Act responsibilities.
ASC workforce will be supported to be confident in understanding and implementing the Care Act 2014 Safeguarding Adults Criteria.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	August 2023	**Completed** The new training will ensure the ASC Workforce have an improved understanding of Multi-agency risk assessments.

ASC workforce will be supported to be confident in understanding and considering fluctuating needs, in relation to Care Act Assessments.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	August 2023	**Completed** The training will support practitioners to better understand how fluctuating needs should be understood in relation to Care Act Assessment and subsequent Care Act intervention.
ASC workforce will be confident in understanding and considering fluctuating Mental Capacity, in relation to Mental Capacity Act 2005.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	21 August 2023	**Completed** The training will ensures ASC Workforces are equipped to consider fluctuating Mental Capacity when planning and completing Mental Capacity Assessments.
To ensure that ASC workforce understand all aspects of coercion and control and what multi-agency best practice is in place in this area.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	August 2023	**Completed** The new training will strengthen ASC Workforce have an improved understanding of Section 76 Serious Crime Act 2015.

ASC Workforce supported to be confident in assessing risk and recording assessment / risk management.	Local	Inclusion in training.	Surrey CC Adult Social Care	SMART assurances offered to DHR.	August 2023	**Completed** The new training will ensure the ASC Workforce have an improved understanding of Multi-agency risk assessments

That 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.	Surrey ICB (designated GP for safeguarding)	Domestic abuse training day scheduled for 7th June 2023. Supervision sessions June and September 2023.	September 2023	**Completed** Intended to improve practice in addressing multiple complex problems.
That Level 3 update sessions in 2023 include high-risk DA and response.	Local	Level 3 update sessions in 2023 include high-risk DA and response.	Surrey ICB (designated GP for safeguarding)	DA training day 7th June 2023. Level 3 safeguarding updates September and November 2023.	December 2023	**Completed** Training which should improve understanding and practice.
That Information sharing processes are established between Surrey GPs and MARAC.	Local	Surrey-wide safeguarding teamwork with the MARAC chairs and administrators to agree and pilot information sharing pathway. Roll out to all Surrey GP practices.	Surrey ICB (designated GP for safeguarding)	Pilot in Spelthorne area to commence February 2022. Countywide roll-out September 2022.	September 2023	**Completed** September 2023 To improve GP involvement in MARAC processes.
Bespoke training to improve the quality of intelligence report submissions should be provided to all public facing officers and staff.	Local / National	In the absence of national training for new entrants to the police service, Surrey police should embark on a local training package.	Surrey Police / Association of Chief Police Officers (ACPO)	Training is being provided to Surrey Police Response Officers and members of the CID by Intelligence Unit staff.	December 2022	**Completed December 2022** Outcome as per recommendation.

Increase awareness amongst the Public and practitioners of the links between domestic abuse and suicide, as this can be hidden by a perfunctory classification such as 'deceased suffered from depression or mental health problems'.	Local	This is addressed in the Surrey Suicide Prevention Strategy 2023-2026.	Surrey Public Health team	Already published and distributed. Partnership agencies to cascade to operational practitioners to ensure the link between domestic abuse and suicide is not lost.	June 2023	**Completed June 2023** The Surrey Suicide Prevention Strategy 20232026 2023. has already been published and has been used in training to ensure professionally recognise the links between DA and Suicide.
Drive awareness among frontline professionals of suicide bereavement as significant risk factor for suicide. Include suicide bereavement as a potential risk factor when assessing for suicide risk.	Local	Incorporate a question about suicide bereavement when assessing adults for suicide risk and explore impact of this bereavement on current state of mind/behaviours. Training workshops for Surrey-based frontline professionals on suicide bereavement.	Surrey Support After Suicide Service (Rethink mental illness)	Available on request for groups of frontline professionals in Surrey – enquiries can be emailed to: surreysupportaftersuicide @rethink.org	September 2023 and continuing	**Ongoing** This recommendation should improve awareness, that individuals who have experienced suicide bereavement particularly at an early age can be a significant risk factor.

