



Domestic Homicide Review
DHR/SAR Monro December 2021
Executive Summary

Author: Dr Liza Thompson

Commissioned by:
Surrey County Council
Runnymede Borough Council

Review completed: February 2024

1. The Review Process

1.1 This joint Domestic Homicide Review (DHR) and Safeguarding Adult Review (SAR) examines agency responses and support given to Monro, a resident of Town A prior to her death in December 2021.

1.2 On the day of Monro's death, she had returned to her home after staying with extended family during the Christmas period. Monro had been suffering with poor mental health, had been using alcohol and had made suicide attempts in the months leading up to her death. Her children had been staying with family members, following a suicide attempt five days before.

1.3 This DHR/SAR examines the involvement that organisations had with Monro, a woman of Lithuanian nationality who was in her early thirties, between January 2020 and Monro's death. It came to light that Monro had lived outside of Surrey prior to January 2020, and therefore information requests were also sent to those areas for five years prior to her moving to Surrey.

1.4 In accordance with Section 9 of the Domestic Violence, Crime and Victims Act 2004, a Surrey County Council Domestic Homicide Review Core Panel meeting was held on 6th July 2022, where the criteria for a DHR was confirmed to have been met. That agreement has been ratified by the Chair of the Runnymede Community Safety Partnership, and the Home Office were informed on 8th July 2022.

1.5 Monro was not the victim of a homicide (where a person is killed by another). However, this review is framed by the 2016 Home Office Domestic Homicide Review Statutory Guidance which states:

“Where a victim took their own life and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.”

1.6 In addition to the decision to hold a DHR – a SAR referral was made and, in accordance with Section 44 of the Care Act 2014, a Surrey Safeguarding Adults Board decision making panel met on 26th July 2022. It confirmed that the criteria for a SAR had been met.

1.7 A decision was made to jointly run the two reviews and an Independent Chair was commissioned to author both reviews within one process, producing one overall report – with the title of Joint DHR/SAR.

1.8 The detailed information on which this report is based was provided in Independent Management Reports (IMRs) completed by each organisation that had significant involvement with Monro. An IMR is a written document, including a full chronology of the organisation's involvement, which is submitted on a template.

2. Contributing Organisations

2.2 Each IMR was written by a member of staff from the organisation to which it relates and signed off by a senior manager of that organisation, before being submitted to the DHR/SAR Panel. None of the IMR authors or the senior managers had any involvement with Monro during the period covered by the review.

Agency/ Contributor	Contribution	Panel member	Role of panel member
	-	Dr Liza Thompson	Independent Chair
Runnymede Borough Council & Rep for the Community Safety Partnership	-	Katie Walker	Community Safety Manager
Surrey County Council	-	Georgia tame	DHR Coordinator
Surrey Safeguarding Adults Board	-	Sarah McDermott	Safeguarding Adults Board Manager
Surrey Police	IMR Chronology	Andrew Pope	Statutory Reviews Lead
Children Social Care (CSC)	IMR Chronology	Tom Stevenson	Assistance Director, Quality Assurance and Performance
Surrey and Borders Partnership NHS Trust (SaBP)	IMR Chronology	Memory Chingozho	Safeguarding Advanced Practitioner
Your Sanctuary	IMR Chronology	Louise Balmer	Adult Community Service Lead
Adult Social Care (ASC)	IMR Chronology	Clement Guerin	Head of Adult Safeguarding
Surrey and Heartlands ICB	IMR Chronology - on behalf of GP Practices	Rebecca Eells	Designated Safeguarding Nurse Adults
Peterborough Women's Aid <i>Representing Lithuanian specialist service</i>	Provided specialist oversight of the review	Amanda Geraghty	CEO
Hospital A	IMR Chronology	-	-
Hospital B	IMR Chronology	-	-
Southeast and Coast Ambulance Trust (SECamb)	Short report Chronology	-	-

3. Author of the Overview Report

- 3.1. The Independent Author who completed the re-write process is Dr Liza Thompson.
- 3.2. Dr Thompson is an AAFDA accredited Independent Chair, who has extensive experience within the field of domestic abuse, initially as an accredited Independent Domestic Violence Advisor, and later as the Chief Executive of a specialist domestic abuse charity. As well as DHR's, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs). She lectures at Christchurch University Canterbury, delivers domestic abuse and coercive control training to a variety of statutory, voluntary, and private sector agencies, and is the current Independent Chair for the Rochester Diocese Safeguarding Advisor Panel (DSAP). Her doctoral thesis and subsequent publications examine the experiences of abused mothers within the child protection system.
- 3.3. Dr Thompson has no connection with the Community Safety Partnership and agencies involved in this review, other than currently being commissioned to undertake Domestic Homicide Reviews in Surrey.

