RUNNYMEDE Community Safety Partnership

surrey safeguarding ADULTS BOARD

Domestic Homicide Review
DHR/SAR Monro December 2021
Overview Report

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Commissioned by:
Surrey County Council
Runnymede Borough Council

Review completed: February 2024

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The Runnymede Community Safety Partnership, Surrey Safeguarding Adult Board, the Independent Chair, and all agencies involved in this review extend their deepest condolences to Monro’s family and friends.

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1. Introduction

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.

2. Confidentiality

2.1 The findings of this DHR/SAR are confidential. Information is available only to participating officers/professionals and their line managers, until after the Review has been approved by the Home Office Quality Assurance Panel and published.

22 Dissemination is addressed in section 11 below. As recommended by the statutory guidance, pseudonyms have been used and precise dates obscured to protect the identities of those involved. Pseudonyms have been provided and agreed by Monro's family.

2.2 Details of the deceased and perpetrator:

Name (Pseudonym)	**Gender**	**Age at time of death**	**Relationship to deceased**	**Ethnicity**
Monro	Female	Early 30's	*Deceased*	Lithuanian
Nojus	Male	Late 30's	*Ex-husband*	Lithuanian

2.3 The following individuals/family members were known to the Review Panel and have been given the following pseudonyms to protect their identity:

Pseudonym	**Relation to deceased:**	**Relation to perpetrator:**
Elder Child	Child	Step-child
Younger Child	Child	Child

3. Timescales

3.1. A DHR referral was made by Surrey Police in July 2022. There was a delay in the referral being made, whilst police ascertained the presence of coercive and controlling behaviour. Whilst the evidence available did not reach the evidential threshold to charge Nojus, the information held indicated that prior to her death Monro had disclosed to various professionals that she had been subjected to domestic abuse.

3.2. As detailed above, the DHR and SAR criteria were met on 6th July 2022 and 26th July 2022 respectively, at the latter meeting it was agreed that a joint review would take place.

3.3. Following a recruitment process, the Independent Chair was appointed on 6th October 2022, and agency summaries of information were requested. The initial panel meeting was held on 17th November 2022, where Terms of Reference were set, and agencies were requested to complete Independent Management Reports (IMRs).

3.4. The deadline for IMR returns was set for end of January 2023, and following some delays, all IMRs were received by the end of April 2023.

3.5. The panel reviewed the IMRs on 5th May 2023, and additional information required was provided to the Independent Chair, ahead of the initial report draft being completed in July 2023.

3.6. The review process was completed in February 2024.

4. Methodology

4.1 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.

4.2. Each IMR was written by a member of staff from the organisation to which it relates. Each was signed off by a Senior Manager of that organisation before being submitted to the DHR Panel. Neither the IMR Authors nor the Senior Managers had any involvement with Monro the period covered by the review.

5. Terms of Reference

5.1 The Review Panel first met on 17th November 2022 to consider draft Terms of Reference, the scope of the DHR and those organisations whose involvement would be examined. The Terms of Reference were agreed subsequently by correspondence and form Appendix A of this report.

5.2 The Purpose of a DHR

5.2.1 The purpose of a DHR (as described in Section 2, paragraph 7 of the Home Office Guidance[1]) is to:

a. establish what lessons are to be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims.
b. 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.
c. apply these lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
d. prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity.
e. contribute to a better understanding of the nature of domestic violence and abuse; and
f. highlight good practice.

[1] Domestic homicide reviews: statutory guidance - GOV.UK (www.gov.uk)

5.3 The Purpose of a SAR

5.3.1 The purpose of a SAR (As described in Chapter 14, Section 14.164 of the Care Act Statutory Guidance[2])

a. The promotion of effective learning and improvement actions
b. Prevention of future deaths or serious harm occurring again
c. Providing insights into the way organisations work together to prevent and reduce the abuse and neglect of adults.
d. To highlight and explore good practice.

5.4 The Focus of a DHR

5.4.1 Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions.[3]

5.4.2 A successful DHR should go beyond focusing on the conduct of individuals and whether procedure was followed to evaluate whether the procedure / policy was sound. Does it operate in the best interests of victims? Could an adjustment in policy or procedure have secured a better outcome for the victim? This investigative technique is sometimes referred to as professional curiosity.[4]

5.4.3 The rationale for the review includes ensuring that agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources and interventions with an aim to avoid future incidents of domestic homicide and violence. The review will also assess whether agencies have sufficient and robust procedures and protocols in place which were understood and adhered to by their staff.[5]

5.5 The Focus of a SAR

5.5.1 There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.

5.5.2 The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.

[2] Safeguarding Adults Reviews (SAR) - Surrey Safeguarding Adults Board (surreysab.org.uk)
[3] Sec 2, Para. 8:
[4] Sec. 2. Para. 10:
[5] Sec. 2, Para.12:

5.5.3 Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.

5.5.4 Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.

5.5.5 Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

5.6 Specific Issues to be Addressed.

i. Were practitioners sensitive to the needs of Monro – were they knowledgeable about potential indicators of domestic abuse and aware of what to do if they had concerns about a victim? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

ii. Did organisations have an understanding of Monro's care and support needs and the impact they had on her, and did they act upon this? If not, why was this?"

iii. How well did organisations work together to safeguarding Monro – in the context of her mental health, alcohol misuse and experiences of domestic abuse?

iv. How accessible were the services to Monro?

v. How was Monro's risk of suicide assessed, and how were these assessments acted upon?

vi. Did the agency have policies and procedures for Domestic Abuse, Stalking and Harassment (DASH) risk assessment and risk management for domestic abuse victims or perpetrators, and were those assessments correctly used in the case of Monro and Nojus? Did the agency have policies and procedures in place for dealing with concerns about domestic abuse? Were these assessment tools, procedures and policies professionally accepted as being effective? Was Monro and Nojus subject to a MARAC or other multi-agency fora?

vii. Did the agency comply with domestic violence and abuse protocols agreed with other agencies including any information sharing protocols?

viii. What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed and professional way?

ix. Did actions or risk management plans fit with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

x. When, and in what way, were the victim's wishes and feelings ascertained and considered? Is it reasonable to assume that the wishes of the victim should have

been known? Was the victim informed of options/choices to make informed decisions? Were they signposted to other agencies?

xi. Was anything known about the perpetrator? For example, were they being managed under MAPPA? Were there any injunctions or protection orders that were, or previously had been, in place?

xii. Had the victim disclosed to any practitioners or professionals and, if so, was the response appropriate? Was this information recorded and shared as appropriate?

xiii. What is known about Monro's engagement with services when she lived outside of Surrey? Was information recorded and shared as appropriate?

xiv. Were procedures sensitive to the ethnic, cultural, linguistic and religious identity of the victim? Was consideration for vulnerability and disability necessary? Were any of the other protected characteristics relevant in this case?

xv. Were senior managers or other agencies and professionals involved at the appropriate points?

xvi. What was the impact of the domestic abuse, and Monro's mental health, suicide attempts and alcohol issues on the children?

xvii. How well did adult and children services (not only social care) interface? In what ways did the different assessments and criteria differ and did these present barriers for cross-agency working – including cross border working.

xviii. What learning can be identified, from this case and from other cases, around the link between capacity and problematic alcohol use?

xix. Are there lessons to be learned from this case relating to the way in which an agency or agencies worked to safeguard Monro and promote her welfare, or the way it identified, assessed and managed the risks posed by Nojus?

xx. Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

xxi. Did any staff make use of available training?

xxii. What was the impact of Covid-19 restrictions on Monro and the children, in terms of isolation/home schooling?

xxiii. What impact did the Covid-19 restrictions have on Monro's access to services, and to services' responses to Monro?

6. Involvement of Family Members and Friends

6.1. The Independent Chair, and member of the Council's Community Safety Partnership visited Monro's family in January 2023.

6.2. Monro's mother, father and brother were very generous with their memories of Monro. They also asked why Monro had not been admitted as an inpatient due to her mental health issues, they stated that Monro had been asking for help and wanted to be hospitalised. They felt that leaving Monro within the community made it hard for her to stop using alcohol, and they equated her mental health issues with her alcohol use.

6.3. Monro equated her alcohol use with her mental health issues, stating that she only used alcohol due to her mental health issues. These co-occurring issues would have made it difficult to treat Monro.

6.4. Following the meeting, Monro's family declined a referral into AAFDA for an advocate. Following the IMR review meeting in May 2023, the Chair again contacted the family to ask if they had given some thought about the AAFDA advocate. The family did not respond to the email.

6.5. The family were contacted again in July 2023 for a pseudonym.

6.6. Upon completion of the report in February 2024 – the family were provided with a copy of the overview report, translated into Russian. In May 2024, Monro's father confirm that he was content with review and the findings.

7. Contributing Organisations

7.1 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.

7.2 Each of the following organisations contributed to the review:

Agency/ Contributor	Service accessed	Service description/criteria	Source of information
Surrey Police	Control Room Staff	A facility in each police force where call operators answer telephone calls from the public.	Staff interviews with Domestic Abuse Team members. Surrey Police Intergraph Computer Aided Dispatcher (ICAD)[6]
	Response Team Officers	Teams of officers responding to emergency and non-emergency calls from the public.	Surrey Police crime information system known as NICHE[7] Police National Computer (PNC)[8] Police National Database (PND)[9]
	Safer Neighbourhood Officers	Small team of police officers and community support officers, dedicated to policing a certain community or area.	
	The Safeguarding Investigation Unit (SIU)	the SIU manages incidents which involve child abuse, domestic abuse and vulnerable adults.	
	Single Combined Assessment of Risk Form (SCARF)	A digital form used by Surrey Police to assess and manage risks related to vulnerable individuals.	
Children Social Care (CSC)	Child in Need Child Protection	Section 17 Children Act 1989 Section 47 Children Act 1989	LCS – record management system Wisdom - where external and internal documents are uploaded. Review of the supervision records, case notes and communication from other partners.

Hospital A	Emergency Department (ED) Ophthalmology clinic	From November 2020 Following incident in February 2021	ED records
Hospital B	Emergency Department (ED) Ultrasound	Last attendance May 2020 Monro accessed this during pregnancy with youngest child	ED records
Surrey and Borders Partnership NHS Trust (SaBP)	i-access Home Treatment Team (HTT) Psychiatric Liaison Team (PLT) Early Intervention in Psychosis (EIIP),	Durg and alcohol services – offering a range of drug and alcohol support and treatment options. Working in general hospitals, with any patient within the hospital who requires psychological help to manage their condition.	Information obtained from the SystmOne (S1) electronic records.
Your Sanctuary	Surrey based domestic abuse charity. Part of Surrey Domestic Abuse Partnership. Independent Domestic Abuse Advisor (IDVA) Hospital IDVA (HIDVA)	Supporting high risk victims of domestic abuse Situated in Hospitals in Surrey – able to	OASIS Case management system Also accessed: Training records for the three involved staff members Police Outreach Referral forms Outreach referral from social worker

[6]This system records all urgent (999) and non-urgent (101) calls to the Surrey Police Contact Centre

[7]Records all crime, non-crime incidents and intelligence pertaining to individuals who come to police notice in Surrey, all reports (SCARF, Dash, minutes of meetings, statements etc are uploaded to Niche files

[8]National police system that records details of warning signals, arrests, convictions and non-convictions

[9] National system that contains up-to-date information drawn from local crime, custody, intelligence, son abuse and domestic abuse systems.

	Helpline Community Outreach Service	take direct referrals from staff for patients attending hospital. Available between 9am and 9pm, every day of the year. Offering information, support and advice. Supporting victims of abuse, who are assessed at any level of risk.	Outreach/Helpline Suicide Prevention Protocol. Risk Assessment and Risk Management of Service Users Policy.
South East and Coast Ambulance Trust (SECAmb)	Ambulance service	Paramedics	CAD (Computer Aided Dispatch) records Patient Clinical Records Safeguarding Records on Datix
Adult Social Care (ASC)	Duty team	Work required under the Care Act 2014: Assessments of care and support needs under s9 Care Act 2014. An assessment may lead to provision of services to that person under s18 or s19 Care Act Adult safeguarding enquiries under s42 Care Act Provision of information and advice under s4 Care Act	LiquidLogic Adults System (LAS) – record management system Wisdom – where external and internal documents are uploaded.