To better use the available information sharing platform Ecins (Data System) to ensure that all actions are completed. To ensure that all actions have a visible audit trail from assigning to closing.	Local	Train admin of CHaRMM / CHaRMM attendees to maximise Ecins usage.	Woking BC / Surrey Police and other CHaRMM members	Woking CHaRMM to implement 1st Jan 2024. Raise to Surrey Community Harm and ASB Reduction Group – 21st September 2023.	July 2024 (unless specified otherwise in milestones	**Completed** The intended outcome is the improvement of record keeping, to ensure a visible audit trail.

Encourage wider use of 'Ecins' amongst partners to ensure all those that attend the CHaRMM are able to access and update cases and can be accountable for assigned actions.	Local	Promote through CHaRMM. Raise at countywide meeting (Surrey Community Harm and ASB Reduction Group).	Woking BC / Surrey Police	Raise at Surrey Community Harm and ASB Reduction Group	July 2024 (unless specified otherwise in milestones	**Completed** The intended outcome is the improvement of CHaRMM records to ensure a visible audit trail.
Introduce into the ToR for CHaRMM that under AOB all outstanding actions that have expired in time to complete, to be addressed on all cases discharged to CHaRMM. The agenda can then provide in advance of the meeting those actions and who they were assigned to so that they can come prepared to answer.	Regional	Agree amendment to ToR. Ensure CHaRMM admin include within agendas.	Woking BC / Surrey Police	Woking CHaRMM by end of year Pending Surrey Community Harm and ASB Reduction Group. Raise with Surrey County Council Community Safety to include in Surrey.	July 2024 (unless specified otherwise in milestones	**Completed** The intended outcome is ensuring that all CHaRMM actions are completed and outcomes recorded.
To review all current policies and procedures that are relatable to domestic abuse and mental health.	Local	Look at current legislation and ensure that new policies and procedures are in place and that good practice is implemented throughout.	Woking Housing	A full suite of policies available and approved and then published.	April 2024	**Completed** The intended outcome is for all Woking Housing policies and procedures relating to DA and Safeguarding to be updated to reflect current legislation.

Initial domestic abuse training to be delivered by an external provider. To have regular training provided on an ongoing basis.	Local / Cross Agency	Arrange with external agency (Your Sanctuary)	Woking Housing	Training provided, staff up to date with relevant information.	April 2024	**Completed** The intended outcome is for all key Woking housing staff to know relevant DA legislation and their responsibilities.
Mental health training to be provided in line with the mental health protocol. To continue training in line with any relevant legislation**.**	Local	Arrange with relevant agencies MVDC will run refresher MH Protocol training in April 2024.	Woking Housing	Training provided, regular ongoing training arranged.	April 2024	**Completed** The intended outcome is for all key Woking housing staff to know relevant Mental Health and Safeguarding legislation and their responsibilities.
To update data information via a bolt on to the existing system within WBC.	Local	Implement asset management modules re compliance and adaptations	Woking Housing	Data to be available to staff to ensure that a complete picture is available to the relevant staff, as opposed to silo working.	September 2024	**Completed** The intended outcome is the improvement of the data information system for the benefit of staff and clients.
For a member of the Resident Services team to attend MARAC when a tenant is on agenda meetings alongside Woking Borough Council's Housing Team. This should be a manager from Housing options and resident	Local	Now in place	Woking Housing	To ensure that the relevant teams have information regarding vulnerable residents and perpetrators and can make sure that any relevant actions are undertaken.	November 2023	**Completed** The outcome is that housing staff have an input in MARAC meetings and are able to ensure that information regarding

services accompanied by Housing Options Officer as a training opportunity.						vulnerable residents and perpetrators can be actioned promptly.