4. Summary Chronology

- 4.1. Monro was born and brought up in Lithuania and was of Russian heritage. Monro had a younger brother, their parents lived together, and they came to settle in England when she was 16 years old. She went to college when she came to England.
- 4.2. Although Monro told practitioners that she had a happy childhood, she also disclosed to Surrey and Borders Partnership (SaBP) clinicians that she self-harmed following the move to England, indicating some trauma around the move – which came at a particularly formative time as she transitioned into young adulthood.
- 4.3. She had a 9-year relationship with Nojus. They had lived together for three years, and then married. During their relationship there had been periods of separation, which culminated in a divorce in February 2021. Her elder child's father lived outside of the UK and did not see his child.
- 4.4. Monro and Nojus were first involved with police in February 2020 when Monro called for help following an incident at their home. Monro also disclosed two years of violence, and Monro's eldest child disclosed violence from Nojus, who was his stepfather. The following day Monro retracted her statement.
- 4.5. Monro was taken into hospital in May 2020, having been found intoxicated at a local park in the middle of the night. She disclosed going through a divorce and being threatened by her ex-husband. Monro followed up with her GP in July 2020 and stated she had not drunk alcohol since the incident.
- 4.6. The relationship between Monro and Nojus continued and the family moved to Surrey in October 2020. In February 2021, Monro called police to report that Nojus had assaulted her and her elder child. Nojus was arrested, Monro was taken to hospital

and the children were left in the care of their grandparents. Monro was risk assessed by police as medium risk, the children were referred to Children Social Care (CSC) and Monro was referred to the local domestic abuse service. Nojus was released from custody following an interview, he was given bail conditions.

- 4.7. A Children and Families Assessment was completed. Monro engaged with the local domestic abuse service and disclosed a history of abuse.
- 4.8. Nojus reported Monro to police and CSC on various occasions over the following months. CSC remained involved with the family through a Child in Need plan.
- 4.9. In April 2021, Nojus applied to the family courts for a contact order, with conditions attached. Throughout the court papers, Nojus refers to Monro as “unpredictable” and raises her drinking and drug use as a concern. He stated that he did not drink and cited the incident in February 2020 – where he stated Monro had been drinking and he was trying to reason with her. The police records for this incident state that he was in the garden, heavily intoxicated, when they arrived.
- 4.10. In May 2021, Monro took an intentional overdose. The ambulance crew, and the hospital, raised a safeguarding concern for the children as they had been in the house at the time. Monro was seen by the Psychiatry Liaison Team in the hospital, she spoke about the abusive relationship, stated that she was afraid of Nojus and disclosed that the overdose was due to his ongoing harassing behaviour. Monro was assessed as low risk to herself, as she had stated she no longer wanted to harm herself.
- 4.11. A Child in Need meeting was held the following week, where Monro and Nojus agreed to limit their contact to what was necessary to organise child contact.
- 4.12. In June 2021, Monro was conveyed to hospital following a self-harming episode. The children were not with her at the time. A safeguarding referral was made for the children. At hospital Monro saw the Psych Liaison Team and told them she was seeing a private psychologist – Monro was referred to the Home Treatment Team.
- 4.13. Monro was assessed as suffering from low mood and anxiety secondary to ongoing psychosocial stressors. Her low mood and anxiety had been further exacerbated by the increased consumption of alcohol for which it was recorded she would benefit from a referral to i-access. It was agreed to commence on an anti-depressant.
- 4.14. HTT supported Monro throughout July, Monro also engaged with alcohol services, the family court process continued – as did the Child in Need process - and the family social worker tried to support Monro engaging with domestic abuse services.
- 4.15. Monro booked into a privately funded rehabilitation facility in October 2021, for ten days.