Surrey and Heartlands ICB – completed IMR on behalf of GP Practices	Registered at GP Practice A – out of area – until October 2020 when she moved to Surrey. From October 2020 onwards registered at GP Practice B	General medical advice and routine appointments	Electronic and paper files Involvement of safeguarding leads for the practices.

8. Review Panel Members

8.1 The Review Panel was made up of an Independent Chair and senior representatives of organisations that had relevant contact with Monro. Panel members did not have any contact with Monro or her family. The panel met on five occasions during the review.

8.2 The members of the panel were:

Agency	**Name**	**Job Title**
Independent Chair & Author	Liza Thompson	
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
Adult Social Care	Clement Guerin	Head of Adult Safeguarding
Children's Social Care	Tom Stevenson	Assistance Director, Quality Assurance & Performance
Surrey Police	Andrew Pope	Statutory Reviews Lead
Surrey Heartlands Integrated Care Board	Rebecca Eells	Designated Safeguarding Nurse Adults
Your Sanctuary	Louise Balmer	Adult Community Service Lead
Surrey and Borders Partnership Trust	Memory Chingozho	Safeguarding Advanced Practitioner
Peterborough Women's Aid (providing specialist oversight of review)	Amanda Geraghty	CEO Representing Lithuanian specialist service

9. Independent Chair

9.1. The Independent Chair, who is also the Author of this Overview Report, is Dr Liza Thompson.

9.2. 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 DHRs, Dr Thompson also chairs and authors Safeguarding Adult Reviews (SARs) which has also assisted with this review. She 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, and she currently convenes a domestic abuse and sexual violence module at Canterbury Christchurch University.

9.3. 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.

10. Other Reviews/Investigations

10.1. The coroner inquest was heard on 9th November 2023. The Coroner concluded that Monro had died by suicide.

10.2. In the summing up, the Coroner stated that Monro had a recent history of alcohol excess due to stress factors in her life, and was known to mental health services from May 2021. Munto did not leave an indication of her intention to end her life. She had consumed sufficient quantities of alcohol to cause notable drunkenness at the time of her death.

11. Publication

11.1 This overview report will be published on the websites of Runnymede Community Safety Partnership, and Surrey Safeguarding Adult Board.

11.2. Family members will be provided with the website addresses and offered hard copies of the report.

11.3 Further dissemination will include:

- Runnymede Community Safety Partnership
- Surrey Safeguarding Children Partnership
- Surrey Safeguarding Adults Board
- Surrey Community Safety Board
- Surrey DHR Oversight Group
- Surrey Domestic Abuse Management Board
- The Leader of Runnymede Council
- The Office of Surrey Police & Crime Commissioner (OPCC)

- Domestic Abuse Commissioner
- The agencies involved on the DHR Panel

12. Equality and Diversity

12.1 The panel considered the protected characteristics of age, disability, gender reassignment, marriage and civil partnership, maternity, race, religion and belief, sex and sexual orientation[10] – and which of these characteristics may have shaped Monro's life experiences.

12.2 The panel agreed that the characteristics of sex would have shaped Monro's experiences – as she was a woman, affected by male violence, and a mother.

12.3 Gender is the term used to refer to the socially constructed cluster of characteristics,[11] or norms, which are deemed to be masculine or feminine. Although a separate concept from the biological definitions of male and female, gender is interlinked with sex because gendered norms are based upon what is expected of each sex.[12]

12.4 Attributed masculine characteristics include toughness and the expectation that men will be violent.[13] Germaine Greer argues that women are expected to be submissive in order to fulfil male fantasies of what is female "normality."[14] This includes an expectation of the inevitability of male violence[15] and the belief that women need to be protected by other men from this violence.[16]

12.5 The fear of male violence in society and in the home therefore puts men in the position of either predator or protector of women. Jennifer Nedelsky argues that this culture of male violence is a constitutive force which shapes women's and men's lives.[17] Women take the fear of male violence for granted; they structure their lives in a way that aims to mitigate the risk of being a victim of this inevitable violence.[18] Yet many in society continue to deny the gendered nature of violence against women.[19]

12.6 The effects of incidents of male violence shape women's relationships on two levels. The individual woman's feelings of violation and shame exist on one level, whilst society's reaction to the violence, which amounts to judgement, minimisation, and shame, exists on a deeper level. Elizabeth Stanko argues that on both levels women view themselves, and in turn other women, through the lens of the male dominated ideology of how women should

[10] Equality Act 2010
[11] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56
[12] Greenberg, J A "Defining Male and Female, Intersexuality and the Collision Between Law and Biology" *Arizona Law Review* 42 (1999) p.265
[13] Hearn, J *The Violence of Men* (1998) p.36
[14] Greer, G *The Female Eunuch* (1993) p.11
[15] Stanko, E *Intimate Intrusions: Women's Experience of Male Violence* (1985) p.9
[16] Nedelsky, J *Laws Relations: A Relational Theory of Self, Autonomy and Law* (2011) p.210
[17] *Ibid* p.204
[18] Stanko, above n 7 p.70
[19] Monckton, J, Williams, A and Mullane, F *Domestic Abuse, Homicide and Gender* (2014) p.19

behave.[20] This gendered view about women's involvement in male violence which dictates that "good women avoid sexual and physical abuse; bad women don't"[21] is prevalent throughout institutional, societal and individual relationships.

12.7 There is also a societal expectation upon women to be caregivers and Martha Fineman argues that "women's historic roles in the family anchor them to that institution in ways that men's historic roles do not."[22]

12.8 The role of a "mother" is a universally possessed symbol[23] and has a value attached to it. Motherhood itself is affected by gendered norms to a greater extent than fatherhood.[24] As Alison Diduck argues, there is an assumption in the relationship between a mother and her child of "never-ending love…timeless and universal duty… (a) romantic ideal…"[25] This gendered expectation of motherhood structures the mothers' lives inside and outside of the home – and more acutely when the mother is also a victim of domestic abuse.

12.9 Mothers are expected to protect children even if the family's difficulties are caused by other people.[26] A failure to measure up to this expectation can easily be construed as "pathological",[27] potentially leading to the removal of the children from the mother's care.[28]

12.10 It is recorded in the Metropolitan Police files that in 2020 when Monro reported Nojus for an assault, she withdrew her statement as she was financially dependent upon Nojus and did not want repercussions. It is also recorded throughout the files that Monro was not employed, and Nojus also cited her dependency upon him in the CA100 form he completed for the family court.

12.11 The protected characteristics of sex and marriage intersect at the point of post-separation financial abuse. Upon marriage both parties are extended rights to one another's finances and income, unless an agreement to override these rights is reached before the marriage in the form of a pre-nuptial agreement.[29]

12.12 The Domestic Abuse Act 2021 recognises economic and financial abuse as specific forms of abuse. Financial abuse involves the misuse of money in order to limit and control another person's current or future actions or freedom of choice.[30] Although financial or economic abuse do not appear to be explicit factors within this review, financial dependency

[20] Stanko, above n 7 p.72
[21] *ibid*
[22] Fineman, M A *The Autonomy Myth: A Theory of Independence* (2004) p.56
[23]Fineman, M "The Neutered Mother" *University of Miami Law Review* 46 (1992) pp.653-54
[24]Boyd, S "Gendering Legal Parenthood: Bio-Genetic Ties, Intentionality and Responsibility" *Windsor Yearbook of Access to Justice* 25 (1) (2007) p.65
[25] Diduck, A *Law's Families* (2003) p.83
[26]Scourfield, J "Constructing Women in Child Protection Work" Child and Family Social Work 6 (2001) p.82
[27] Clarke, K "Childhood, Parenting and Early Intervention: A Critical Examination of the Sure Start National Programme" Critical Social Policy 26 (2006) p.701
[28] Scourfield above n8 p.78
[29] Uniform Premarital Agreement Act 1983
[30] Financial and economic abuse - Women's Aid (womensaid.org.uk)

upon Nojus was a factor in Monro's life and would have shaped her decisions and experiences.

12.13 Although the challenges Monro faced with mental ill health, and subsequently with alcohol misuse are not included in the Equality Act's protected characteristics, it could be argued that Monro's experiences of both of these issues made her particularly vulnerable and would have shaped her life experiences.

12.16. The Government recognise that there are often associations between complex needs and domestic abuse.[31] The 2016 National Crime Survey revealed adults who had taken illicit drugs in the last year are more likely to report being a victim of partner abuse[32] and substance use features in around half of intimate partner homicides.[33]

12.17. Recently published Home Office research of DHRs spanning 2020-2021 found that 58% of victims within DHRs were recorded with at least one vulnerability, and 31% of victims had more than one vulnerability.

12.18. However, the relationship between problematic alcohol use, mental health and domestic abuse is not straight forward.[34] Mental health issues resulting from the psychological distress of domestic abuse may lead to the use of alcohol as a coping mechanism. [35]

12.19. Monro was Lithuanian, she had moved to the UK with her family when she was a teenager.

12.20. As a country, Lithuania had the highest alcohol consumption rates in the early 2000s, which led to alcohol policies being introduced which have recently been hailed a success by the World Health Organisation.[36] Lithuania also has a very high suicide rate - in 2018, there were 32.7 deaths by suicide per 100,000[37] – this was the world's highest rate, and more than twice the worlds average. [38] There are links between alcohol use and suicide which remain an issue,[39] and there also remains a stigma around mental health

[31] Home Office *Transforming the Response to Domestic Abuse* (2018) p.10
[32] Gadd, D et al "The Dynamics pf Domestic Abuse and Drug and Alcohol Dependency" *The British Journal of Criminology* (59) (2019) p1037
[33] Robinson, A et al "Findings from a Thematic Review into Adult Deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews" *Cardiff University* (2018)
[34] Gadd et al above n 25
[35] Iverson K et al "Predictors of Intimate Partner Violence Revictimisation: The Relative Impact of Distinct PTSD Symptoms, Disassociation and Coping Strategies" *Journal of Traumatic Stress* (2013)
[36] Alcohol Policy Development: Three Country Success Stories - Movendi International
[37] Stumbrys, D et al "The Burden of Mental Health-Related Mortality in the Baltic States in 2007-2018" *BMC Public Health* (2022)
[38] World Bank: Improved Provision of Mental Health Services Benefit Lithuanian Youth
[39] Jokubonis, D "Alcohol Use and Suicide in Lithuania, Shouting Out Loud" *Eurpopean Psychiatry* 66 (2023)

throughout Lithuanian society.[40] Community based mental health care which has been set up to tackle the issues, has not been very successful, partly due to the mental health system remaining hospital-centric, with few care pathways for community based support.[41]

12.21. There is evidence that domestic abuse continues to be prevalent across Eastern Europe[42] Lithuanian national crime data indicates that 24% of women have been or will be a victim of domestic abuse in their lifetime. However, domestic abuse is not recognised as a specific offence in Lithuania and is an optional additional "variable" to be included on crime reports, at the discretion of police officers investigating crimes. For this reason, national crime data is not a reliable source for identifying prevalence of domestic abuse in Lithuania. There may have been some level of acceptance by Monro, and her family, of the inevitability of Nojus' controlling and abusive behaviour.[43] Research has indicated that 51.2% of women have or will be victims of domestic abuse, and that 50% of this abuse will be psychological.[44] Other sources state that in Lithuania violence within a domestic setting is the second most common crime in Lithuania.[45]

12.22. Economic abuse and sexual abuse remain largely unrecognised by lawmakers, society, and individuals within Lithuania. This lack of recognition is rooted in the patriarchal context and gendered condition of Lithuanian society. Women in contemporary Lithuania still tend not to seek professional help for abuse, regardless of the endemic prevalence of the abuse they experience.[46]

12.23. Although Monro had lived in the UK since she was a teenager, her Lithuanian nationality would have shaped her experiences and her outlook on life. It is recorded that she spoke mostly Lithuanian or Russian at home. Presumably as her family – including Nojus - were all Lithuanian they continued to observe the cultures and tradition of their home country, and her friendship groups may have been made up of people with a similar background and heritage.

