RUNNYMEDE Community Safety Partnership

surrey safeguarding ADULTS BOARD

DOMESTIC HOMICIDE REVIEW / SAFEGUARDING ADULTS REVIEW

Into the death of Tracy (Pseudonym)

In March 2022

EXECUTIVE SUMMARY

Independent Review Chair and Report Author
Michelle Baird MBA.BA.
Review Completed: 23 October 2023

CONTENTS

1. THE REVIEW PROCESS

1.1. This summary outlines the process undertaken during the Review into the death of Tracy (pseudonym) who was a resident in an area in Surrey at the time of her death.

1.2. The following pseudonyms have been used for the deceased, her husband and her friend to protect their identities and those of their family members: Tracy (the deceased), Robert (her husband) and Natasha (her friend).

1.3. Tracy, who had a history of poor physical and mental health problems had been the victim of domestic abuse over a number of years. In March 2022, after being missing for 3 days, Tracy was found dead behind a garden shed at her home by her younger child. According to statements provided to the Police, the family had not reported Tracy missing.

1.3.1. An empty diazepam blister pack was found next to Tracy's body along with a coke can and a mobile phone. Tracy's body was lying on top of a blanket.

1.3.2. Tracy's younger child called Tracy's mother who then called the Police. On arrival of the Police and ambulance service, early indications were that Tracy's cause of death was an overdose. Paramedics informed the Police that Tracy's body had been there for some hours and not overnight or longer.

1.4. On 26 September 2022, following a Review undertaken by Surrey Police's Suicide Prevention Lead, Surrey Police notified the Chair of the Runnymede Community Safety Partnership of Tracy's death which occurred in March 2022.

1.5. The Runnymede Community Safety Partnership Chair and Panel noted that the circumstances of Tracy's death may require a Safeguarding Adults Review (SAR) to be conducted. The DHR was delayed until the outcome of the SAR referral was provided to allow for a joint Review to be conducted if required. In January 2023, a decision was taken by the Surrey Safeguarding Adults Board that this would not be a joint Review.

1.6. A decision to undertake a Domestic Homicide Review was taken by the Chair of the Runnymede Community Safety Partnership on 26 January 2023 and the Independent Domestic Homicide Review Chair was appointed on 27 March 2023. A pre-meeting of the DHR was held on 28 March 2023 to agree process, timescales and Terms of Reference.

1.7. The Home Office and the Coroner were informed by the Runnymede Community Safety Partnership of the decision to commission a Domestic Homicide Review on 31 March 2023. A further update was provided to the Home Office by the Review Chair on 18 April 2023 regarding timescales.

1.8. The Review identified a number of safeguarding issues which were to be the subject of a recommendation and drawn to the attention of the Safeguarding Adults Board in order that they be appropriately addressed. A request was then made by the SAB that the Review should now become a combined DHR/SAR. On 28

September 2023, the Chair of the Review sought Home Office agreement for the status of the Review to be amended to a joint Review. This was agreed and further time was granted for the Review.

1.9. A post-mortem was conducted. The toxicology found evidence that Tracy had taken zopiclone, quetiapine and possibly hydroxychloroquine in excess, prior to death. The combination of these drugs may have resulted in acute lethal toxicity. Following the Coroner's inquest hearing in June 2022, Tracy's cause of death was multiple drug toxicity and the conclusion was death was by suicide.

1.10. Seven of the eight agencies contacted confirmed relevant contact and were asked to secure their files.

2. CONTRIBUTORS TO THE REVIEW

2.1. The following eight agencies were contacted:

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

- **Children Social Care Surrey County Council (CSC):** This service had contact with Tracy in 2014 relating to an application made by Tracy to be a foster carer. An IMR was completed which provided background information to Tracy's history. A senior member of organisation is a Panel member.

- **Metropolitan Police Service:** This Police Force had relevant contacts with Tracy and Robert. An IMR was completed, a senior member of this organisation is a Panel member.

- **Office of the Public Guardian:** This organisation had contact with Tracy and were contacted requesting an IMR to be submitted. The Review received no response from them, however, the referrals made by them to Adult Social Care have been included in the Report.

- **Surrey and Borders Partnership NHS Trust (SaBP):** This Trust had contact with Tracy and an IMR was completed. A senior member of this Trust is a Panel member.

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

- **Surrey Police:** This Police Force had relevant contacts with Tracy and Robert. An IMR was completed, a senior member of this organisation is a Panel member.

- **Your Sanctuary:** This organisation had contact with Tracy and an IMR was completed. A senior member of this organisation is a Panel member.