- 4.16. The Child in Need process continued throughout October, November and December 2021. During this time, Monro engaged with private therapy sessions provided by the rehabilitation facility.
- 4.17. A family court hearing was held mid-November 2021. The court requested both parties to file final statements and proposals for child arrangements and requested health and CSC reports to be updated. An interim order was made for the younger child to stay with Nojus fortnightly weekends and a hearing was set for February 2022.
- 4.18. In mid-December 2021, Monro's eldest child was found by neighbours in the street at 11pm. He was upset and told them his mother was intoxicated and had been smashing things in the house. Police attended and Monro stated she had been arguing with Nojus, no signs of neglect to the children, or damage to the property were noted, the children were cared for by the grandparents and Nojus from this point until Monro's death.
- 4.19. The following day Monro posted messages on social media which were causing the family concern, police and ambulance were contacted, and upon arrival they found Monro with a large self-inflicted wound. She was cradling a soft toy as if it were a baby. Monro was conveyed to hospital, where she was assessed as suffering alcohol induced psychosis. Monro was referred to alcohol services and discharged home the following day when she was no longer intoxicated. Monro had requested an in-patient admission; however, it was felt by Psych Liaison Team that this was not in her best interests.
- 4.20. Later that day, Monro's parents called an ambulance for Monro as she was sending them photos of self harm. On arrival Monro told the ambulance crew that she was drinking alcohol to deal with her mental health issues, which she believed was untreated as she did not fit any criteria for services. Monro was conveyed to hospital, where she was again seen by Psych Liaison. Monro had taken a packed bag with her, and requested an admission for mental health in-patient support. It was the Christmas period, and she had been at home alone without her children. She was told that she did not fit the criteria for a mental health admission.
- 4.21. Monro stayed with extended family for Christmas, and a couple of days after Boxing Day, she returned home stating she was picking up belongings. When she did not return, her uncle went to her home and found her suspended from the stairs.

5. Conclusions

- 5.1. Monro was not recognised as an adult with care and support needs. She was responded to as a mother with mental health and alcohol issues which impacted on her children.

- 5.2. Monro's children were recognised as her protective factors. When they were no longer in her care, this factor did not appear to be taken into consideration when assessing the risk which she faced from herself.
- 5.3. Monro's children were victims of domestic abuse, as now recognised within the Domestic Abuse Act 2021. Information could have been shared with the 0-19 team, flagging the children as victims of domestic abuse, and specialist support could have been offered to the children, and/or Monro as a family.
- 5.4. Cultural competence is the ability to view the world through the lens of other people, in all their diversity. The review indicates a lack of cultural competency throughout services, when responding to Monro. An assumption was made that because she had lived in the UK for many years, that she would not be affected by her Lithuanian and Russian culture.

6. Lessons to be Learnt

6.1. Surrey Police

- 6.1.1. This case has identified a lack of capacity for the Domestic Abuse Team at Town A to complete PND checks within their unit. The review has learned that timely access to PND checks can be problematic which has the potential to detrimentally impact on the accuracy of assessing risk. Information likely to be revealed by a PND check includes details of a previous incidents involving victim or perpetrator, which has the potential to increase the likelihood of a judicial disposal.
- 6.1.2. An internal study has been made of the allocation of PND licences across the force, and the checks can be made via the Data Bureau – so although there may not always be staff available in each team with the requisite skills, the facility to undertake the checks is available at all times.
- 6.1.3. The requirement to conduct a PND check is included in the investigation check list for all domestic abuse and other high harm investigations, and forms part of all the force's "minimum standards of investigation policy."
- 6.1.4. The review also highlights the availability of a Force Suicide Prevention Advisor; this role effectively supports the policing responses to incidents involving self-harming with intention of ending life. The Advisor reviews all occurrences marked as 'attempted suicide' in accordance with the working definition "*Having gone beyond a merely preparatory act, but for the intervention of someone or something, or a change of mind by the subject, or a failure of the chosen means of suicide to prove lethal, the subject would have died.*" Whilst in this case the occurrences involving Monro were correctly labelled attempted suicides, this is not always the case. Information about the Force Suicide Prevention Advisor role should be shared, along with the working definition of attempted suicide.