13. Background Information

13.1. As detailed above, 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

[40] Sumskiene, E "Stigma as an Obstacle to Paradigm Change in Mental health Care in Lithuania" *European Psychiatry* (41) (2017)
[41] The provision of community-based mental health care in Lithuania | en | OECD
[42]https://emerging-europe.com/news/traditional-narratives-continue-to-roll-back-womens-rights-in-eastern-europe-and-central-asia/
[43] European Institute for Gender Equality *Data Collection on Intimate Partner Violence by the Police and Justice Sector* (2018) Data collection on intimate partner violence by the police and justice sectors: Lithuania | European Institute for Gender Equality (europa.eu)
[44] Žukauskienė R et al "Prevalence and Patterns of Intimate Partner Violence in a Nationally Representative Sample in Lithuania" *Journal of Family Violence* (2021) 36 pp.117-130
[45]https://www.lrt.lt/en/news-in-english/19/1119436/domestic-violence-second-most-common-crime-in-lithuania
[46] Grigaitè, U et al "Between Experience and Social 'Norms', Identification and Compliance: Economic and Sexual Intimate Partner Violence Against women in Lithuania" *Journal of Gender Based Violence* (2019) pp.303-321

settle in England when she was 16 years old. She went to college when she came to England.

13.2. 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.

13.3. 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.

13.4. Her elder child's father lived outside of the UK and did not see his child.

13.5. Monro had a close relationship with her parents, and her grandmother – all of whom lived in the Surrey area and offered Monro support throughout the period of the review.

13.6. There were no financial concerns raised, apart from Monro stating she was financially dependent upon Nojus, and Nojus citing Monro's lack of employment in the family court papers. Monro is reported to have been involved in a cleaning business with her mother and also had some form of partnership in a restaurant business, although the details of this are unclear.

13.7. In April 2021 Nojus applied for a contact order with conditions attached not to change younger child's surname, move him abroad, or to another part of the country, and also some prohibitive condition around religion – he cited financial abuse of the younger child – because she bought an expensive bike for the older child and the younger child still had an old scooter with broken brakes. Also, psychological abuse re the younger child because he said the younger child seemed depressed when he visited him.

13.8. Nojus cited an incident where she had fallen down the stairs drunk and reported that he had caused her injuries. He also cited psychological abuse to himself – that she would say he was useless, worthless and a bad partner. He said she didn't work from 2012 until 2019 – and he took the financial burden onto his shoulders. He cited now paying half of the rent and cites her misspending money.

13.9. Nojus cited emotional abuse – stating that she would not allow him to go out with friends – although he does state:

> "I know that if person is not jealous than it could mean that he or she does not love partner."

13.9. 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.

13.10. Monro's parents told the Chair that Nojus was a heavy drinker, and Monro's drinking had become worse when they were together.

13.11. Within the family court documents, Nojus cites Monro's erratic and worrying text messages as a concern – stating that she sent them late at night and he would not see them until the morning, and because of this he was concerned that it may be too late to help her. The police records of Nojus' harassment allegations against Monro states that her late night text messages kept him awake and he was only getting a couple of hours sleep per night.

13.12. Nojus states throughout the CA100, where the question is asked whether the applicant has help or assistance from any agencies or professionals, that the social worker is helping him.

13.13. At court, Monro was represented by a solicitor and Nojus was a Litigant in Person.[47]

13.14. The s7 report[48] of the social worker notes that due to the current instability, in part caused by Monro's health, it is difficult to make long-term recommendations regarding where youngest child should reside. The report notes the child is currently in the care of Monro and continues to have regular contact with Nojus. The author of the s7 report, who is the family's allocated social worker, recommends that whilst Monro is fully engaging with the support both professionally and for her family the youngest child should continue to live with her, and if Monro can maintain the changes, it would be the long term recommendation of the local authority for the youngest child to reside with Monro, and have regular contact with Nojus.

13.15. During the scoping period, Monro spent some time in a private rehabilitation facility, which was self-funded. Whilst in therapy Monro disclosed her previous suicide attempt in May 2021. She had 1:1 therapy during these 10 days and explored the domestic abuse she had been subjected to. The therapist worked with Monro on showing compassion to herself and learning to ask for help.

13.16. During the treatment group, Monro stated that she always had to please her family, and sought approval from others, which was triggering for her. She stated that her relationship with her mother had broken down due to her drinking, she stated that she knew her mother loved her.

13.17. The staff at the treatment centre said Monro was an engaging and pleasant woman. She was wearing a wig, as she had shaved her hair during a period of crisis before she admitted herself to the facility. Monro had paid for ten nights, and they confirmed to the

[47] Advice for Litigants in Person- Courts and Tribunals Judiciary

[48] This is a report ordered by the Court, under section 7 of the Children Act 1989. This section of the Act allows judges to seek help from a relevant professional when they are required to determine a dispute about the upbringing of a son. The report gives a full and detailed picture of the circumstances of the son and highlights important safety or welfare concerns needs to be aware of in order to make a decision.

Chair that when she left the facility, she was ready to go. She opted and accessed ongoing therapy.

13.18. Monro's response to Nojus raising an issue with her mental ill health, alcohol misuse, and medication through the family court process, is as follows:

> "The information contained within this paragraph is accurate. One week before I admitted myself to the rehabilitation centre my parents advised me to stop my medication and mental health illness. I have learnt from my experience that this is not advisable. I did stop taking my medication which caused me to have very bad mood swings and I called a doctor who advised me to take one tablet immediately which I did. I decided to admit myself to a specialist centre to seek further assistance. I self-admitted to the detox service, but I did not require a detox. This was because I was not assessed as requiring one by the experts there…. It is right that I am trying very hard to become alcohol free and am doing everything I am being asked of. I also understand this is a process which will not be completed overnight. I am trying to be open and honest with everyone in relation to my alcohol use and will do everything I am asked of. The organisation is also finding me a sponsor who is a female and has stayed sober for two to three years. I hope I will be able to learn from their past experiences. I am also attending group meetings with Alcoholics Anonymous. These are zoom meetings where we check in and share experiences together. It is not simply about alcohol use but more about the emotions involved and the triggers for using alcohol…. I am also completing counselling on a private basis."

13.19. Monro's i-access practitioner recalls that Monro was very positive and pleased with being abstinent, she was very engaged and happy with the progress she had made, and the practitioner was shocked when she was informed that Monro had passed away.

14. Chronological Overview

14.1. The following section will present a chronological overview of Monro's contacts and engagement with services. This will be followed by an analysis of these contacts in section 15.

14.2. In 2017, Monro attended Hospital B ED, with a reported fox bite on her arm. She had scratches to her face. She stated that a fox had tried to attack her puppy when she was at the park, and she defended the puppy, sustaining the injuries.

14.3. In July 2019, Monro was taken to Hospital B by ambulance with chest pain, dizziness and vomiting, she was hyperventilating and had pins and needles. She disclosed that she had taken drugs and alcohol the night before, with Nojus. She stated that she had taken a "normal amount". She was assessed, and discharged home.

14.3. In February 2020, Monro called Metropolitan Police Service (MPS) at around 10pm reporting that she and Nojus had "a fight", that she had been pushed and hit in the face and that it was not the first time he had been violent. Police attended the home, Nojus was intoxicated and located in the garden. He stated that Monro had thrown something at

his head when he had poured her alcohol down the sink. When spoken to, Monro disclosed violence, which had been happening for the past two years. She showed the officer bruising from old injuries. When spoken to, Nojus had an explanation for all of these incidents, all of which involved Monro being intoxicated. Monro's eldest child also disclosed violence from Nojus, which Nojus denied and stated that Monro was poisoning her child against him. Nojus also described the nine-year-old as manipulative in order to get attention from his mother.

14.4. The next day, Monro retracted her statement – she was concerned that she was financially dependent upon Nojus and did not want repercussions if she supported prosecution.

14.5. Covid-19 pandemic restrictions started in March 2020 – limiting the movement of the general public and calling for people to stay home.

14.6. On 13th May 2020, Monro was taken into hospital by ambulance at 5am, she stated that she had woken up to take her dog for a walk at 1am – and then had lost consciousness in the park, and her next memory was waking up at 4am as the ambulance crew arrived. She reported to drinking 1.5 bottles of wine. It is noted that the children were staying with family, and so were not in the house at the time. Monro reported that she was in the process of a divorce and was being threatened by her ex-husband. Monro declined an IDVA referral.

14.7. On 8th July 2020, Monro had a consultation with GP Practice A following the ED attendance on 13th May 2020. Monro told the GP that she had drunk too much that day but had not drunk alcohol since that incident.

14.8. Monro and children registered with GP Practice B in October 2020.

14.9. On 29th November 2020, Monro was taken into Hospital A ED by ambulance, with sudden onset back pain. She was discharged with pain relief and a muscle relaxant. Advised to follow up with GP if symptoms persist – GP updated via letter.

14.10. On 2nd February 2021, Monro called Surrey Police to report that Nojus had assaulted her elder child, and verbally abused and assaulted Monro, causing her facial injuries. The operator could hear arguing. Officers attended and spoke to all parties separately. Nojus was arrested, Monro was taken to Hospital A and the children were left in the care of their maternal grandparents.

14.11. At Hospital A, Monro had a CT scan, and a follow up appointment with ophthalmology.

14.12. Monro made statement to police, stated they had recently moved from London, following a period of separation due to domestic abuse perpetrated by Nojus. That evening she had intervened when Nojus had assaulted her eldest child, who was Nojus' stepchild – and she had been injured by Nojus. Medium risk DASH was completed, a CSC

request for support[49] was made, Operation Encompass[50] information was shared with the children's school, and a referral to the domestic abuse outreach service was made. The SCARF level of need for the children was assessed as 4, and for the adults as 2-3 – and were shared with children and adult social care. There was no documented consideration of Monro as an adult with care and support needs.

14.13. When in custody, Nojus told officers that Monro had been drinking all day and had instigated an argument – he denied assaulting Monro. Bail conditions were in place once Nojus was released from custody.

14.14. It is recorded that at this point Monro had no income of her own, the flat was privately rented, and she received financial support from her mother.

14.15. Following the CSC referral, a Children and Families Assessment commenced.

14.16. Following the police referral, Monro was contacted by domestic abuse charity, Your Sanctuary, on 4th February 2021. Monro disclosed a history of abuse, and discussed housing, finances, their children, and support networks – the support worker advised regarding safety planning. It was agreed that the support worker would call back in three weeks.

14.17. In the early hours of 20th February 2021, Nojus contacted police to report that Monro was intoxicated, was messaging him via Instagram and he deemed that she was unable to care for their children. Police welfare check found that Monro had been drinking but not at the level to make her incapable of caring for the children. Monro's parents were called and came to take the children. Monro became emotional when speaking about Nojus and indicated that there "was more to investigate", however did not disclose anything further to the Investigating Officer. A SCARF was completed at level of need 3 for the children. No signs of child neglect.

14.18. On 22nd February 2021, ASC reviewed the police referral following the incident on 2nd February 2021. The systems were checked, and no record of Monro, as no evidence of care and support needs, no further action taken.

14.19. On 1st March 2021, Monro updated police, she had not sustained any lasting damage to her eye, Nojus had moved out of the family home, the relationship had ended, and Monro no longer wished to support a prosecution. Case filed with no further action.

14.20. Your Sanctuary's support worker called Monro as planned on 3rd March 2021, there was no answer, and they followed up with a text message. The support worker tried again on 11th March 2021, and spoke with Monro who stated she felt good, she was working and felt safe. The case was closed, and Monro was advised to contact Your Sanctuary again if she required their support.

[49] A referral

[50] Home : Operation Encompass

14.21. On 19th March 2021, Nojus contacted CSC OOH team to report that Monro was using alcohol and drugs – the information was included into the Children and Families Assessment.

14.22. A further Your Sanctuary referral was made for Mon 22nd March 2021. The records indicate that Monro was not called, as she had recently received a programme of support, and there had been no further incident.

14.23. On 6th April 2021, the initial Child in Need meeting was held, professionals and parents agreed the plan and parents agreed to engage with support offered.

14.24. Late on 7th April 2021, Nojus called police concerned that Monro was intoxicated, due to some misspelt words in a text message she had sent – he was concerned for the eldest child's welfare – as he was caring for the younger child at the time. Police attended the following morning and did not find any cause for concern.

14.25. A C100[51] was received by the local family court. This was completed by Nojus requesting a without notice[52] hearing regarding the care of their youngest child. The reason for a without notice hearing was that Nojus believed Monro would manipulate the children to make false allegations and would have time to speak to the social worker, he alleged her drinking was problematic, and stated that he did not drink.

14.26. On 23rd April 2021, Monro contacted police with a concern about her youngest child's welfare in his father's care. She sounded intoxicated so police undertook a welfare check with her. No concerns for youngest child identified. It is recorded that Monro had reported Nojus repeatedly calling her and threatening to remove the children from her. The responding officer identified that CSC were involved with the family, and so created a report of the incident, and a SCARF was submitted for the children, level of need 3.