2.2. All IMR Authors have confirmed that they are independent of any direct or

indirect contact with any of the relevant parties subject to this Review.

3. THE REVIEW PANEL MEMBERS

3.1. The Review Panel consists of experienced Senior Officers from relevant statutory and non-statutory agencies, none of whom had any prior contact with Tracy or Robert.

3.2. The Panel Members:

Michelle Baird	Independent Domestic Homicide Review Chair
Katie Walker	Community Safety Manager - Runnymede Borough Council
Sarah McDermott	Manager - Surrey Safeguarding Adults Board
Georgia Tame	Domestic Homicide Review Coordinator - Surrey County Council
Andrew Pope	Statutory Reviews Lead - Surrey Police
Helen Milton	Designated Adult Safeguarding Nurse - Surrey Heartlands Integrated Community Board (ICB) for GPs
Suzannah Townsend	Team Manager - Adult Social Care Surrey County Council
Thomas Stevenson	Assistant Director Quality Practice and Performance Children Social Care - Surrey County Council
Charlotte Underwood	Safeguarding Advisor & Consultant Psychiatrist - Surrey and Borders Partnership NHS Trust (SaBP)
Louise Balmer	Adult Community Lead - Your Sanctuary
Lisa Brothwood	Detective Inspector - Metropolitan Police

The Review Panel had four formal 'Teams' meetings:

- Pre-Meeting - 28th March 2023 (pre-meeting to agree Terms of Reference and Timescales)
- First Panel Meeting - 7th June 2023
- Second Panel Meeting - 4th September 2023
- Third Panel Meeting - 17th October 2023

4. CHAIR AND AUTHOR OF THE OVERVIEW REPORT

4.1. The Chair of this Domestic Homicide / Safeguarding Adults Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Runnymede Community Safety Partnership or the Surrey Safeguarding Adults Board, and is independent of all the agencies involved in the Review. She has had no previous dealings with Tracy or Robert.

4.2. Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-

Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Effective Freedom Techniques (EFT).

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

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

5. TERMS OF REFERENCE

5.1. This Domestic Homicide / 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 Domestic Homicide Reviews.

5.2. Agencies that have had contact with Tracy and/or Robert should:

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

5.3. The Review Panel will consider:

- Each agency's involvement with the following, from January 2017 until the date of Tracy's death in March 2022, as well as all contact prior to that period which may be relevant to domestic abuse, violence, controlling behaviour, self-harm or other mental health issues.

- Tracy who was 58 years of age at date of her death.

- Robert who was 58 years of age at the time of Tracy's death.

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

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

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

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

[1] The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7).

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

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

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

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

- The Review will also highlight good practice.

6. SUMMARY CHRONOLOGY

6.1. The synopsis of the case has been informed by chronologies of the contact agencies had with Tracy and Robert as well as information provided by Natasha, Tracy's friend.

6.2. Tracy was the eldest of two children. She was 10 years old when she witnessed her father collapse whilst the family were on holiday, and described the time following her father's death as "*a blur*". Tracy recalled being aware of her mother worrying about how they were going to manage financially without Tracy's father.

6.3. Tracy met Robert when she was 21 years old and married 3 years later, they had two children.

6.4. The family moved to the United Arab Emirates (UAE) in 2003 before returning to the United Kingdom in 2010. Tracy reported to professionals in the United Kingdom, that she was subjected to domestic abuse by Robert throughout the marriage. This included a significant and violent assault in 2009 whilst living in the UAE, whereby Robert is alleged to have punched and strangled Tracy. She reported to professionals that this resulted in a fractured cheek bone, and a metal plate fitted in her cheek and was hospitalised for two weeks.

6.5. In 2009, whilst living in the UAE, Tracy called Natasha and confided to her about the abuse that Robert had perpetrated against her. Tracy spoke of the assault that occurred in September 2009, Robert allegedly punched Tracy in the face and broke her orbital bone. This assault occurred after Tracy read a '*sex text'* that Robert had sent to "*another woman*".

6.6. Natasha informed the Review Chair, that in the years after the assault, Tracy had disclosed that Robert had refused to take Tracy to the hospital, withheld her

passport and insurance document which resulted in Tracy not being able to attend the hospital on her own. Tracy did not drive and was reliant on Robert's driver to drive her around. Natasha suspected that Robert may had told his driver not to take Tracy to hospital.

6.7. After being in a relationship with Robert for 30 years, Tracy and Robert separated in 2014. They continued to hold joint business ventures despite their separation.

