CONFIDENTIAL

RUNNYMEDE Community Safety Partnership

Domestic Homicide Review

Angela

2024

Overview Report – Executive Summary

Author: Deborah Cartwright, MSc. Associate of Aegis Safeguarding Services Ltd.

Report concluded: 1.11.24

1. The Review Process

1.1 This summary outlines the process undertaken by a local Surrey Community Safety Partnership domestic homicide review panel in reviewing the death of Angela who was a resident in their area.

1.2 The Community Safety Partnership determined that this executive summary should be limited to key learning due to the ongoing need to safeguard Angela's children and wider family.

1.3 Angela is a pseudonym chosen by her close friends. She was a working woman with children who lost her life to alcohol and drug use after years of coercively controlling abuse by her husband. There were no criminal proceedings as Angela's death was believed to be by suicide. The coroner found her death to be 'alcohol and drug related'.

1.4 The process began, before the coroner's findings, with an initial meeting of the local Community Safety Partnership domestic homicide review steering group in February 2023. Based on the scoping information available a decision to undertake a domestic homicide review was made. All agencies that had contact with Angela and her husband prior to the point of death were contacted and asked to confirm whether they had any involvement with them.

1.5 A total of twenty-five agencies were asked to secure their records and contribute information to the Review for the defined period. All agencies provided a return to the Panel's request, each return was evaluated, and a decision made whether a full account was required by way of an Individual Management Review (IMR) and chronology.

2. Contributors to the Review

2.1. Twenty-five information requests were issued, and more than half had no contact with Angela and/or her husband. The remaining agencies were asked to complete an IMR and chronology. Those agencies were:

- Surrey Police
- Metropolitan Police
- General Practitioner
- Surrey & Borders Partnership Trust
- General & Maternity Hospital
- Central Surrey Health 0-19 Team
- South-East Coast Ambulance Service
- Surrey Adult Social Care (ASC)
- Surrey Education
- Local domestic abuse charities

2.2. The Panel met on six occasions to review the information received, to make an analysis and to review the draft overview report. All panel members were independent of direct or indirect contact with Angela and/ or her family, either in person or via any management responsibility. Agencies represented on the panel were:

- Community Safety Partnership
- Adult Social Care
- Police
- Domestic Abuse Specialist
- Surrey & Borders Partnership Trust (Mental Health)
- Surrey Public Health (Suicide Prevention)
- National Probation Service
- Children's Social Care
- Surrey Heartlands ICB

2.3. Angela's friends contributed to the review through interviews and by making comments on the overview report. Despite attempts to engage Angela's family in the review, these attempts were unsuccessful.

3. Author of the Overview Report

3.1. Following an open commissioning process the local Surrey Community Safety Partnership decided to appoint Deborah Cartwright as the independent Chair and report author for this Review. Ms Cartwright is a former Senior Manager within the Social Sector, with her last substantive role being that of Chief Executive of a large domestic abuse charity. Ms Cartwright has extensive safeguarding practice and knowledge, has worked as a frontline practitioner and senior manager in mental health services, and this being her first Review process, has been mentored throughout by John Ross of Aegis Safeguarding. Ms Cartwright was trained by AAFDA as a domestic homicide Review chair in 2022 and has been subject to the updated training during the life of this report.

3.2. Ms Cartwright is independent of Surrey agencies having not been involved either directly or indirectly with the members of the family concerned or the delivery or management of services by any of the agencies. She has Chaired the meetings of the Panel, the members of which have directed the writing of this Report.

4. Terms of Reference

4.1. The full terms of reference for this review will not be published due to safeguarding concerns for Angela's children and wider family. However, the panel determined a scope for the review that incorporated Angela's early marriage and pregnancies, to understand the emergence of and agency identification and responses to domestic abuse. This was especially relevant as there was initially a lack of clarity as to whether Angela or her husband was the victim of domestic abuse in their household.

4.2. To do so they set key lines of enquiry, in summary these were:

- (Did they) recognise or consider themselves to be a victim of abuse?
- (Did they) recognise or consider themselves to be a perpetrator of abuse?
- Did (they) disclose to anyone and if so, was the response appropriate?

- Was this information recorded and shared where appropriate?
- Were services sensitive to the protected characteristics within the Equality Act 2010 in respect of (all parties)?
- When, and in what way, were (their) wishes and feelings ascertained and considered?
- Is it reasonable to assume that their wishes should have been known?
- (Were they) informed of options/choices to make informed decisions?
- (Were they) signposted to other agencies?
- Was consideration of vulnerability or disability made by professionals in respect of (all parties)
- How accessible were the services for (them)?
- (Were they) subject to a Multi-agency Risk Assessment Conference (MARAC) or any other multiagency forum?
- Did (they) have any contact with a domestic abuse organisation, charity, or helpline?

5. Key issues arising from the review

5.1. It would be usual to include a summary chronology at this point of the document. However, it was the Panel's and Community Safety Partnership's view that disclosing actual details of this timeline could place Angela's children and wider family at risk.

5.2. The summary lessons to be learned found by the Panel were:

- Coercive control can be hidden within patriarchally normalised heterosexual relationships.
- Coercively controlling perpetrators use the state to enact control by making allegations of abuse against their victims and creating fear of the state in their victims.
- Women who experience coercive control within patriarchal systems can have the impacts of that abuse misidentified as poor mental health rather than as symptomatic of abuses.
- The fear of state interventions and the prevailing norms of one's social class requires practitioners to have professional curiosity and a commitment to

triangulate information set within sound knowledge of the dynamics of domestic abuse.