To ensure that there is a process in place so that vulnerable people who need to move into suitable, settled homes are monitored regularly so that their housing needs can be met as soon as possible.	Local	Assisted Bidding to be set up wherever possible for vulnerable applicants as per the new process	Woking Housing	To ensure the process is reviewed and put in place.	April 2024	**Completed** By assisting vulnerable people to bid, or by bidding on their behalf, for suitable settled homes regularly, so their housing needs can be met as soon as possible.
The Rough Sleeper Team to work with other support agencies and other organisations to assist vulnerable people to access a suitable property as they become available.	Local	Ensure vulnerable applicants are offered housing support and ensure good communication with other agencies.	Woking Housing	Rough Sleeper Team set up in 2019.		**Completed** The outcome is an informed, enhanced service for vulnerable persons to access suitable accommodation.
That properties are inspected by an Occupational Therapist (OT) before a tenant moves in to ensure the needs of people with mobility challenges can be addressed at the property where	Local	Make referrals to OT where mobility issues identified	Woking Housing	Set a policy /procedure whereby this is done.	January 2024	**Completed** Policy email from Strategic Director

possible before the new tenant moves in.						
All case notes to be input in a timely manner.	Local	Ensure all new staff are trained to input comprehensive yet concise notes on housing system as soon as possible.	Woking Housing	Record keeping to be regularly monitored.	January 2024	**Completed** Policy email from Strategic Director
Policies and procedures to be reviewed/updated.	Local	Review/Update (or develop new), any relevant homelessness policies.	Woking Housing		March 2023	**Completed** Outcome is that all policies and procedures are kept up to date.

To improve record keeping through the completion of training and skills workshops around case notes and what to include.	Local WSC	Management to ensure this takes place by agreeing training programme and reviewing record keeping policy and practice.	Women's Support Centre (WSC)	Review how detailed information being recorded	27 July 2023	**Completed 27 September 2023** The outcome is the improvement in note taking and record keeping.
To ensure all avenues are explored by personnel to encourage client engagement and retention.	Local WSC	To ensure training takes place to improve staff communication skills.	Women's Support Centre (WSC)	Review if best practice taking place to reduce early drop out	27 July 2023	**Completed 27 August 2023** The outcome is to reduce client drop out.

To ensure all key WSC personnel have a sound working knowledge of the Mental Capacity Act and how/when it should be utilised to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.	Local WSC	Management to liaise with Safeguarding experts from specialist agencies to gain a sound working understanding of Mental Capacity Act responsibilities and ensure a filtered down approach of understanding to the rest of the team.	Women's Support Centre (WSC)	To introduce a clear policy for staff and monitor how Informed decision making based on Mental Capacity Act is utilised	01 Dec 2023	**Completed** The intended outcome is to ensure that all WSC personnel understand their role in protecting and empowering those who may lack capacity to make their own decisions.
A management review/dip sample of MARAC actions being documented on client case notes and follow up records being made to include outcomes and whether MARAC/MODUS has been updated.	Local Your Sanctuary only	Ensure YS personnel are informed of the requirement to include in client's records relevant information including MARAC outcomes as appropriate.	Your Sanctuary	Completion of training and management review 21st September 2023	September 2023	**Completed** Outcome is to enable decisions relating to clients to be fully informed.
For follow up actions for MARAC or any other professional meeting to be clearly documented and recorded on the client case notes.	Local Your Sanctuary only	We now have a MARAC policy which outlines the need for all actions to be recorded on our case management system, Oasis.	Your Sanctuary		September 2023	**Completed** Outcome is to ensure decisions relating to clients are based on all available information.
Identified a need for a more consistent approach to MARAC and record keeping.	Local Your Sanctuary only	We have appointed a MARAC advisor/administrator to oversee the MARAC process.	Your Sanctuary	Introduction of new record keeping system October 2023	September 2023	**Completed** Outcome is the improvement in record keeping.