6.8. Tracy had a number of physical health problems, including Systemic Lupus Erythematosus (SLE Lupus)[2], Sjögren's Syndrome[3], primary bilary cirrhohosis[4] and coeliac disease[5].

6.9. In September 2015, Adult Social Care (ASC) became involved with Tracy in relation to her role as a carer for her older child. Tracy wanted to ensure the right care arrangements were put in place for her older child, in anticipation that her physical health conditions may be life-limiting. ASC recorded they intended to carry out a carer's assessment under S10 of the Care Act[6], but this was not completed.

6.10. On several occasions, ASC embarked on work with Tracy on the basis that there were significant issues to be addressed, and concluded that this did not require any formal assessment or action. With the information known to them, they should have seen Tracy as a person with care and support needs.

6.11. Divorce proceedings commenced in 2016 and were lengthy and acrimonious, which weighed very heavily on Tracy's mental health. Tracy had over 50 direct contacts with her GP between January 2016 and March 2022, and the majority of these were related to the ongoing Court proceedings. One of the greatest complexities was Tracy's capacity to understand and engage with the divorce and financial settlement.

6.11.1. There were numerous letters from the Family Court, regarding this and a Court order was issued, requiring Tracy's GP to provide an opinion on whether Tracy lacked capacity in relation to these aspects. The GP described feeling out of their depth with the Court request and sought medico legal support from their medical defence organisation, and was advised that the GP had no alternative but to comply as this was issued as a Court Order.

6.11.2. The GP's opinion was that Tracy *did* lack capacity to follow and engage with the Court proceedings at that time, as evidenced by her chaotic thought processes and self-declared inability to concentrate or remember what the extensive paperwork was about. Tracy was appointed a McKenzie Friend[7] via the Court in June 2018.

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[2] Systemic Lupus Erythematosus (SLE) is an autoimmune condition which can affect many parts of the body, including the skin, joints and internal organs.
[3] Sjögren's Syndrome is a long-term condition that affects parts of the body that produce fluids, like tears and saliva.
[4] An autoimmune disease that attacks the healthy cells and tissues in the liver.
[5] An autoimmune disease that damages the small intestine when gluten is consumed.
[6] Section 10 of the Care Act 2014 requires a local authority to assess whether a carer has needs for support (or is likely to do so in the future), and what those needs are.
[7] A McKenzie Friend is a person who accompanies an individual to Court to help, support and offer advice.

She did go on to have an independent psychiatric evaluation, but this was not until 2021.

6.12. On 4 December 2017, Tracy disclosed multiple historic and unreported domestic abuse incidents perpetrated by Robert during their relationship to the Police. This included the serious assault in 2009.

6.12.1. Tracy provided a statement to the Police on 5 December 2017 with supporting evidence, including a surgeon's report from 2009 and a series of photographs of the bruising to her arm from the assault in 2015-2016. She informed Officers that the delay in her reporting the assaults was that she had "*always been too afraid to report it as the consequences for me would have been too much"*.

6.12.2. A DASH risk assessment was completed with Tracy and graded medium risk. A referral to outreach domestic abuse support was completed and a warning marker/flag was added to Tracy's Police record, identifying her as at medium risk of domestic abuse by Robert.

6.12.3. A Police investigation was undertaken which lasted five months. Robert was voluntary interviewed under caution on 31 January 2018 and denied all the allegations of the assault. Robert stated the bruising to Tracy's arm was a result of her overuse of prescribed steroids for the treatment of Lupus. However, he did state that the injuries she sustained in 2009 were as a result of him defending himself when Tracy attacked him with boiling water.

6.12.4. No further action was taken by Surrey Police due to time limits on the reported offences[8], a lack of supporting evidence and limitations on jurisdiction[9]. Officers recorded that although Tracy had provided supporting photos of the bruising to the arm, they were not time dated. A GP's letter regarding bruising to the arm suggested that the likely cause was from an insect bite and neither the GP's letter nor the surgeon's report suggested that the injuries were inflicted by a physical assault.

6.12.5. A referral from Surrey Police was sent to Your Sanctuary on 7 December 2017. As well as documenting the physical assaults, the referral identified financial abuse by Robert against Tracy. Your Sanctuary attempted to contact Tracy on 8, 11 and 12 December 2017, but there was no answer.

6.13. On 14 December 2017, Your Sanctuary managed to get in contact Tracy. Tracy informed the Outreach Worker that she had "*a lot going on at the moment*". Tracy advised she would like to be added to the list for the Freedom Programme[10] course that was due to take place in March 2018. Tracy was provided with the number for the Your Sanctuary helpline and advised she could contact them if she needed any further support.