14.27. On 4th May 2021, Nojus contact Surrey police to report his concern about the children. Monro had told him they had been to Hospital B, but she had not given any further details. The officers attended, Monro's parents were there along with Monro and the children. The children were spoken to and confirm they had been unwell so had been to Hospital A – no concerns raised. Records indicate that Monro had called 999 due to the children having high temperatures and vomiting, she was advised to convey them to the emergency treatment centre – Monro's parents attended to assist. Nojus also contacted CSC to raise concerns about the children being in the Hospital A – the social worker undertook a welfare check with no concerns.

[51]This is an application form for a Child Arrangement Order – which is a legally binding order that determines the parenting arrangements for a son. The applicant competes the form and submits to the family court, when a separated couple cannot reach an agreement on the issues such as where a son will live, who they will see, or what they can do.

[52] This is a hearing without the other party in attendance – these will generally only be held if the applicant can show that if the other person had notice, they will take steps which could defeat the purpose of the application – for example the applicant won't be safe, or there is some other exceptional urgency which means there is no time for the applicant to give notice.

14.28. On 7th May 2021, also Nojus made a report to Metropolitan Police Service (MPS), which was transferred to Surrey Police. He alleged harassment from Monro. He alleged that her alcohol use had increased during 2019, and that she had also started to use cocaine. He stated she was jealous, and during a stag party (date undisclosed) she had sent explicit photos and videos to entice him home from being out with his friends. He made allegations about her fabricating domestic abuse, and about harassing him with calls and messages despite being told not to contact him by the social worker. He stated concern for the children and asked for this concern to be recorded, he did not want to take any further action at this time.

14.29. On 11th May 2021, Monro took an intentional overdose, and told her grandmother whilst on a phone call. Monro's grandmother called Monro's parents who drove to her house, found her unconscious and called an ambulance. She was taken to Hospital A ED, and the children were cared for by Monro's parents. The ambulance crew and the hospital raised a safeguarding concern with CSC as the children were in house at the time. Monro received treatment for the overdose. She was seen by the PLT, disclosed the intentional overdose, and stated she was in an abusive relationship, despite being divorced in February 2021 she was still in fear of her ex-husband. She stated that the overdose was due to her ex-husband's ongoing accusations and harassment, which she could not deal with anymore. Monro told the clinician that she believed her life was worth living and she said that she had no intention, thoughts or plans to self-harm again when she went home. She said that she did not wish to lose her children and realised what she did was wrong and said that it did not resolve the problem. She wanted to get better and engage with services.

14.30. Monro was assessed as a low risk to herself at the time of the assessment. This was because she stated she no longer wanted to harm herself. She said, "it made things worse and did not solve anything." She confirmed that she did not have any intent, thoughts or plans to harm herself again. The clinician wrote that: "However, possibly risk can escalate depending on the level of stress or harassment from her husband". Risk to others was recorded as low. Risk from others was recorded as low to medium, as she was at risk of emotional abuse and harassment from Nojus.

14.31. The clinician did not find any evidence of an enduring mental illness and identified psycho-social stressors due to breakdown in relationship and harassment from her husband. Monro was advised to call Mind Matters[53] to self-refer for therapy to suit her needs, she was also advised to continue to see her private psychologist for support, to consider attending the Safe Haven[54] and utilise the Crisis Helpline as required. Monro was provided with a leaflet detailing support services available in Surrey, and she was discharged from the Psychiatric Liaison Team (PLT) – a letter was sent to GP Practice B with an update.

14.32. A Child in Need meeting was held on 19th May 2021, where Monro and Nojus agreed to limit their contact to what was necessary for organising contact with the children. The school noted the impact of the current situation on the children.

[53] Mind Matters : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)
[54] Safe Havens : Surrey and Borders Partnership NHS Foundation Trust (sabp.nhs.uk)

14.33. On 21st May 2021, Monro contacted the GP, she discussed how she was stressed, she had recently had a breakdown, due to ongoing issues with Nojus. She requested counselling and something to help her sleep. Both were provided, and she attended a follow up appointment two weeks later. Monro was offered longer term medication which she declined.

14.34. On 25th June 2021, an ambulance was called to Monro who had cut her arms, she had written a note stating that she no longer wanted to live. Her eldest child was with grandparents and her younger child was with their father. Monro's friend had found her and had called an ambulance. A safeguarding referral was made for the children, and a SCARF level 2/3 sent to the Contact Centre. Monro was conveyed to Hospital A and was seen by PLT. She was noted as having a private psychologist since March 2021. PLT referred Monro to Home Treatment Team (HTT) and her GP was updated.

14.35. On 26th June 2021, the HTT contacted Monro following the referral received the day before, which was linked to the Hospital A attendance on 11th May 2021. Monro presented 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.

14.36. Monro's risk from others was assessed as low, although it is stated that she was at "risk of emotional abuse, including bullying". She was assessed as being at medium risk from herself due to alcohol and substance misuse. However, she was assessed as a low risk to herself from suicidal thoughts, as she had denied thoughts of suicide or self-harm. Her children were recorded as protective factors.

14.37. On 27th June 2021, HTT called Monro, she sounded stable in mental state and reported no concerns to share with the HTT. She denied thoughts of suicide or self-harm, no plans or intent in place, her children were again identified as protective factors. Her risk was rated as low.

14.38. During this time, Nojus refused to return youngest child to Monro's care.

14.39. On 28th June 2021, HTT undertook a review. It was noted that Monro's presentation was fairly risky with two suicidal acts within a month. There were some biological symptoms of depression, with a background of chronic social stressors. It was also noted that during the telephone contact, Monro presented as generally doing well, feeling better and reported not taking any alcohol. Reported seeing a psychologist privately once a week which she found helpful and had a social worker whom she saw weekly. The plan was for Monro's medication to be reviewed. She was referred to i-access, the HTT team would contact the Social Worker and HTT would continue with a final follow up and refer to the Community Mental Health Team or continued support.

14.40. On 29th June 2021, the HTT visited Monro. She expressed that her ex-partner had abused her emotionally, physically, sexually and she was still hurting from the scars of that abuse. She mentioned that she had been informed by the social worker that he

wanted to keep her younger child, and this was still traumatising her. Monro told the HTT worker that she was in touch with a solicitor for advice. The risk assessment remained low to moderate, as she continued to deny any thoughts of self-harm despite the ongoing distressing experiences. She was made aware of Crisis Line, and also informed of Safe Haven drop-in times. Monro's care was transferred to Community Mental Health Team.

14.41. On 30th June 2021, the family social worker contacted domestic abuse service Your Sanctuary to request support for Monro – she was advised to ask Monro to make contact herself whenever she felt the need for support.

14.42. On the same day, Monro was seen at home by HTT. Her parents were also present. It was noted that there were no overt psychotic symptoms observed. She reported feeling "fine" and positive, despite the circumstances with her estranged husband. Denied any thoughts of ever being suicidal or thoughts to harm herself or anybody else. She reported being optimistic about her future, her children being protective factors and was grateful for the support she was getting from her parents.

14.43. Between 1st July 2021 to 14th July 2021, Monro was seen on six occasions for support by HTT. During this period her risk level was rated as low as she denied having thoughts of suicide, self-harming, plans or intent. She denied the use of alcohol. She informed the team that she was receiving private therapy from a therapist. It was decided to refer her to the local CMHRS. However, the CMHRS felt there was no need for their service as she was already receiving therapy from a private therapist. She was therefore discharged from the HTT, with a plan to work with i-Access.

14.44. On 15th July 2021, Monro was seen by i-access. She reported ceasing drinking three weeks previously. Her goal was to maintain abstinence.

14.45. Monro submitted her response to Nojus' CA100 on 27th July 2021. She responded that they had both used alcohol and substances together, and that Nojus continued to have an issue with alcohol. She stated that she did not want to stop Nojus from seeing their child and did not require fact finding[55] regarding domestic abuse – she just did not want her child removed to live with Nojus fulltime. She also raised the question about relocating to another County.

14.46. On 29th July 2021, an interim CAO was made by the family court. It set out that the children would live with Monro and contact between Nojus and the children should be fortnightly, Friday to Sunday, a s.7 report would be requested from CSC, a GP report regarding Monro's mental health and both parties would be required to take a hair strand test regarding alcohol and drug use. The next court hearing was set for 17th November 2021.

[55] This is a special hearing which is arranged to decide whether an alleged incident took place or not. The court hearing considers the evidence surrounding allegations. They are common in family law cases, but can also happen during other family law proceedings, such as for domestic abuse injunctions or divorces.

14.47. Also on 29th July 2021, Monro was assessed by i-access and it was agreed that Monro would attend key work sessions, agreed Relapse Prevention Group pathways and information provided, advice and information given on effects of alcohol on body. Monro was aware of relevant support services such as Crisis line. Suggested peer support groups such as AA and SMART.

14.48. Between 29th July 2021 and 29th October 2021 Monro engaged with i-access. Monro attended seven relapse prevention groups, and self-management and recovery training sessions with i-access – with a view for abstinence from alcohol misuse.

14.49. On 2nd August 2021, CSC were contacted for the s.7 report, as part of the family law proceedings. Also on the same day, Monro submitted a s.8[56] application, requested a Child Arrangement Order with the child living with her, and Prohibited Steps Order as Nojus had not returned the younger child previously in June 2021. The hearing had already been set for 17th November 2021, and this s.8 was included in the information for that hearing.

14.50. On 4th August 2021, CSC received a call from Nojus reporting that Monro was intoxicated, they undertook a welfare check and noted that Monro seemed exhausted and was being prescribed diazepam. No concerns were raised. A Child in Need meeting was held on 9th August 2021, no further concerns raised, plan to progress.

14.51. Around this time, Monro suggested a move to another County to make a new start.

14.52. On 18th August 2021, Monro's solicitor requested a medical report from her GP.

14.53. On 13th September 2021, Monro contacted her GP regarding a minor physical ailment, this was the last contact Monro had with her GP.

14.54. A further Child in Need meeting was held on 22nd September 2021 – the plan was to continue. Five days later Monro's father contacted the social worker with concerns about her alcohol intake. This was discussed with Monro.

14.55. On 4th October 2021, Monro booked into a privately funded rehabilitation facility.

14.56. On 11th October 2021, Monro missed her i-access appointment, as she was still in the private facility - a further one was booked for 29th October 2021 – however it is unclear if she attended this re-booked appointment. From the 11th of October 2021 to 29th of October 2021 she did not attend four sessions however she informed i-access that she had been attending Steps Together Rehab where she had self- referred hence her not attending the Relapse Prevention Group (RPG) and Self-Management and Recovery Training sessions. She also reported engaging with AA and therefore it was agreed to discharge her from i-access.

[56]Children Act 1989 – this is an application for a Prohibited Steps Order – which is an order that can be granted by the court to stop one parent exercising their parental responsibility in a way that is not in the son's best interests.

14.57. Monro finished her 10-day rehabilitation programme on 14th October 2021, she was provided with a 24-hour helpline for emotional support, and ongoing therapy, a support worker and a weekly support group – all provided virtually.

14.58. The private care facility called her for a welfare check up on 15th October 2021 – suggested a domestic abuse service referral at this point.

14.59. As part of the discharge from the private facility, Monro had four therapy sessions booked. The first was on session on 3rd November 2021, where goals were set to resolve the relationship with her mother, and to put boundaries in place.

14.60. A Child in Need meeting was held on 8th November 2021, the plan was to continue.

14.61. On 10th November 2021, the private therapy session was spent discussing the relationship with Monro's ex-partner – she stated that she is scared of him and that he would take her child away. She stated that Nojus had been telling the child that they would come to live with him, and the child was confused about this.

14.62. On 11th November 2021, the GP had recorded "full abstention from alcohol".

14.63. On 17th November 2021, during the private therapy session Monro stated that she felt unwell, and had a fever, she talked about her childhood and how she always sought her parent's approval or attention, even negative attention. She said she felt unlovable.

14.64. Also on 17th November 2021, the family court hearing was held. The outcome of this was a Child Arrangements Order, giving Monro permission to withdraw her application to relocate out of County, requiring Monro and Nojus to file a final statement and proposals for child arrangements, and requests for GP and CSC reports to be updated with current issues. In the interim the arrangements were to remain the same, with the child staying with Nojus fortnightly for the weekends. The next hearing was set for the 7th February 2022 and was set to be the final hearing.