APPENDIX B: Glossary of Terms

CFC	Cause for Concern
CARA	Child at Risk Alert
CHaRMM	Community Harm and Risk Management Meeting
CIAG	Community Incident Action Group
DA	Domestic Abuse
DASH	Domestic Abuse Stalking and Harassment Risk Assessment
DVDS	Domestic Abuse Disclosure Scheme
DVPN	Domestic Violence Disclosure Scheme
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
IDVA	Independent Domestic Violence Adviser
ISSP	Individualised Safety and Support Plan
LADS	Liaison and Diversion Service
MARAC	Multi-Agency Risk Assessment Conference
SMART	Self-Management and Recovery Training

APPENDIX C: Bibliography

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APPENDIX D: Surrey GPs & MARAC Information Sharing Guide

What is MARAC?

A Multi Agency Risk Assessment Conference (MARAC) is a confidential meeting to discuss how to help domestic abuse victims, aged 16 or over, at high risk of murder or serious harm. Membership includes domestic abuse specialists, police, children and adult's social care, health, and other relevant partners. They consider the victim, family, and perpetrator, share information, and agree safety plans for each survivor. In Surrey, the MARAC process is managed by Surrey Police. The local operating protocol including a list of partner agencies that attend MARAC and referral forms can be found here: Multi agency risk assessment conferences - Healthy Surrey. Enquiries and MARAC referrals can be made via the Surrey MARAC Coordinators email: MARACCRU@surrey.pnn.police.uk

About Domestic Abuse

Anyone can be a victim of domestic abuse, but some people, particularly women, are much more likely than men to be victims/survivors of high risk or severe domestic abuse. Approximately 95% of those going to MARAC or accessing specialist domestic abuse services are women. We know from the Crime Survey for England and Wales that four out of five victims/survivors of domestic abuse do not tell the police and that women may be more likely to disclose domestic abuse to a health care professional. Seeing their GP is a vital opportunity for identification and disclosure of abuse and access to support. For more information on Domestic Abuse and the support services available visit: Surrey Against Domestic Abuse - Healthy Surrey

Coercive and Controlling Behaviour (CCB)

Domestic Abuse isn't always physical, coercive, and controlling behaviour is also a crime and can have a serious impact on mental health, liberty, sleep, and lifestyles. People will not usually disclose being controlled or coerced as they will not understand it in this way or even know it is a crime. They may instead talk about the controls being put on them, having to notify current or previous partners of their movements or being financially controlled. These are some of the most destructive behaviours in domestic abuse and are often the most hidden.

What is the GP's role in relation to MARAC?

- To share relevant information and expertise with MARAC agencies to assist safety planning.
- To record relevant information shared at MARAC on the survivor and children's records, only if safe to do so.
- To consider domestic abuse and safety when you next see the victim/survivor, children, or perpetrator.

GPs can refer directly to MARAC if they have serious concerns about a patient, using either the SafeLives DASH risk assessment criteria or professional judgement. There are specialist domestic abuse services who can provide support and advice to patients and professionals. You can find out more about the services available in Surrey here: How

to get help - Healthy Surrey or by phoning the Surrey Domestic Abuse Helpline 01483 776822, 9am to 9pm, 7 days a week.

Information Sharing & Consent

GPs should only share information with MARAC that they consider to be proportionate and relevant to safeguarding either the victim or child(ren).

All cases referred into MARAC have been assessed as high risk or are considered as high risk through professional judgement; this means the victim is at high risk of serious harm or homicide, and as such, GPs and other services may share relevant information without patient consent. This includes:

- If the GP has concerns about the welfare of child(ren) or a vulnerable adult and believes they are suffering or likely to suffer harm.
- If there is a risk of serious harm or homicide in not sharing the information (all victims referred to MARAC will have already been assessed as experiencing high risk domestic abuse by the agency who referred the case to the MARAC).