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[8] Summary only offences must be commenced within 6 months of the criminal act that is being reported.
[9] Article 44 of the Istanbul Convention extends the jurisdiction of the United Kingdom Courts to be able to prosecute certain violent or sexual offences outside the United Kingdom by a United Kingdom national. The Domestic Abuse Bill 2020 extends the jurisdiction to domestic law.
[10] Freedom Programme is s a course for women who are in, or have experienced, an abusive relationship. The aim of the programme is to help women understand the beliefs held by abusive men, identify and challenge any shared beliefs and help women come to terms with the abuse they have experienced.

6.14. On 15 March 2018, Tracy reported to Surrey Police the theft of £650 million of family shares by Robert. Surrey Police investigated, but concluded this was a civil dispute as it was considered to form part of the divorce proceedings and the matter was filed with no recorded offences. Officers subsequently submitted a SCARF[11] and Vulnerable Adults at Risk Notification (VAAR) on 21 May 2018 due to Tracy appearing "*gaunt and unkempt"*. The Officer had concerns, that Tracy may be struggling to take care of herself.

6.15. Tracy contacted Surrey Police on 10 June 2018 to report financial and controlling abuse perpetrated by Robert. This included Robert closing the joint bank account to prevent Tracy accessing the money. Officers visited Tracy and established her concerns related to financial matters in the ongoing divorce proceedings. No direct evidence of controlling or financial abuse was apparent, and the matter was filed with no offences recorded.

6.16. On 27 June 2018, the Community Mental Health Recovery Services (CMHRS) received a request from Tracy's GP for a specialist mental health referral. A letter was sent to Tracy with a scheduled appointment with a Community Psychiatric Nurse (CPN) for 18 July 2018. Tracy contacted CMHRS on 13 July 2018, stating she was unable to make the appointment on 18 July 2018 and requested this was moved to a date in the future, to allow for her newly prescribed medication to take effect. CMHRS agreed on 18 July 2018 that Tracy could be discharged back to her GP who could re-refer in six to eight weeks' time.

6.16.1. At no point during Tracy's contact with (CMHRS) was there any record of her capacity being assessed or discussed for any specific reason or decision, example safeguarding concerns, her care and support needs or her welfare.

6.16.2. Tracy was deemed to be at low risk from Robert and initially expressed no fear for her safety. She told professionals that she was a victim of historical abuse from Robert, and there was no evidence to suggest that CMHRS identified her as at risk of post-separation abuse from Robert. No discussions were conducted with the Police or MARAC.

6.17. On 17 September 2018, Tracy attended an assessment with CMHRS. She disclosed her past experience of domestic abuse by Robert and that she was struggled to come to terms with the divorce proceedings. Tracy stated that despite the physical abuse she endured she did not want her marriage to end due to her Catholic faith. Whilst in a relationship with Robert she had a high quality of life and now had no money to support her family, to the extent that she had struggled to arrange representation in Court.

6.17.1. CMHRS concluded that there was no specific role for them and provided Tracy with contact details for support services. Tracy was discharged from CMHRS back to her GP on 19 September 2018.

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

6.18. On 2 October 2018, as part of an ongoing investigation by Surrey Police into alleged bigamy by Robert, Surrey Police submitted a SCARF and VAAR for Tracy. The SCARF and VAAR were submitted, after Robert raised concerns over Tracy's ability to care for her older child. These were shared with Adult Social Care.

6.18.1. Within the SCARF, it stated "*She [Tracy] has recently stated that she will commit suicide rather than leave the family property*". The SCARF noted that Tracy had also recently been declared bankrupt and therefore could not act as her older child's Power of Attorney for financial matters.

6.18.2. Adult Social Care MASH noted that Tracy was awaiting a carer's assessment, in light of the divorce. ASC MASH passed the referral to the ASC Locality Team, but the referral was returned to MASH to query whether her older child was open to CMHRS. ASC contacted CMHRS on 8 October 2018 and confirmed that Tracy's older child was not open to them.

6.19. On 12 March 2019, Tracy asked ASC if they could support her older child in gaining a protective order, to prevent Robert from having contact. ASC advised they would be unable to do this, but signposted Tracy to information regarding protective orders for domestic abuse and provided contact information for Your Sanctuary domestic abuse support. Tracy later informed ASC that she attended a week-long course with Your Sanctuary, but this does not appear to be accurate from Your Sanctuary records.