14.65. On 19th November 2021, Monro attended Hospital A ED with back pain and high temperature. She was admitted to a ward. Monro had been in pain for a few days following a medical procedure. A history of domestic abuse was noted. No acute reason was identified for the pain – this improved following antibiotics and pain relief – she was discharged on 22nd November 2021.

14.66. Monro did not attend the final private therapy appointment booked on 1st December 2021.

14.67. On 15th December 2021, a Child in Need meeting was held, the plan was to continue.

14.68. On 18th December 2021, Monro's eldest child was found in the street at 11pm. He was crying and told them that his mother was intoxicated and was smashing things in the house. Police were contacted and attended the home – Monro admitted to drinking alcohol, and stated she was arguing with Nojus over her internet spending. There were

no signs of neglect or damage to the property. Officers took the child to his grandparents, who told officers they were going to start family court proceedings for care of the children as they were receiving weekly called for assistance. A SCARF level 3 was submitted by police.

14.69. The following day, Monro's parents, and another separate third party, contacted 999 as Monro had posted an Instagram photo of her self-harming at home. They were on their way but lived an hour away – on arrival crews found Monro with her parents – she was conscious with a large self-inflicted wound. She appeared to be experiencing a psychotic episode and was cradling a soft toy as if it were a baby. She was calm but did not recognise her parents. She could not recall how she had acquired the injury, until the crew located the knife and then she stated she used the knife to harm herself as "nobody loves her". She was wearing lingerie and stated that her husband had "put her in it". The children had been away from the home since the incident the day before, so were not present during this time. Monro was conveyed to Hospital A for an assessment of the wound, and continued to cradle the toy on route to Hospital A. The information was shared with CSC.

14.70. At Hospital A, Monro was kept on an assessment unit in ED due to intoxication and drowsiness and was reviewed by PLT on 21st December 2021. She presented as psychotic, PLT did not believe this was a clear-cut psychosis due to the reported high level of alcohol use leading to the admission. A plan was made to refer Monro to Early Intervention in Psychosis (EIIP), i-access for help with alcohol, Crisis Line & Haven, referred to Hospital Independent Domestic Violence Advocate – and she was discharged from PLT.

14.71. The referral was screened by EIIP on 22nd December 2021. It was agreed that Monro required i-access input, and it was decided that she was not appropriate for EIIP assessment due to her symptoms being present for only 24 hours and her alcohol use – it was assessed that her symptoms were alcohol related.

14.72. A strategy discussion was held on 21st December 2021 and s.47 agreed, to progress to Initial Child Protection Conference. It is noted that the children would not be returning to live with Monro at this time.

14.73. On 22nd December 2021, the Your Sanctuary HIDVA service received a referral from PLT, this related to a disclosure made by Monro regarding domestic abuse from her husband. A call was made by the HIDVA to Monro the following day, there was no answer.

14.74. On 24th December 2021, the GP received a discharge letter from the Hospital A, within this it stated that Monro had requested in-patient admission, however the PLT nurse had not felt this was in Monro's best interests.

14.75. The same day, the ambulance service received a call from Monro's parents, she had text her mother photos showing self-harm, stating she was going to take her own life. Ambulance arrived – it is noted Monro stated that EIIP had not opened her case due to not meeting the criteria, and that Monro was drinking to deal with her mental health issues,

which she stated was untreated due to incorrect referrals and no psychiatric diagnosis. Monro was conveyed to Hospital A.

14.76. At Hospital A Monro was seen by PLT. Monro stated she had called an ambulance for herself because she wanted help. She had been drinking alcohol and then cut her arms and tried to inject air into her veins, she stated she felt ok with no suicidal thoughts and reported as not intending to end her life, but to punish herself. Monro declined community-based support, it is noted that she was not happy with the community support and had brought a packed bag with her for in-patient admission. PLT assessed Monro a low risk regarding self-harm and risk of accidental death by misadventure due to high-risk behaviours whilst under the influence of alcohol When Monro became aware that admission was not being offered, she walked out of the assessment room, and said she wanted to leave. It was noted that she appeared to have capacity to make decisions about her care and treatment. The plan was to remain open to i-access, the recovery college, crisis line and Safe Haven contacts were given, and she was discharged from PLT.

14.77. The Your Sanctuary HIDVA attempted to call Monro again on 29th December 2021.

14.78. On 29th December 2021, Monro had been staying with her extended family over the Christmas period, and had returned home, stating she was picking up belongings. When she did not return, her uncle went to her property and found her hanging from her stairs.

15. Analysis

15.1. Introduction

15.1.1. There was no evidence, from any of the agency case notes, that any agency explored Monro's cultural heritage. During a period of crisis in June 2021, Monro had self-harmed, and had left a suicide note which was written in Russian. The language in which the letter was written was only referenced within the Hospital A and LPS notes, there was no professional curiosity, or information shared with other agencies suggesting that Russian may be Monro's preferred language. This indicates an assumption that because she could speak fluent English and had lived in the UK for many years, she was always most comfortable with English, including during periods of distress and when speaking about sensitive matters.

15.1.2. Some IMRs indicated that because Monro had lived in the UK since her late teens, she was fully integrated into UK life and there was no evidence that her Lithuanian/Russian nationality had impacted upon her life. Contrary to this, every person's characteristics, life experiences, social environments and relational ties impact on their lives – it is vital that practitioners across all services understand this when responding to the needs of the people they support. This review highlights a gap in cultural competency across all services, both during the time they worked with Monro and also for the majority of the agencies involved in the review, during the preparation of IMRs for the DHR.

15.1.3. This review has also highlighted the importance of professionals understanding the heightened risks of suicide when a person's children are no longer living with them – particularly when they have repeatedly stated that their children are their protective factor. If they identify their children as the reason for living, and they have also indicated suicidal ideation – or suicide attempts – once their children are no longer living with them, this places them at much higher risk of completing suicide.

15.1.4. Nojus' coercively controlling behaviour is evident throughout the chronological overview of this review. With the benefit of hindsight, and ability to triangulate information from gathering a combined chronology and IMRs, it is clear to identify behaviours which were intended to control Monro post separation, and how these behaviours led to Monro's mental health declining. These behaviours were "invisible in plain sight"[57] throughout Monro's engagement with agencies prior to her death, and this review should be utilised as a case study to help professionals identify this behaviour when working with families in the future.

15.1.5. The following sections will provide an analysis of individual agencies, and will be followed by themes which were identified across the services and systems.

15.2. Surrey Police

15.2.1. Following the incident on 2nd February 2021, the primary response by officers and the secondary investigation by the Safeguarding Investigation Unit (SIU) were of a good standard and in accordance with policy. Following Monro's statement retraction, evidence led prosecution was considered but the insufficiency of evidence prevented this. The allegation that Nojus was assaulted has not been crimed separately[58], and following the review of this information a reminder has been sent to the Investigating Officer to follow this up.

15.2.2. The actions taken by officers on 20th February 2021, following the welfare call from Nojus was appropriate and according to policy.

15.2.3. On 8th April 2021, following a call from Nojus to police regarding Monro's ability to care for eldest child – younger child was with Nojus – police responded when resources were available, although this was the following day. The police operator ascertained through questioning Nojus that a more immediate response was not required and considered the call to be malicious after conducting enquiries.

15.2.4. On 23rd April 2021, following a call from Monro to police regarding Nojus' treatment of the younger child during contact visits, the reporting officer made direct

[57] Wiener, C "Seeing What is Invisible in Plain Sight: Policing Coercive Control" *The Howard Journal of Crime and Justice* (56) (2017) Seeing What is 'Invisible in Plain Sight': Policing Coercive Control - WIENER - 2017 - The Howard Journal of Crime and Justice - Wiley Online Library

[58] https://www.police.uk/pu/about-police.uk-crime-data/

contact with the Emergency Duty Team,[59] shared information and ascertained that the children were subject to a Child in Need plan, with a meeting being planned in a few days. The reporting officer consulted a supervisor who advised creating a CP report and submitting a SCARF for the children, it was shared with CSC, with level of need 3. This was an appropriate response by police with information shared with CSC in order for consideration and inclusion in a forthcoming meeting.

15.2.5. On 4th May 2021, Nojus contacted The Metropolitan Police Service (MPS) to report harassment from Monro, this was correctly transferred to Surrey Police in accordance with policy. Nojus was adamant that he did not feel harassed and would not support Monro being arrested or prosecuted, he only reported the situation as he was concerned about the children, although it is not clear what concerns were raised about the children. Surrey Police Officers visited Monro and checked the welfare of the children, they found everything was in order and there was no cause for concern. The officers described that the couple were going through a difficult divorce and there were a number of issues that necessitated contact between them. There was input on the case from supervisors and the Domestic Abuse Team. The case was closed in accordance with the wishes of Nojus. The response was effectively managed between the MPS and Surrey Police and in accordance with policy.

15.2.6. Following the call from Nojus to police on 7th May 2021, where he raised a concern for the children. Officers attended the family home; Monro's parents were present. The officers attended the home, no concerns were raised. The reporting officer graded the SCARF green and raised a concern that the children were caught in the acrimony between their parents. There were no criminal offences identified during this contact with Nojus and Monro and the situation was dealt with appropriately.

15.2.7. Although Police were following due process each time Nojus called with a concern about the children's welfare, each time they followed this up with a visit to Monro they were unwittingly feeding into Nojus' controlling behaviour, as he appeared to be using Police as an ongoing tool of control following their separation. He was doing this through the narrative of concern for the children, however what specific concerns he had were not recorded, and the use of Police appears to be particularly heavy handed if his intentions were coming from a place of care for Monro.

15.2.8. Police were called by ambulance service on 25th June 2021, Monro had cut her arm and left a note stating she could not live anymore. The children were not at the property, ambulance took Monro to Hospital A. Police completed a SCARF and shared this with adult services for Monro, with a level of need 2/3. A SCARF for children was shared with CSC, as a level 3.

15.2.9. On 18th December 2021, officers were stopped in the street by Monro's neighbour who had found elder child crying in the street. He stated Monro was intoxicated and smashing property. Police attended the home, contacted grandparents who took eldest child to their home, and a SCARF level 3 was submitted to CSC for the children.

[59] Out of hours social care contacts - Surrey County Council (surreycc.gov.uk)

15.2.10. A friend, and Monro's parents called an ambulance on 19th December 2021, following an Instagram post of Monro self-harming, officers attended with an ambulance, who conveyed Monro to Hospital A. A SCARD graded red was submitted, and shared with adult mental service, level of need 2/3 and with CSC for the children level of need 3. The reporting officer stated in the SCARF text that without support another incident/attempted suicide could occur. The occurrence was noted on a database by the suicide prevention force advisor, a PNC[60] created, and Niche record flagged suicide risk in accordance with policy.

15.2.11. On 21st December 2021, a detective sergeant from the child protection team attended a strategy discussion. There were no actions for police. It was agreed that the children would not be returning to Monro in the short term, and that a s.42 assessment would commence.

15.2.12. On 29th December 2021, Monro was found by her uncle, and declared deceased at the scene by paramedics. An investigation was undertaken by Surrey police. There was no suicide note found, an autopsy gave cause of death as hanging and toxicology found traces of alcohol sufficient to cause 'notable drunkenness'. There was no evidence of suspicious circumstances or involvement of another party, the conclusion reached by police was that Monro took her own life.

15.2.13. Surrey police involvement with Monro and her family had resulted in eight SCARF reports, which were all graded and shared with partner agencies. All SCARF reports were detailed and of a good standard, including narratives of officer observations and opinions.

15.2.14. On each response safeguarding was a priority and the welfare of the children checked. Medical assistance was provided to Monro by the ambulance service who conveyed her to Hospital A on three occasions. The information gathered by police in response to these incidents was shared with partner agencies.

15.2.15. Following the report to police by Monro that she had been verbally and physically abused by Nojus on 21st February 2021, Monro also informed officers of a previous incident which had pre-empted a period of separation. Nojus was arrested, interviewed, and given bail conditions in furtherance of safeguarding. The DASH was graded medium risk, the investigation assigned to the SIU[61] and Monro referred to support agencies. Monro did not make any further disclosures about abuse and declined to support the investigation further. Without supporting evidence sufficient to pursue a prosecution the case was closed. The investigation was conducted in accordance with policy. Consultation regarding this incident revealed that a PND[62] check was not conducted. This was mainly due to an insufficient number of staff with the required skill to do this, however PND checks are vital to inform risk assessments and safeguarding.