6.2. GP Practice A

6.2.1. Monro was not well known to her GP practice, having registered in October 2020 during the Covid-19 pandemic and repeated national lockdowns. There is no indication that Monro had difficulty accessing GP services, and the contacts she did have appear to have been appropriately managed. Monro's experience of domestic abuse, and her mental health, alcohol misuse and self-harming were documented in the GP record - through communication from other health providers.

6.2.2. The contacts of May and June 2021 showed evidence of a positive relationship between Monro and the GP; Monro spoke with candour regarding her difficulties and was able to make appropriate requests for support, through medication and a counselling referral.

6.2.3. The GP records note the safeguarding referrals made by the respective hospitals, but no information regarding the outcome of these was copied to the GP, and no additional information was requested by either Children's or Adults' Social Care. The GP record is the only health record which follows a patient and is key to ensuring safeguarding risks are documented.

6.3. Hospital A

6.3.1. Hospital staff should be supported to feel able to submit MARAC referrals if they identify a patient as being at high risk of harm. Hospital staff should not rely on other agencies involved to assess the situation and refer into MARAC, as they may see or be told more or different information than other professionals.

6.3.2. Monro was not identified by Hospital A as an adult with care and support needs. There were opportunities for referrals into ASC for Monro. Although there were referrals for the children into CSC, the Hospital staff did not recognise that Monro may also need safeguarding.

6.4. Surrey and Borders Partnership Trust

6.4.1. Following Monro's treatment for self-harm at Hospital A on 21st December, she was again conveyed to Hospital A on Christmas Eve. At this time Monro requested an admission, which following a risk assessment was not felt by PLT to be necessary. Monro's risk of suicide was deemed to be low. There did not appear to have been consideration of the cumulative effects of domestic abuse, the ongoing effects of Nojus' controlling behaviour, or the immediate impact of Monro's children not being with her over the Christmas period.

6.4.2. SaBP have been developing a Trust wide knowledge and understanding of domestic abuse, which should support situations such as Monro's in the future. For example, SaBP have introduced a Domestic Abuse Champions forum, which meets four times per year. The purpose of the forum is to empower champions

within their services. Research and updates regarding domestic abuse are shared with the Champions and updates.

6.4.3. Training around domestic abuse specific safeguarding has been part of the SaBP level two and level three safeguarding training for some time. However, this and other reviews have highlighted the need for specialist domestic abuse training, delivered to all staff. There is currently a business case being developed to access and roll out this standalone training throughout the Trust.

6.4.4. There have been recent changes to SystmOne which allows practitioners to view all risk assessments for a patient together. This allows context when assessing risk, and will encourage practitioners, including PLT to take into account non-recent and cumulative risks of harm when assessing a patient's risk from others and risk from themselves.

6.4.5. Think Family Guidance has been developed for SaBP practitioners. This has been shared across the Trust to encourage staff to consider all members of the family when assessing risk, safety planning, and offering services and support.

6.5. Children Social Care

6.5.1. The Family Safeguarding model of practice within Children's Services emphasizes the need to respond to families with support that assists parents to recover and to resume their role as protective and nurturing parents. It could be argued that an earlier formal child protection response using a Child Protection Plan may have gathered a network of support around the family.

6.5.2. As has been seen in other situations, the communication between adult's and children's services occurred because of the contacts initiated by individual professionals, rather than this being an accepted and expected way of sharing information and shaping plans to support and protect all those involved in receiving support. There are ongoing discussions within both departments on how this good practice can be codified and set as an expected standard of good practice.

6.6. Your Sanctuary

6.6.1. When further referrals are received for victim/survivor, following their previous case being closed, follow up contact must always be made, even if the referral does not relate to a new "incident". Your Sanctuary should be delivering a 'needs led' service that victim/survivors can engage with as and when they need.

6.6.2. Since the scoping period for this review, policies and practice have been enhanced regarding referral intakes, and helpline staff taking calls from professionals.

6.6.3. Your Sanctuary Outreach workers have recently been trained in the use of the Homicide and Suicide Timeline¹ and this will further improve practice.