6.20. On 24 May 2019, the Metropolitan Police received a report that Tracy was receiving threats from Robert. This was transferred to Surrey Police and a request for a welfare check for Tracy was made. There was no corresponding record of this in Surrey Police records, primarily due to a change in the Surrey Police internal IT systems.

6.21. Adult Social Care received a referral from the Office of the Public Guardian on 25 May 2021, requesting a home visit be made to check on Tracy's welfare. The referral stated that Tracy "*may be confused*" and was at risk of abuse or neglect.

6.22. On 27 May 2021, Adult Social Care deemed that there was no reasonable cause to suspect Tracy was at risk of abuse or neglect, and that whilst she presented with care and support needs, she had demonstrated an ability to protect herself and contacted appropriate agencies with her concerns. It was recorded that a S9 assessment was proportionate.

6.23. ASC received a further referral from the Office of the Public Guardian on 11 January 2022, raising concerns for Tracy in light of her previous experience of abuse by Robert. ASC concluded that Tracy did not have care and support needs, which was inconsistent with previous assessments and closed the case.

6.24. In March 2022, the day that Tracy went missing, she had a telephone consultation with her GP. Tracy confirmed she had no intention of self-harm or suicide. The GP recorded that Tracy sounded in a good mood, reported she was sleeping well, and her stress was reducing. There was no indication that Tracy needed urgent intervention.

6.25. Sadly, Tracy's younger child found her dead behind a shed in the back garden of her home in March 2022. The younger child informed Officers from Surrey Police that Tracy had previously mentioned thoughts of suicide, although she had stated that "*she would never do this because she was too strong".* An investigation by Surrey Police established that there was no evidence of third-party involvement.

6.26. At the time of Tracy's death, the long, acrimonious divorce proceedings had not yet been concluded.

7. KEY ISSUES AND CONCLUSIONS

7.1. The Review Panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contacts with Tracy and Robert.

7.2. Following her separation from Robert, Tracy disclosed to all agencies that she had suffered domestic abuse perpetrated by Robert. This included a significant assault when Tracy and Robert were living in the United Arab Emirates and further domestic abuse on their return to the United Kingdom.

7.3. The domestic abuse disclosed by Tracy was not recognised by agencies in all its forms. Tracy experienced post-separation abuse. Post-separation abuse can be defined as the ongoing, willful pattern of intimidation of a former intimate partner including legal abuse, economic abuse, threats and endangerment to children, isolation and discrediting and harassment and stalking (Spearman, Hardesty and Campbell, 2022)[12].

7.4. For Tracy, the post-separation abuse she experienced was perpetuated by financial inequality and power and control dynamics through ongoing divorce proceedings. Tracy stated that there were times when she was discredited by Robert (and possibly legal representatives) regarding her mental health. This was further impeded by Tracy being unable to fund a course of action that may have supported her or resulted in signposting to agency provision. This was evident in the suggestion of a privately funded psychologist report regarding her capacity to understand the Court proceedings.

7.5. Although some agencies recognised the resulting impact the divorce proceedings were having on Tracy, no agency identified that Tracy was experiencing post-separation abuse in a wider context. There were missed opportunities for referrals to be made for specialist outreach domestic abuse support services.

7.6. Past experiences of domestic abuse are likely to form an ongoing presence of fear of the perpetrator. For Tracy the post-separation abuse was set against a background of additional stresses such as her caring responsibilities for her older child, her extensive physical health conditions, an ongoing neighbour dispute and mental health concerns.

[12] Spearman KJ, Hardesty JL, Campbell J (2022). 'Post-separation abuse: A concept analysis'. Journal of Advanced Nursing, p1225-1246.

7.7. Tracy's care and support needs were not always recognised and responded to. There were missed opportunities to undertake S9 assessments for Tracy and consideration as to what additional support could be offered to her to keep her safe from abuse.

7.8. Domestic abuse has additional impacts on people with care and support needs. Perpetrators can use a victim's dependency to assert and maintain control. In particular Tracy's physical health conditions and concerns that she needed to ensure the correct support was in place for her older child should her health deteriorate. She also remained financially attached to Robert with shared company assets and the family home in which Tracy and her children continued to reside. Financial dependence was a fear Tracy articulated, having witnessed her mother experiencing this following the loss of Tracy's father. This may have intensified her worries and sense of uncertainty.

7.9. There were a number of missed opportunities to provide Tracy with additional support as a carer for her older child via a carer's assessment. There was a pattern in which Tracy would request support and then advise agencies this was no longer required.