[60] National police system that records details of warning signals, arrests, convictions and non-convictions

[61] This is now the Domestic Abuse Team (DAT)

[62] Database search that would reveal any previous contact with other police forces outside the Surrey area

It is recommended, in the interest of safeguarding, that units dealing with domestic abuse matters are considered a priority when allocating access to PND courses.[63]

15.2.16. Following the incident, and the couple separating, Nojus called police on four occasions regarding the welfare of the children due to Monro's use of alcohol. On each occasion officers attended the family home, in accordance with priority grading when resources became available, and engaged with Monro and the children, and investigated the allegation. Whilst there were signs that Monro had consumed some alcohol, the officers found no evidence of child neglect or safeguarding measures to be activated. With no evidence found to support the need for police intervention there was a natural questioning of the motives for Nojus reporting these matters to police and his application for custody of his child. As time progressed it was evident that Monro was consuming more alcohol and was suffering increased mental illness – whilst this supported Nojus' concerns for the welfare of the children, it is likely that the increased alcohol consumption as a direct response to the ongoing harassment by Nojus, via police and Children's Social Care.

15.2.17. In March 2021, intelligence was added to the Niche record of Monro regarding the financial transactions of an account in her name. The transactions related to significant sums of money being paid in and out to a gambling company. It has not been possible to ascertain any further information regarding these reports or confirm that the user of this account was Monro. Therefore, this information has not been added to the chronology, however, this information was available to staff having subsequent contact with Monro and may have been worthy of further enquiries as it may be a factor in her mental health deterioration, consideration may also have been given to sharing the information with partner agencies.

15.2.18. Coercive control was not identified within Monro's contact with Surrey police. Each response to Monro and/or her family by Surrey Police was otherwise professional, supportive, incidents were investigated, and information shared.

15.2.19. The review considers that the role of Force Suicide Prevention Advisor is an asset to benefit the policing response to incidents of attempted suicide. The advisor ensures that alerts are created and that referrals for help and support are appropriately made.

15.2.20. Police responders assessed Monro as being at high risk of taking her own life on 19th December 2021. This was reflected in the SCARF report as Red and was shared with mental health services. Also, alert markers were added to Niche and PNC following the involvement of the suicide prevention force advisor. Two days later a family strategy meeting was held in which information was shared.

15.2.21. The actions taken to manage the risk following the report of domestic abuse by Monro were comprehensive: Nojus was removed from the family home under arrest, Nojus was given bail conditions to prevent contact with Monro, Outreach referrals were

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made, domestic violence safety kit provided, regular contact with Monro by the Investigating Officer[64] and visits by a dedicated domestic abuse car were made.

15.2.22. On each of the occasions contact was made with Monro by officers there is evidence of support and advice given. Monro's wishes were taken in to account at all times and in the case of DA allegations the prevailing reason that the case was closed as no other evidence could be found.

15.3. Surrey and Heartlands Integrated Care Board – GP Practice A & GP Practice B

15.3.1. At the start of the review period, Monro was registered with GP Practice A. She moved to Town A, Surrey and registered GP Practice B in October 2020.

15.3.2. Monro had limited contact with the two GP surgeries, with two consultations in 2020, and four in 2021. She only had repeated contact with one GP, who she consulted with on 21st May 2021, and 3rd June 2021. Of the 4 direct GP contacts, two were for minor ailments.

15.3.3. Although Monro had limited contact with the GP practices during 2020-2021, there is a significant amount of correspondence included in her GP records, which gives a detailed picture of her experience of domestic abuse, and her mental health, alcohol misuse and self-harming.

15.3.4. GP records note safeguarding referrals were made by the EDs of Hospital A and Hospital B, but it is not clear if these were child or adult safeguarding referrals; no information on the outcome of either referral was sent to the GP practices. A safeguarding children referral was made by Hospital A on 21st December 2021, as Monro had self-harmed in front of her children, there is no further information regarding the outcome of this referral.

15.3.5. The main direct contacts of any significance were with GP Practice B in May and June 2021. On 21st May 2021, Monro had a telephone appointment to request medication to help her sleep, and a referral for counselling support. She discussed her divorce, and the fact that she had a restraining order against her ex-husband. It is also noted that the police and a social worker were involved, but there are no details regarding this from those agencies. The GP prescribed appropriately, warning against long-term use of sleeping tablets, and referred Monro for counselling support. No referral to domestic abuse outreach was made, but with the other agencies involved, the GP may have assumed this was already completed. The GP booked Monro a follow-up appointment for two weeks' time, which is good practice and enhances continuity of care and support.

15.3.6. Monro had a review with her GP, as planned on 3rd June 2021 – this was with the same GP. She was sleeping and feeling better in herself, and her parents were staying with her for support. The GP discussed whether more support, or longer-term medication

[64] Check oif this needs a refwerence

was required, but Monro was happy to monitor how she felt and to seek further review as needed.

15.3.7. Given that Monro was having regular contact with mental health and substance misuse services during the latter part of 2021, and that the GP was aware of this – it does not seem that additional GP input would have been identified as necessary at that time. Monro had not formed a relationship with any particular GP, and it is not clear whether she would have accessed support from the GP Practice that she did receive from the other health providers she was engaged with.

15.4 Hospital A

15.4.1. Monro was seen on a number of occasions in the Emergency Department (ED) at Hospital A.

15.4.2. Following the attendance of Monro as a result of the assault in February 2021, practitioners were sensitive to her needs including identifying the risks and impact of domestic abuse on her children. The Trust's policy regarding safeguarding children was followed and a request for support form was completed. As Monro attended ED with the police, staff were reassured that appropriate follow-up regarding any potential crime would be undertaken. Police advised that it was safe to return home once she had been cleared from a medical perspective. Appropriate medical follow-up in relation to her eye injury was arranged and Monro attended the required appointment.

15.4.3. The attendance that followed in May 2021 where Monro had taken an overdose appears to have been appropriately managed. Hospital A staff had a primary focus on meeting her physical health needs, however, on each attendance, there was a referral to, and an assessment undertaken by someone from the psychiatric Liaison Team (PLT) which is a service provided through Surrey and Borders Partnership (SaBP). Each speciality area worked together to ensure that both mental and physical health needs were considered. A further request for support was submitted to safeguard the children given that they had been present in the house at the time of the overdose and it was also ascertained that they were safe in the care of their grandparents whilst Monro was being seen in the hospital. Information relating to the attendance was also shared with Monro's GP, this outlined the intentional overdose taken and having been seen and discharged by PLT.

15.4.4. Monro attended ED again the following month having cut her arm; she had left what was described as a suicide note, written in Russian. She explained to medical staff that she had broken up from an abusive relationship in the preceding February, there was nothing documented that the relationship was continuing. Again, Monro was referred to the PLT for assessment once medically stable.

15.4.5. The documents show clear involvement across multiple disciplines, including seeing a private psychologist and social worker weekly, and the GP having prescribed medication for stress. Although a further request for support was not completed, it is noted that contact was made with children's services.

15.4.6. The PLT Nurse discussed the care plan agreed with Monro with the consultant psychiatrist and a referral to the Home Treatment Team for follow-up was arranged. Further safety netting with crisis team contacts being given and a referral into i-access was offered.

15.4.7. There was one further medical attendance at ED where historic domestic abuse was noted but there was no follow up or referral deemed necessary.

15.4.8. The following month Monro attending having cut her arm again. As before, Hospital A staff managed her physical health requirements and a referral for PLT assessment made. The PLT were unable to undertake an assessment initially as Monro was intoxicated and was very drowsy. She was noted to be under i-access but not mental health services at the time. A further psychiatric assessment was completed following her admission and a referral was made to the Early Intervention in Psychosis (EIIP) service with community follow up. The ED notes do refer to safeguarding concerns, however no referral for either Monro or the children has been located within hospital records. There was a referral made into the domestic abuse outreach service as a result of the DA disclosure, although it is not clear whether the DA was current or historic from the notes, unfortunately, despite several attempts to make contact, the service did not manage to speak to her before her death. There was clear indication that Monro was concerned that her children would be removed from her care, and she was seeking help from Citizen's Advice, a further referral to the DA outreach service was completed.

15.4.9. There was a further attendance, three days after Monro was discharged from the above attendance. The ED documentation indicates that Monro was seeking help, she had attended ED with a bag packed for admission. Again, injuries were cleaned and glued, and a referral made for a further PLT assessment. Monro was assessed by PLT, and then discharged from the service. Although the ED paperwork notes that Monro self-discharged and left the department without signing the documentation, this would not have been necessary as she had already been discharged by the medical team ahead of the PLT referral and so did not actually self-discharge. The medical discharge checklist was completed ahead of the PLT assessment.

15.4.10. There was some recognition of Monro's needs which is reflected in the referrals made to health services as outlined above. There was good initial information sharing and identification of the risks of domestic abuse exposure to the children in the home, and then again later regarding their exposure to Monro's drinking and self-harm behaviours; with later referrals being made into the domestic abuse outreach service for Monro to be supported.

15.4.11. There was ED documentation that Monro was engaging with privately provided therapeutic services, however there was no further exploration of this and therefore no record of whether this was Monro masking her vulnerabilities.

15.4.12. Trust staff followed the Domestic Abuse policy following the disclosure made by Monro in February 2021. The referral was made to children's services in line with the policy requirement. Hospital A staff are not trained to complete the DASH and as police were in attendance, the expectation would be that this would be completed by them and

referred to MARAC as necessary if Police had identified Monro to be at high risk. As outlined above, at 15.4.8 Hospital A made a referral into the domestic abuse outreach service in June 2021 following Monro attending ED. At this point the outreach provider attempted to make contact; signposting to mental health crisis support was given following each attendance.

15.4.13. Hospital staff should be empowered to make MARAC referrals if they identify that a patient is high risk, regardless of police, or other agencies, involvement. The MARAC referral does not require a DASH completion or submission, and a referral can be submitted based upon the professional judgment of any professionals.

15.4.14. There does not appear to have been any consideration of Monro's care and support needs outside of her role as a mother. Referrals were made to CSC for her children and to domestic abuse services, however there could have been consideration of an ASC referral for her individual needs.

15.5 Hospital B

15.5.1 Monro attended Hospital B ED four times between 2017 and 2020.

15.5.2 The attendance in 2017 presented an interesting situation, where Monro stated she had been bitten by a fox, and had scratches on her face. This could have been discussed further, as a human being attacked by a fox is a very unusual occurrence.

15.5.3 The attendance in 2019 indicated a history of substance abuse but this was not addressed or explored with her, and she was discharged to her GP. The discharge summary did not mention substance misuse or suggest support in the community given that she has children.

15.5.4 In 2020, when she was found in the park and brought to ED by ambulance, there was better coordination of her health needs and good information sharing as a referral was sent to children's services. The police were involved, and they carried out a welfare check to the home to ensure the children were safe.

15.5.5 The medical focus of Monro's attendance at Hospital B was adequate and she received good care. However, other social issues were not identified which could have led to early intervention. The learning for Hospital B is therefore around professional curiosity, and enquiry regarding safety, risk taking behaviours and domestic abuse. The information must also always be shared, especially when there are children involved.

15.5.6 Since the period of the review, ongoing training in ED around identification of concerns and professional curiosity has been introduced.

15.6. Children Social Care

15.6.1. The reason for CSC involvement with Monro and her family, was related to the allegation of domestic abuse made against Nojus in February 2021, when Monro presented at Hospital A. The family was responded to through the Child in Need case framework. There was no previous history within Surrey at the point of referral, although subsequent information about similar concerns around domestic abuse in other boroughs came to light as part of the assessment activity. There was nothing at this initial stage of assessment which suggested that a higher level of intervention was required and indeed until the period immediately before Monro's death this remained the case.

15.6.2. CSC role is to primarily focus on the impact of parental difficulties on any children and whether their welfare is compromised, but it is clear from the records that Monro was seen as someone who needed support and was someone who accepted support. At an early stage of involvement, the parents had separated, and Monro was seen as the principal carer, albeit Nojus had regular staying contact with his child. Monro was accepting of support and demonstrated insight into her situation, she was proactive in identifying her own solutions. There was a small extended family network which offered respite and support to the family and who stepped in to offer Monro childcare when this was needed. Monro's children were seen as well cared for, although towards the end of her life, her elder child appeared to be demonstrating some impact from her alcohol dependency and this was affecting their relationship. Although he accessed counselling support from his school it is not clear how much he or his younger brother were aware of the previous para-suicide attempts.