6.6.4. This review has also raised learning regarding professional curiosity. Your Sanctuary have recently introduced professional curiosity training. This will remind and encourage all staff to ask open and inquisitive questions, not just of those they are supporting, but of other practitioners and agencies.

6.6.5. Two new Designated Safeguarding Leads have been introduced. Their role is to advise and support front line staff with safeguarding issues.

6.6.6. Service Managers have reviewed the key topic headings on the OASIS case management system, to ensure staff address specific risk factors, vulnerabilities, care and support needs, at each contact with victim/survivors. This will help staff to dynamically consider risk and will allow for greater insight when making specialist service referrals outside of the organisation.

6.6.7. This review also raised learning for the Your sanctuary Helpline, following a call from Monro's social worker in June 2021. There was no discussion or exploration with the social worker, and no further action was taken, despite the social worker attempting to access specialist help from Monro.

6.6.8. Helpline staff have been retrained, and they have also attended internal professional curiosity training, to encourage exploratory questioning.

7. Recommendations

7.1. Multi-Agency Recommendations

7.1.1. Surrey Safeguarding Adults Board (SSAB) will review their policies and procedures to ensure there is a section covering domestic abuse and adults at risk, for access by all local partners. This should include the identification of coercive and controlling behaviours, and the effects of non-recent experiences of domestic abuse.

7.1.2. A scoping exercise will be undertaken to identify the current available guidance available to assist professionals in identifying care and support needs. Any guidance which is identified as being suitable for multiagency use, will then be shared with all partners for use by their staff.

7.1.3. CSC and ASC teams will be reminded of the importance of keeping a person/family's GP Practice up to date with details of safeguarding concerns, in line with existing policies and procedures.

¹ Professor Jane Monckton-Smith

- 7.1.4. A scoping exercise will be undertaken to identify services available for children who are victims of domestic abuse, with a view to raising awareness with the public.
- 7.1.5. A multi-agency “Suicide and Domestic Abuse” learning event will be delivered, bringing together learning from this review, alongside thematic learning from similar reviews in Surrey.
- 7.1.6. A multi-agency learning briefing tool will be developed, addressing the following learning points:
- i) The benefits of convening a multi-agency professionals meeting where domestic abuse is identified as a factor for an adult, where other multi-agency forum/mechanisms are not triggered, and where the adult consents to the information being shared within a multi-agency meeting.
 - ii) Awareness of Surrey Adults Matters
 - iii) Recognition of the ongoing effects of domestic abuse following the end of a relationship.
 - iv) Utilising translation apps and programmes to translate the Healthy Surrey domestic abuse information for people with English as their second language.

7.2. Surrey and Borders Partnership Trust

- 7.2.1. SaBP will introduce standalone domestic abuse training for their practitioners. This will include learning around the cumulative effects of non-recent abuse, and the ongoing effects of harassment from ex-partners.
- 7.2.2. A learning event from this review will be delivered to the SaBP Domestic Abuse Champions Forum. The event will reiterate the learning from the multi-agency learning event referenced at 18.1.5.
- 7.2.3. A briefing will be developed for dissemination to all SaBP staff. This will focus on the link between domestic abuse and suicide, issues linked to patients identifying their children as protective factors, and the mental health effects of ongoing harassment from ex-partners.
- 7.2.4. SaBP will develop an agency specific Professional Curiosity Resource Pack, which will be available on the Trust’s intranet.

7.3. Your Sanctuary

- 7.3.1. For Your Sanctuary to improve their risk assessment processes during triage calls. To take into consideration factors such as barriers that survivors may face in accessing services.
- 7.3.2. To increase knowledge and awareness of child safeguarding risk indicators and escalation processes within the Adult Outreach Team. To increase knowledge of civil orders as part of safety planning with survivors.

7.4. Surrey County Council

- 7.4.1. Cultural aspects of domestic abuse will be introduced into the Surrey County Council domestic abuse training offer.

7.5. Adult Social Care

- 7.5.1. A learning tool will be developed and shared with social workers in reflective practice sessions, specifically addressing identification of care and support need and appropriate assessment, signposting and collaborative work with partner agencies.
- 7.5.2. The legal team will produce guidance for social workers engaged with the coronial process.