7.10. The stresses that Tracy was experiencing were often attributed to the ongoing divorce proceedings, but few agencies recognised that Tracy may have been experiencing caregiver's stress. Signs of caregiver's stress can include anxiety, becoming easily agitated or angry, feeling low, misusing substances including prescribed medication, missing medical appointments, having frequent health related issues, poor sleep and weight loss or gain.

7.11. Almost all these factors were experienced by Tracy within the Review timeframe, and at times may have been attributed to mental health concerns due to the narrative that Tracy lacked capacity.

8. LESSONS TO BE LEARNED

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

Adult Social Care Surrey County Council (ASC)

8.2. ASC identified that during their work with Tracy, her individual care and support needs were not always identified. This was particularly apparent for Tracy who was experiencing issues with her mental health and emotional wellbeing and had experienced (and was still experiencing) domestic abuse, and there was a known risk of suicide. Tracy's care and support needs were impacting on her personal relationships, caring responsibilities, and her divorce proceedings.

8.3. There was a lack of professional curiosity into the information provided by Tracy. Subsequent partnership working, particularly with Tracy's GP and CMHRS was ineffective and a holistic approach with the family was not undertaken.

8.4. The learning from this Review will be shared with the Quality Improvement Group to explore how this can be improved in the future.

Metropolitan Police Service

8.5. The IMR Author submits that whilst there were some issues identified, these were early on in the Review timeframe. Since that time period, significant changes have been made to the Metropolitan Police Service's public protection policies and therefore, any identified learning is no longer relevant to current practice.

Surrey and Borders Partnership NHS Trust (SaBP)

8.6. SCARF reports were appropriately reviewed, however it was not always clear what actions were taken. There is ongoing work within the Trust around record keeping with a specific focus on risk assessments, care plans and crisis and contingency plans.

8.7. There is a need for increased recognition of post-separation abuse. There is ongoing work within the Trust around domestic abuse, in particular staff training, raising awareness and promoting safeguarding procedures.

8.8. Despite awareness that Tracy was deemed to lack capacity in relation to Court proceedings, there was no consideration given to whether a mental capacity assessment should be undertaken. A briefing for all staff on safeguarding procedures and the Mental Capacity Act will be shared.

8.9. The learning from this Review will be shared through training, internal learning platforms and governance arrangements.

Surrey Heartlands Integrated Care Board (ICB) for GPs

8.10. Whilst Tracy had a positive relationship with her GP, the support she needed went far beyond what would be considered reasonable for one professional to provide. Patients with complex needs can often become reliant on one trusted professional.

8.11. Greater consideration needs to be given to how practices identify their most complex and dependent patients, in order to support both patient and professional. A number of the acute hospital trusts have "high intensity user" teams, and practices should be supported in developing similar internal arrangements. It is worth noting that many practices have some processes in place, and this enables sharing of good practice across primary care networks and GP federations.

8.12. GPs will often support patients at times of relationship breakdowns, including separation and divorce. Consideration should be given to the coexistence of domestic abuse alongside acrimonious separations; both as a reason for the relationship breakdown and as coercive/controlling behaviour through the Courts. Staff need to be empowered in asking and enquiring about post-separation abuse and offering referrals to specialist support services if domestic abuse is found to be a factor.

Surrey Police

8.13. Tracy made a number of disclosures of offences to Surrey Police. The standard of some of the investigations was insufficient with Officers not always following all reasonable lines of enquiry and a delay in the arrest of Robert.

8.14. There were two incidences identified of unhelpful and inappropriate comments made in supervisory reviews during investigations.

8.15. Issues were identified in relation to failure in correctly recording a crime transfer from a neighbouring Police Force.

Your Sanctuary

8.16. Tracy expressed a desire to undertake the Freedom Programme course due to take place in March 2018. There was no follow up from Your Sanctuary to see if Tracy wished to engage with the course and whether Your Sanctuary could arrange this for her. Your Sanctuary need to consider how they can ensure that longer term, future actions are recorded and completed. This is particularly relevant when the case is closed, and no ongoing support is requested.

9. RECOMMENDATIONS

Adult Social Care (ASC)

9.1. ASC will use the learning from this Review to inform the ongoing work of the Safeguarding Improvement Group, which is overseeing this programme of work. In particular, the effectiveness of ASC work to recognise that a person has care and support needs, particularly where:

1) Those needs arise from issues to do with the person's mental or emotional wellbeing.

2) The needs are impacting on outcomes such as developing and maintaining family or other personal relationships; accessing and engaging in work, training, education or volunteering; making use of necessary facilities or services in the local community including public transport and recreational facilities or services; and carrying out any caring responsibilities the adult has for a child.