15.6.3. Although there have been staffing challenges in Surrey, Monro and her children had a consistent social worker, who was in turn managed by the same manager throughout the period of involvement. The Family Safeguarding Model[65] envisages a wraparound service compromised of the children's social worker and other workers who may provide specialist input. In this situation that would most likely have been support from specialist workers in both domestic abuse and/or substance misuse services. This level of specialist support was not available to Monro, because of recruitment issues. Monro did access mental health and substance misuse support from community-based services and through her own privately funded psychologist and detox programme. The social worker undertook the work around domestic abuse, whilst also trying to access specialist domestic abuse services for Monro.

15.6.4. Although Monro and her parents were of Lithuanian nationality and Russian heritage, she had spent half of her life in the UK. There were no specific markers identified that suggested that the problems she faced were rooted in her cultural identity or exacerbated by her culture – however this was never explored with Monro.

15.6.5. A Child & Family Assessment was commenced following the referral in February 2021, and was completed in March 2021 with a recommendation that the family be supported under a Child in Need Plan. In the work undertaken as part of the Child & Family Assessment and ongoing work under Child in Need, the social worker had a number of sessions with Monro and discussed the parental relationship. They had split up on three previous occasions but had reconciled. Monro reported long-term controlling

[65] Effective-family-resilience-SSCP-Dec-2020-v7.pdf (surreyscp.org.uk)

behaviour from Nojus. At this time the parents were no longer living together, and although it was accepted that this did not necessarily increase safety, both were willing to access separate counselling support and reported no intention to reconnect. There was ongoing contact that centred on staying contact arrangements between Nojus and his child. During the assessment, it was noted that Monro was drinking alcohol as a way of coping with her situation. The children remained open to Children's Services throughout 2021 and into 2022 under CIN Plans.

15.6.6. The social worker made a referral to Your Sanctuary on 22nd March 2021.

15.6.7. On 23rd April 2021, Monro reported that Nojus had threatened to have her children "taken away" because of her level of alcohol use – this occurred outside the children's school during handover of the younger child for weekend contact. This was recorded as illustrating how Nojus used the children as a way of maintaining elements of control over Monro despite their separation.

15.6.8. Following a call to police by Nojus on 7th May 2021, raising a concern that the children had been to hospital the day before, the social worker liaised with the Designated Safeguarding Lead at the children's school, who reported that Monro was very upset and felt that she was being constantly observed by Nojus.

15.6.9. Social worker's notes suggest that the period prior to Monro's suicide attempt on 25th June 2021 was very calm, with Monro reporting that she was not drinking, was engaging with her psychologist and that the relationship with Nojus was amicable. The elder child was with their grandparents at the time of the suicide attempt, and younger child was with Nojus. The incident prompted Nojus to raise concerns about his child's safety whilst in the care of his mother and threatening to retain the care of his child, but the child was returned to Monro on 30th June 2021, following Monro's discharge from hospital and a legal letter sent from Monro's solicitor. In follow up conversations between Monro and the social worker, Monro stated that Nojus had a new partner who had contacted Monro via social media, telling her to leave Nojus alone – and this had sent her "over the edge".

15.6.10. The social worker submitted a further referral to Your Sanctuary on 30th June 2021, and was advised that various previous referrals had not led to engagement from Monro.

15.6.11. In July 2021 Monro was discharged by CMHRS but was engaged with I-access and had what appears to be private psychology. In July she referenced moving out of County, but this was abandoned in August 2021 because of imminent family law proceedings brought by Nojus in respect of his child. The maternal grandmother had moved in with Monro to provide additional support. In this period Monro appeared to be doing well, she was accessing online groups and had remained abstinent from alcohol since June. She had been referred to the online Freedom Project but had not taken this up by September 2021. In relation to the family law proceedings, the social worker recorded that they were unclear what Nojus wanted in relation to contact and that this appeared to be more of an exercise in "punishing" Monro.

15.6.12. Monro relapsed in October 2021 and again began drinking heavily in the evenings and weekends. This followed stopping her prescribed medication which resulted in rapid deterioration of her mood. When intoxicated Monro would frequently call Nojus in the night. She booked herself into a 10-day privately funded detox on 11th October 2021 with "Steps Together" rehab. During this period elder child was cared for by his maternal grandparents and younger child went to live with his father. Nojus is described as being very supportive of Monro in this period.

15.6.13. When Monro completed the detox, she returned to her own home rather than to her parents' home and the children returned to her care. In the last supervision note before Monro's death, there is reference to Nojus knowing which buttons to push to destabilise Monro and undermine her mental health but there is no recorded information suggesting that the couple were in communication beyond that necessary to facilitate contact with the youngest child.

15.6.14. On 19th December 2021, Monro attempted to take her life and was conveyed to Hospital A. She remained on an assessment unit, due to being intoxicated and drowsy, and was seen by PLT on 21st December 2021. In this time, she said that a lot of her alcohol consumption was an attempt to "make herself feel better" because of what was wrong with her mind. This latest incident triggered a Sec.47 Child Protection Investigation process. The children had remained in the care of the maternal grandparents and Nojus respectively.

15.6.15. The work completed with Monro included consideration of the "Power & Control Wheel" and the "Cycles of Abuse" both of which she engaged with fully, evidenced insight into the ways in which the relationship was affected by different types of controlling behaviour from Nojus. This included financial control up until the time that Monro became financially independent, sexual control where Monro reported Nojus asking her to do things that she was not comfortable doing and then withholding any sexual contact for extended periods if she refused. There was also the control exercised through the threat of having her children removed or in keeping younger child in his care following contact. The family law proceedings initiated by Nojus could be seen in this light as they heightened Monro's anxiety.

15.6.16. The Family Safeguarding Model envisages the involvement of specialist workers, in this case skilled in dealing with domestic abuse and substance misuse issues. As Monro did not engage with Your Sanctuary or any other specialist service most work was undertaken by the social worker. It is clear from the case records that the worker initiated the expected conversations around identifying red flags, keeping safe and responding to coercive control, and that Monro responded to these conversations positively.

15.6.17. Nojus also engaged in some direct work, and his view was that he was motivated by concern for his child, that he felt that at times his child was at risk in Monro's care because of her alcohol dependency, and it was this concern that made him call the police on a couple of occasions to undertake welfare checks. He did not accept that he was controlling and suggested that Monro was manipulative and controlling in return.

15.6.18. Social work support was concentrated on ensuring the children's wellbeing in this period, elder child was accessed to counselling support via his school, and Monro took advice from her psychologist in supporting younger child around his relationship with his father, and particularly when Nojus introduced a new partner. On the occasions when Monro self-harmed her children were elsewhere. It is unclear how pre-meditated some of the para-suicide attempts were, other than perhaps those where a note was left.

15.6.19. It could also be considered that the absence of her children exacerbated her mental ill health and contributed to the reasons for the suicide attempts.

15.6.20. At no time did Monro disengage from the social worker and continued to respond to planning around how she could access support for herself. She was proactive in identifying her own support, such as when she arranged her own detox in October 2021. She engaged with i-Access but seemed to prefer to use her own resources to access psychological support. There is no sense of "disguised compliance" but rather a pattern of hopefulness and planning for the future, such as her plan to move to Birmingham in August 2021 for a fresh start, followed by a deterioration in her mental health or a relapse into alcohol use. In these periods where Monro was not in control, she used the support offered by her parents.

15.7. Adult Social Care

15.7.1. ASC received three referrals regarding Monro. All were from Surrey Police. None led to any involvement from ASC.

15.7.2. The first two referrals were submitted together and related to the police attending Monro's home on 2nd February 2021, and their contact with her the following day.

15.7.3. The third referral was following the police attending Monro home on 25th June 2021 when she had appeared to have attempted suicide.

15.7.4. The decision making in response to the referrals in February 2021 was made by the Contact Centre, who carry out work to meet s4 Care Act duties. They reviewed the referrals and as there was no evidence of care and support needs decided no action from ASC was required. There is no indication on the referrals that the police had discussed with Monro that they were making a referral to ASC.

15.7.5. The referral of June 2021 was passed by the Contact Centre to the Mental Health Duty team, as it appeared to the Contact Centre that there may be an appearance of mental health issues and/or substance misuse issues. The Mental Health duty team wrote "No appearance of care and support needs at this time". At this point, it was known by some agencies that there had been a referral to SaBP's HTT, and the plan for HTT was to make a referral to i-access. Monro had demonstrated an ability to seek help and support herself. Within Care Act guidance, arguably, she met the threshold for Early Help, appeared to need support or help due to a physical or mental impairment or illness (including drug and alcohol use) and may have required universal and targeted services working together. This was the offer by SaBP.

15.7.6. At times, Monro became vulnerable given her mental health and alcohol/substance misuse, which may have impacted on her developing and maintaining family or other personal relationships and carrying out any caring responsibilities the adult has for a child, during those limited periods and it appeared that Monro was at risk of abuse or neglect at those times. An assessment of Monro's care and support needs could have been offered following the referral in June 2021 had the contact centre been aware of this.

15.8. South-East and Coastal Ambulance Service (SECAmb)

15.8.1. The Patient Clinical Records describe many clinicians being very sensitive to Monro's immediate needs at the times of contacts, however, there is no evidence that there were potential indicators of domestic abuse presented to SECAmb clinicians.

15.8.2. At time of incidents SECAmb did not have access to patient's health records, other than those held by the ambulance service. Therefore, crew would not have been cited on Monro's care and support needs unless she had disclosed those directly, or another professional had disclosed these to SECAmb – neither of these scenarios happened.

15.8.3. Crew shared detailed clinical notes at handover with the ED staff.

15.8.4. Crew raised safeguarding concerns with the local authority about Monro and her children on three occasions. These concerns were made for the attention of both adult and children services, primarily regarding Monro's mental health. Whilst SECAmb clinicians are always encouraged to seek consent for safeguarding referrals, the three referrals made for Monro and her family were without consent. On two occasions, she did not have capacity to consent, and referrals were made in her best interest. On the third occasion, the referral was made without her consent; the reason for not gaining consent was that Monro was concerned that her children would be taken from her. However, it was recognised that the family were already well known to social care and therefore it was appropriate for the clinicians to record their findings and for these to be passed to the local authority under well establish information sharing agreements.

15.8.5. Assessment and decision making for ongoing care responsibilities are not carried out by SECAmb. Acute, pre-hospital assessments and decision making were carried out, within the scope of the attending clinicians, with the patient's care being passed to the local hospital.

15.8.6. As a non-case holding agency, risk management plans fall outside SECAmb's remit. The "appropriate service" offered was treatment and conveyance to A&E, which was accepted by the patient and completed.

15.8.7. During most contacts with Monro, she is documented as having mental capacity to make her own decisions regarding treatment and ongoing care. When offered ED attendance, she accepted this, and was conveyed accordingly. As ED treatment was the

most appropriate pathway for Monro, to which she agreed to, there was no requirement for signposting elsewhere.

15.9. Surrey and Borders NHS Partnership Trust (SaBP)

15.9.1. Monro was first referred to the SaBP PLT at Hospital A on 11th May 2021, and then subsequently following further ED attendances. Monro was also known to SaBP i-access services - she completed Relapse Prevention Groups.

15.9.2. It is recognised that the domestic abuse which Monro had been subjected to during her relationship with Nojus, and his continued control of her following the end of their relationship, was not fully taken into account within the assessments by the PLT. This is a developing topic within SaBP, and all staff are currently being trained to take the whole person and situation into account when assessing risk.

15.9.3. SaBP recognise that to support families to make changes that are helpful and long-lasting professionals need to consider the family as a whole and work with all the members of the family and professionals involved with the family. If the needs and desired outcomes of each person in the family is understood, sustainable change is more likely to be achieved.

15.9.4. SaBP have developed a robust Think Family Guidance for Practitioners document that supports staff in applying Think Family Approach in their practice.

15.9.5. Monro's parents were spoken to, and staff were assured that her parents were staying with her and supporting her when she was discharged. Staff provided opportunities for Monro's parents to provide their views on her treatment and were fully engaged. Staff were aware of CSC involvement and that children had a social worker.

15.9.6. However, SaBP staff involvement and collaborative work with the CSC was limited, and there was a lack of exploration regarding Monro's experiences of abuse from Nojus, during their relationship and since they had separated.