The professional sharing the information must:

- Ensure the information to be shared has been assessed against the Caldicott Principles and any potential non-compliance escalated to the Practice's Caldicott Guardian.
- Only share information which is relevant and proportionate to the level of risk of harm to a named individual or known household
- Balance the risk of not sharing information against the need to preserve confidentiality.
- Document any decision to share information (or not) within the patient and child(ren)'s records*

*It is unlikely that the GP will be certain of the extent of the perpetrator's knowledge of domestic abuse disclosures or allegations to other agencies. Therefore, in most circumstances, the GP will NOT record information within the perpetrator's notes.

Lawful grounds for sharing without consent

All personal information must be shared fairly and lawfully. In relation to MARAC information sharing the legal grounds are either:

- Consent (the individual referred to MARAC has given explicit consent to share their information with MARAC partners) or, where consent has been refused,
- Legal Obligation i.e. you are obliged to process the personal data to comply with the law (see appendix one for 'grounds in UK legislation which require or enable the sharing of information' in relation to MARAC).

Information Sharing Protocols

GP Practices are encouraged to become signatories to the Surrey Multi-Agency Information Sharing Protocol (MAISP). It is not legally binding but sets good practice

standards that organisations need to meet to comply with relevant legal duties in relation to the sharing of personal information. Information can still be shared without a protocol if a legal basis has been clearly identified. Further information about the MAISP is available here: Information sharing protocol for multi-agency staff - Surrey County Council (surreycc.gov.uk)

MARAC Resources for GPs

SafeLives are a national charity dedicated to ending domestic abuse. The SafeLives Knowledge Hub provides professionals with tools and resources to help the effective operation of MARACs. Resources specifically for GPs can be found here: Resources for GPs | Safelives

The Process for GP information Sharing with MARAC

For further, more detailed, guidance please see:
General Medical Council 'Confidentiality - good practice in handling patient information'. gmc-guidance-for-doctors---confidentiality-good-practice-in-handling-patient-information---70080105.pdf (gmc-uk.org)

The Department of Health & Social Care 'Domestic abuse: a resource for health professionals'. Domestic abuse: a resource for health professionals - GOV.UK (www.gov.uk)

SafeLives MARAC Guide for GPs here: Multi-Agency Risk Assessment Conference Guidance for GPs_0.pdf (safelives.org.uk)

Surrey MARAC Protocol: Multi agency risk assessment conferences - Healthy Surrey

Community Safety, Surrey County Council (December 2022)
Email: communitysafety@surreycc.gov.uk

Appendix E: The Seven Golden Rules to Information Sharing

1. Remember that the General Data Protection Regulation (GDPR), Data Protection Act 2018 and human rights law are not barriers to justified information sharing but provide a framework to ensure that personal information about living individuals is shared appropriately.

2. Be open and honest with the individual (and/or their family where appropriate) from the outset about why, what, how and with whom information will, or could be shared, and seek their agreement, unless it is unsafe or inappropriate to do so.

3. Seek advice from other practitioners, or your information governance lead, if you are in any doubt about sharing the information concerned, without disclosing the identity of the individual where possible.

4. Where possible, share information with consent, and where possible, respect the wishes of those who do not consent to having their information shared. Under the GDPR and Data Protection Act 2018 you may share information without consent if, in your judgement, there is a lawful basis to do so, such as where safety may be at risk.You will need to base your judgement on the facts of the case. When you are sharing or requesting personal information from someone, be clear of the basis upon which you are doing so. Where you do not have consent, be mindful that an individual might not expect information to be shared.

5. Consider safety and well-being: base your information sharing decisions on considerations of the safety and well-being of the individual and others who may be affected by their actions.

6. Necessary, proportionate, relevant, adequate, accurate, timely and secure: ensure that the information you share is necessary for the purpose for which you are sharing it, is shared only with those individuals who need to have it, is accurate and up todate, is shared in a timely fashion, and is shared securely.

7. Keep a record of your decision and the reasons for it – whether it is to share information or not. If you decide to share, then record what you have shared, with whom and for what purpose.