- Victims of domestic abuse may use violent resistance which requires professionals to have regard to the drivers of behaviour rather than working with binary labelling systems (i.e. perpetrator/ victim) as these may cause labelling biases in later incidents.
- Schools must embed trauma-informed practice to balance the prevalent focus on student performance and provide context for performance issues that may enhance safeguarding and opportunities to intervene early for students who are experiencing domestic abuse at home.
- Mental health services must consider the suicide risks faced by those who fall between the gap in crisis and community services with a specific focus on the rigour of discharge plans and service accessibility.
- Practitioners must consider the cultural implications present for families when undertaking direct safeguarding work. These considerations should be cognisant of the background, origins, prevailing beliefs and attitudes, religious belief and potential intersection of belief systems for members of the family.

6. Recommendations from the review

6.1. In line with the requirement for confidentiality, these recommendations have had any defining features removed.

IMR Author Recommendations

Education

i. Establishment of good practice advice, guidance and training for education professionals and associated agencies/professionals to improve understanding of children's home environments and identification and reporting of 'away from home' caring arrangements, both with family and through private fostering methods, through the notification and recording of children staying away from the family home.

ii. Establishment of good practice advice, guidance and training for education professionals and associated agencies/professionals to improve the identification of Young Carers with explicit recognition of gender-normative unconscious bias.

iii. Build on current Trauma Informed Practice Awareness that shapes how vulnerable children access the curriculum.
iv. Establishment of good practice advice, guidance and training for education professionals and associated agencies/professionals to improved professional curiosity through utilising creativity and innovation that captures how we hear the voices of children particularly those for whom the school culture creates inaccessibility.
v. Establishment of good practice advice, guidance, and training for education DSL/DDSL to improve record keeping and analysis of records.
vi. Establishment of good practice advice, guidance, and training for all agencies to improve the timeliness of information sharing between agencies to understand children's lived experience

Children's Social Care

vii. Children's Social Care case supervision to recognise that where parents split and reconcile on more than one occasion and domestic abuse is a repeating feature in child protection referrals, safety planning must recognise the ongoing risk and parallel plan for reemergence of previous risk behaviours.
viii. Children's Social Care practitioners should ensure that where extended family members are viewed as safe adults that their views are sought and incorporated within Child & Family Assessments.

Hospital – Maternity & General

ix. Maternity staff to improve recognition and reporting of adult vulnerabilities during pregnancy through bespoke safeguarding training sessions.
x. Staff to receive safeguarding training and updates with a focus on decision making and ensuring that all referrals are properly documented.
xi. Hospital to ensure staff can engage with specialist domestic abuse training for ongoing development of understanding the continued effects of DA (including physical abuse and coercive control) on survivors.

Surrey & Borders Mental Health Trust

xii. Psychiatric Liaison Service to review and monitor the time scales for referrals to CMHRS following individuals' attendance at A&E departments.

General Practice

xiii. Health Centre to engage with learning from this DHR to consider issues present when working with patients at times of relationship breakdown and whether appropriate consideration has been given to the presence and impacts of domestic abuse, and any required specialist domestic abuse outreach signposting/referrals.

xiv. Surrey G.P.s Level 3 safeguarding training to include awareness of high-risk indicators, such as, separation and risk escalation.

Central Surrey Health

xv. Central Surrey Health 0-19 service to develop a pop-up prompt on community health records ensuring that routine enquiry takes place with associated audits of practice in this area.

Panel Recommendations

xvi. Surrey Police to use the learning from this review to inform training regarding the use of allegations and counter-allegations by perpetrators of domestic abuse that hides the primary victims' experiences.

xvii. Surrey Police to ensure that supervisory reviews include consideration of underlying dynamics of abuse and the potential of violent resistance as a response to coercive control.

xviii. Surrey Police undertake audits of risk reviews, with consideration to the potentially positive impact where these are provided by specialist supervisors as well as the inherent risk of grading down risk which disregards the voice of the victim.

xix. Specialist Children's Services case supervision for children's social care to recognise that relationship breakdown is not necessarily a protective factor where there is domestic abuse.

xx. Adult Social Care to ensure that SCARF referrals are logged on the client database (LAS) and not stored separately, ensuring they are readily available for review.

xxi. All agencies to review their relevant policies regarding the signposting of individuals to other agencies, developing flexible, person-centred responses that include supporting engagement (as opposed to signposting) with consent.

xxii. GPIMHS, and the commissioners of this service, adopt the ICB policy of offering three appointments in a way which ensure that individual reasonable adjustments are considered.

xxiii. Surrey County Council to ensure that cultures where misogynistic norms are prevalent, and may impact on violence against women and girls, are included in the county domestic abuse training offer.

xxiv. Domestic abuse services should be reminded about the importance of notifying Surrey Police about the existence of non-molestation orders, subject to the consent of the individual, even where these are not obtained by the domestic abuse service.

xxv. Surrey Public Health Team to include alcohol screening as a practice recommendation within its updated Suicide Prevention Strategy.

7. Conclusion

It is not possible to say whether the recommendations identified in this review would have changed the outcome for Angela. However, the panel were able to identify some vital learning opportunities that could make the future safer for someone in Angela's position.

The panel offer their sincere condolences to the family of Angela for the sad loss of their mother, daughter, sister, and friend in such tragic circumstances.