   - The person who has experienced domestic abuse.
   - There is a risk of suicide.

3) Application of the Mental Capacity Act 2005, particularly in relation to:

   - Situations in which the parent of a person over 16 years old is refusing the offer of an assessment of that person.
   - Risk assessment practice, including assessment of suicide risk.
   - Professional curiosity.
   - Ensuring effective partnership working with others, including mental health services, police and GPs.

Surrey and Borders Partnership NHS Trust (SaBP)

9.2. A briefing for all staff on safeguarding procedures and the Mental Capacity Act to be shared through internal governance arrangements.

9.3. Learning themes from this Review to be shared through training, internal learning platforms and governance arrangements.

9.4. A briefing for all staff to recognise post-separation abuse to be shared across the Trust, within safeguarding internal training and Quality Assurance Group meetings.

Surrey Heartlands Integrated Community Board (ICB) for GPs

9.5. Learning from this DHR to be used to support practices in regularly reviewing "high intensity users" to ensure appropriate support is available to the individual and the professionals involved in their care.

9.6. Learning from this DHR is used to support staff working with patients at times of relationship breakdown and considering if domestic abuse is a factor. Specialist Outreach signposting/referral to be supported when identified as appropriate.

Surrey Police

9.7. To address performance issues identified in relation to inappropriate supervisory comments recorded within investigations. Feedback to be given to Officers concerned and learning to be shared.

9.8. To address performance issue identified in relation to failure to correctly record a crime transfer from a neighbouring police service. Feedback to Officer concerned and appropriate action to be taken if deemed necessary.

9.9. To address performance issues identified in relation to standard of investigation, reasonable lines of enquiry not being followed.

Your Sanctuary

9.10. Your Sanctuary Management team to review the process both as written in policy and as understood 'on the ground' by all staff, in relation to how to ensure any longer term/future actions are recorded and completed. This is particularly relevant when the case is closed as no ongoing support was requested.

9.11. The DHR Panel's recommendations and up to date action plan at the time of concluding the Review on 23 October 2023 are detailed in the template below. After publication of this report, the Runnymede Community Safety Partnership and Surrey Safeguarding Adults Board will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

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
The learning for Adult Social Care from this DHR touches on issues ASC have seen in other reviews. This indicates that these are not issues that ASC will quickly resolve and anticipate a programme of work will be needed. ASC will use the learning from this review to inform the ongoing work of the Safeguarding Improvement Group, which is overseeing this programme of work. In particular, the effectiveness of ASC work to recognise that a person has care and support needs, particularly where: 1) Those needs arise from issues to do with the person's mental or emotional wellbeing. 2) The needs are impacting on outcomes such as developing and maintaining family or other personal relationships; accessing	Local	To present a report to our Safeguarding Improvement Group (SIG) on the learning from this review, so that the SIG can incorporate this learning within its programme of improvement work.	Adult Social Care	The presentation will have been given to our Safeguarding Improvement Group. A series of workshops have been rolled out to the locality managers highlighting the role of assessment in promoting wellbeing and preventing abuse, along with guidance on actions to be taken where there are assessment refusals.	31 Dec 2023 Mar/ Apr 2023	**Action Outstanding** To be timetabled at the SIG in November. **Mar/Apr 2023** Part 1 sessions led by the DASS on: 08/03/2023 15/03/2023 20/03/2023 30/03/2023 Part 2 sessions led by the Principal Social Worker and Head of Safeguarding on: 10/05/2023 12/05/2023 18/05/2023 23/05/2023 01/06/2023 Outcomes are being measured through regular audits and supervision to

and engaging in work, training, education or volunteering; making use of necessary facilities or services in the local community including public transport and recreational facilities or services; and carrying out any caring responsibilities the adult has for a child. • The person who has experienced domestic abuse. • There is a risk of suicide. 3) Application of the Mental Capacity Act 2005, particularly in relation to: • Situations in which the parent of a person over 16 years old is refusing the offer of an assessment of that person. • Risk assessment practice, including assessment of suicide risk. • Professional curiosity. • Ensuring effective partnership working						ensure learning is embedded and is being utilised. The PSW will oversee this work. The themes can be followed up at the following forums: reflective practice sessions, lunch and learn sessions, the Community of practice and the Operational Managers Group meetings. A risk enablement framework is under development.

with others, including mental health services, police and GPs.						
Surrey and Borders Partnership NHS Trust (SaBP) - A briefing for all staff on safeguarding procedures and the Mental Capacity Act to be shared through internal governance arrangements.	Local	Safeguarding training to include the Mental Capacity Act with use of key studies and compliance of the Mental Capacity Act-training will be monitored in the Trust.	SaBP	The Safeguarding team and the Legal team to provide guidance and discussion on complex case discussions. To share national and local updates through the internal governance.	31 Dec 2023	**Action Outstanding** The intended outcome is that staff having gained a better understanding of the MHA and safeguarding procedures will be more confident in dealing with complex cases.
Learning themes from this Review to be shared through training, internal learning platforms and governance arrangements.	Local	Briefing on learning themes to be provided to all Trust staff.	SaBP	Learning from all SARs and DHRs are shared through training, team meetings and internal governance.	31 Dec 2023	**Action Outstanding** Outcome is that staff will through training improve their knowledge and efficiency in such cases.
A briefing for all staff to recognise post-separation abuse to be shared across the Trust, within safeguarding internal training and Quality Assurance Group meetings.	Local	In the Safeguarding training and Ambassadors against domestic abuse meetings to include the signs of post separation abuse.	SaBP	To share information from legal documents such as the Domestic Abuse Statutory Guidance and monitor how it is imbedded in daily practice.	Ongoing	**Ongoing** The intended outcome is that staff will through training and support, improve their understanding and efficiency in dealing with post-separation abuse.
Learning from this DHR to be used to support practices in regularly	Local	Learning is embedded within level 3 safeguarding update training and practice leads'	Surrey Heartlands ICB (for GPs)	Learning is included in next round of training events (autumn 2023-	Late spring 2024.	**Ongoing** The outcome is to improve staff

reviewing "high intensity users" to ensure appropriate support is available to the individual and the professionals involved in their care.		safeguarding supervision sessions.		spring 2024) and quarterly leads' supervision sessions.		understanding of the needs of high intensity users and thereby, enhance the support available to them.
Learning from this DHR is used to support staff working with patients at times of relationship breakdown and considering if domestic abuse is a factor. Specialist Outreach signposting/referral to be supported when identified as appropriate.	Local	Learning is embedded within level 3 safeguarding update training.	Surrey Heartlands ICB (for GPs)	Learning is included in next round of training events (autumn 2023-spring 2024)	Late spring 2024.	**Ongoing** With the intention of making staff more aware of the dangers of relationship breakdown and possible domestic abuse.
To address performance issues identified in relation to inappropriate supervisory comments recorded within investigations. Feedback to be given to Officers concerned and learning to be shared.	Local	Case referred to Senior Manager. Individual feedback not possible due to officers' having left the service. Submission to the bimonthly Surrey and Sussex Investigations and Intelligence Learning Board (IILB) for discussion/force wide communications.	Surrey Police	Learning to be discussed at next scheduled IILB on 23/10/2023.	31 Dec 2023	**Action Outstanding** Sharing the learning through discussion in this manner, should remind Officers of the dangers of ill-considered comments.
To address performance issue identified in relation to failure to correctly record a crime transfer from a neighbouring police service. Feedback to Officer concerned and appropriate action to be taken if deemed necessary.	Local	Case referred to senior manager to provide feedback to the officer concerned and to take appropriate action as deemed necessary.	Surrey Police		31 Dec 2023	**Action Outstanding** The outcome is that this Officer will recognise the importance of correctly recording information in the future.

To address performance issues identified in relation to standard of investigation, reasonable lines of enquiry not being followed.	Local	Provide guidance for officers in relation to conducting effective investigations and the need to pursue all reasonable lines of enquiry when investigating offences.	Surrey Police	The learning point has been included on a learning submission for the next scheduled joint force IILB scheduled on 28/08/2023. Updated guidance/ guidelines released by the College of Policing on 28/08/2023 in relation to improving and conducting effective investigations is to be implemented in police training and to be monitored by the Investigative Improvement Board. This is a new directive.		**Ongoing** The intended outcome is for Officers to improve their investigative skills.
Your Sanctuary Management team to review the process both as written in policy and as understood 'on the ground' by all staff, in relation to how to ensure any longer term/future actions are recorded and completed. This is particularly relevant when the case is closed as no ongoing support was requested.	Local	Review recording of notes and group session requests or the follow through for ongoing support.	Your Sanctuary	New case management system in place to ensure effective note recording. All information regarding clients/survivors recorded on the same platform to ensure consistency of information sharing.	14 Jul 2023	**14 Jul 2023** This has had a very positive impact on how our information is stored and shared internally and externally and has enabled us to follow up on requests for further support.