15.9.7. There was also a lack of consideration of Monro as an adult with care and support needs. SaBP could have raised a concern with ASC when presented with the Monro's mental health, alcohol use, domestic abuse, and social environment. No referrals were made to ASC by SaBP.

15.9.8. On 24th December 2021, Monro attended Hospital A's ED with a bag packed and indicated that she wanted to be admitted to a psychiatric in-patient bed.

15.9.9. Monro's risk of suicide was assessed as medium, with no current suicidal thoughts, plans or intent. She stated self-harm was to punish herself. It was not felt that admission to a psychiatric ward would be beneficial as she did not have any acute symptoms of mental illness. Her symptoms appeared to be in the context of alcohol misuse, emotional dysregulation, and impulsive self-harming behaviours.

15.9.10. There is no record of Monro's family situation being considered as a risk factor. In every previous assessment or contact with SaBP, Monro's children are recorded as her protective factors. However, in this situation she did not have the care of her children, yet this does not appear to have been considered a risk factor.

15.9.11. Taking into consideration Monro's home and social environment, the fact that it was Christmas Eve, and she was returning home alone, there was a distinct lack of safety planning recorded. Monro's family could have been contacted for assistance, or Monro could have been considered for a short-term crisis bed.

15.10. Your Sanctuary

15.10.1. Your Sanctuary had contact directly with Monro, and with other professionals in relation to Monro, from February 2021 to December 2021.

15.10.2. The first contact was via two police referrals received on 3rd February 2021, relating to a common assault and an ABH against Monro. On 4th February 2021, an outreach worker called Monro. They talked through the existing safeguarding that was in place, this included Police conditional bail applied to Nojus and a 'DA Kit' that the police had provided Monro with. The outreach worker also discussed the civil options of a non-molestation order and occupation order with Monro should these become relevant post bail. Monro explained that she jointly rented her flat with Nojus and they lived there with their children who were currently being home schooled due to Covid. Monro disclosed previous domestic abuse from a year ago and said she had left Nojus for a few months after that. She said she was feeling overwhelmed but had a hospital appointment that afternoon in relation to the physical injury she had suffered as a result of the latest assault. The outreach worker established that Nojus was the main source of household income but Monro had some very limited financial independence and access to some savings and her own bank account. Monro expressed some concerns over whether Nojus would pay the rent if she obtained an occupation order which meant he could no longer reside there. Thus, the possibility of post separation financial/economic abuse was identified. Monro explained her family, grandmother and mother, lived in the neighbouring county and she had support from them but was very keen for ongoing outreach support. Due to this the outreach worker arranged to follow up with another call for 11th February 2021.

15.10.3. The notes from this contact demonstrate that important safety and wellbeing issues were understood, and the support Monro wanted was discussed. However, there is no indication that any DASH was completed and there are no notes relating specifically to 'Risk' made in relation to this contact.

15.10.4. The DASH may not have been completed on this first call as Monro had indicated that she was already feeing overwhelmed. Your Sanctuary work to a trauma informed model, which often means that risk assessments are not completed via phone during the initial call, the risk assessment asks some fairly invasive questions and the

support workers prefer to build rapport before launching into the DASH, and this is usually completed face to face. The support worker may also have been led by the police DASH, as this would have been shared with the referral.

15.10.5. However, had DASH questions been asked of Monro, she may have disclosed more detailed information which would have allowed for a better picture of what was 'overwhelming' her, and what the specific risks were. This would have potentially identified if she had any vulnerabilities or needs that would impact her staying safe and formed part of her safety and support plan.

15.10.6. The lack of risk assessment is contrary to Your Sanctuary policy in place at the time, which required a DASH to be completed as soon as possible. Since the scoping period for this review, Your Sanctuary policies have been amended to ensure they reflect a trauma informed approach, and that professional judgement and the police DASH is also used to inform risk levels, where completing the DASH with the victim at the early stages would negatively impact their wellbeing.

15.10.7. During the follow up call on 11th February 2021, Monro described feeling calmer, the children being happier and the atmosphere much better as it was quieter and there was no shouting. Monro did express fear that Nojus may try to take their youngest child if his bail conditions weren't in place, but no further detail recorded about this on case notes.

15.10.8. There could have been more professional curiosity around the risk that Monro felt Nojus may pose in relation to the "taking" of the youngest child. It may have been assumed that this was being covered by the social worker, who was due to visit Monro that day. However, it was unclear from the records whether this was an Adult Social Worker or a Children's Social Worker – neither was there a record of the purpose of the visit. This would also have benefited from more exploration.

15.10.9. On the 3rd March 2021, the outreach worker attempted to call Monro as agreed but there was no answer and no voicemail message was left, but a text message was sent to Monro. The outreach worker set a task to call Monro again in one week if Monro did not call her back from the text.

15.10.10. On 11th March 2021, the outreach worker called Monro again – this time Monro answered and stated she was feeling good, she was working, she felt safe, and she was seeing a psychologist and was 'calming down'. She said that Nojus was living with his brother and having contact with his child. She reported feeling safe and that she was not looking for any kind of injunction. She indicated she was sorting out her benefit situation and finances and overall seemed to be doing well. Due to this information from Monro, the case was closed, and Monro was advised to contact Your Sanctuary if she needed further support.

15.10.11. On 22nd March 2021, the social worker made a referral to Your Sanctuary – this referral was not opened, and the social worker was advised that Monro had already received a programme of support. This is a missed opportunity, as the context behind the referral was not known – Monro could have been presenting an alternative view of

her current situation to the outreach worker 11 days before – or indeed the abuse or risk of abuse may have escalated in that time. Since the scoping period for the review, Your Sanctuary staff have received significant training around the service provision on offer. The language of "programme of support" used during this encounter is not reflective of the Your Sanctuary's working practices, which offer an open service regardless of previous support given.

15.10.12. The social worker again contacted Your Sanctuary on 30th June 2021, this time via the Helpline – requesting support for Monro. The call handler advised the social worker to pass Monro the Your Sanctuary contact details to make contact herself. This did not happen, and again this is a missed opportunity for Your Sanctuary to support Monro. Many victim/survivors will struggle to make contact themselves - for many reasons, and since the scoping period for this review there has been a significant amount of training provided to the helpline advisors, exploring why survivors may not feel able to seek access to support themselves, and potential barriers they may face.

15.10.13. Since these encounters in March and June 2021, Your Sanctuary have developed policies and training which would preclude this type of response happening again.

15.10.14. On 21st December 2021, a referral to the HIDVA service was made by the PLT. The referral related to a disclosure Monro had made during the PLT assessment regarding Nojus' behaviour, and Monro had indicated that she would like some support. Calls were made to Monro by the HIDVA on 22nd and 23rd December 2021. There was no reply, and an attempt was made again on 29th December 2021. When there was no response, the HIDVA advised the referrer, and asked them to pass on the Helpline number to Monro when she next spoke to her. These attempts, and the follow up with the referrer is good practice. However, Monro had passed away on 29th December 2021.

15.10.15. Although the HIDVA did not speak to Monro, the information on the PLT referral may have indicated care and support needs. The HIDVA service could have raised a concern with ASC, in the form of a consultation to discuss Monro's issues without making a formal referral.

15.11. Covid-19 restrictions [66]

15.11.1. In March 2020, the National Covid-19 restrictions came into force which restricted the movement of the general public. Meetings with health and social care professionals were moved to either telephone, or virtual video conferencing.

15.11.2. It is understood from the information held regarding Monro and her family, that during the early part of the restrictions Monro and Nojus had separated following the incident in 2020. They were living outside of Surrey at the time. They rekindled their relationship after a few months, during the summer period of 2020 the restrictions were loosened a little, therefore the family may not have been as isolated during this time.

[66] See timeline-coronavirus-lockdown-december-2021 (instituteforgovernment.org.uk) for reference

15.11.3. At the point of the incident in February 2021, the second phase of the National Covid-19 restrictions were nearing their end. However, health and social care agencies continued to meet virtually for many months – and some services have remained hybrid depending on circumstances.

15.11.4. Therefore during 2021, when Monro was receiving support and accessing services for her mental health and alcohol issues, some of the contact may have been affected by the ongoing post-Covid working practices.

15.11.5. The Covid-19 pandemic affected the ambulance service in many ways, but it did not change their attendance to emergency patients. In fact, for a long time, the ambulance service was one of the only agencies still entering people's homes.

15.11.6. There is no indication that the Surrey police response was affected by Covid-19 restrictions.

15.11.7. At the time of Your Sanctuary's first contact with Monro, Covid-19 restrictions were in place, and working practices had been adapted meaning that outreach and helpline staff were working remotely. This meant that there were potentially fewer opportunities for casual peer support, interaction, and supervision, but they have not found any indication that this had an impact on service delivery.

15.11.8. Monro would ordinarily have been seen face to face, and Your Sanctuary are now back to seeing victim/survivors face to face. As discussed above, this provides a more trauma informed environment to complete DASH assessments and ask difficult questions.

15.11.9. During the first two years of the Covid-19 pandemic, a significant portion of GP patient contacts took place by either phone, or video link. During Monro's time registered with Practice B, she had four direct contacts, one of these was face to face, in February 2021 – and the others were all via phone.

15.11.10. Hospital attendances were affected during the Covid-19 restrictions as people were not permitted to have someone with them when attending ED or visiting when admitted. Staff fatigue and sickness levels were also high during this time.

15.11.11. When attending Hospital A, Monro was referred to i-access, although it appears that there was no referral made into Hospital A's Alcohol Liaison Service. At this time, staff were redeployed from their primary roles into frontline clinical services; this was the case for the Alcohol Liaison Nurse (ALN) who was a lone practitioner within the Trust at the time. This led to a restricted service, however they may have had the opportunity to provide some support to Monro during the first admission in December 2021 had a referral been made. The Trust ALN would also have referred Monro into i-access, however, as this service was already involved in her care the impact would have been mitigated. The Alcohol Liaison Service in the hospital has since been expanded adding greater resilience in the service.

15.11.12. The CSC responses to Monro and her children were not affected by any period of Covid restrictions, and CSC maintained in-home visiting throughout. Child in Need meetings were hybrid with both in-person and virtual attendance.

15.12. Co-occurring Conditions – Alcohol and Mental Health

15.12.1. It is clear from the information available that alcohol misuse impacted on Monro's ability to make decisions to keep herself safe. A recent publication[67] providing advice and support to practitioners faced with dependent[68] and chronic[69] drinkers who are also highly vulnerable[70], highlights the need to use existing legal powers wherever possible, and not to allow the person's denial and refusal to stop intervening if they are at risk.[71]

15.12.2. The Care Act 2014 states that a person does not need to lack capacity to be vulnerable, or self-neglecting. Neither of the referrals made to ASC were picked up, following the triage stage concluding that Monro had no care or support needs.

15.12.3. It is also problematic to assume that if a person can care for themselves when they are sober, that they do not require intervention. Alcoholism is a "chronic relapsing condition"[72] and the fact that they have been at risk during intoxication previously, indicates that this could happen again. Relying on assessments which are made during periods of sobriety is unlikely to help the person in the long run – the whole trajectory of their condition must be considered. In Monro's case, she presented as well kept and articulate, yet when intoxicated self-harmed with the intention of suicide – it is the risk of this behaviour which should have been assessed rather than her sober presentation of reasonableness. Preston-Shoot argues that long term, evidence-based views are required when responding to people with chronic and complex alcohol use – such as Monro 's.[73]

15.12.4. The view that people are entitled to make unwise decisions can be taken out of context. The Mental Capacity Act Code of Practice states that "People have the right to make decisions that others might think are unwise."[74] The Mental Capacity Act has a more measured statement: "The following principles apply for the purposes of this Act… A person is not to be treated as unable to make a decision merely because he makes an unwise decision."[75] However, "For the purposes of this Act" is a critical caveat. This is not a general statement about the right to make unwise decisions in all contexts. Also,

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[67] Safeguarding-guide-final-August-2021.pdf

[68] Alcohol addicted drinking at levels that make them physically dependent

[69] Alcohol dependent for a long time – usually decades

[70] People who present a high level of risk to themselves, and suffer long term negative effects. One indicator is a high use of emergency services.

[71] Safeguarding-guide-final-August-2021.pdf p.8

[72] *ibid*

[73] *Ibid*

[74] Department for Constitutional Affairs, Mental Capacity Act 2005 Code of Practice (London, 2007) p.19

[75] Mental Capacity Act 2005 in Practice (publishing.service.gov.uk)

the word “merely” is relevant, the fact that the decision is unwise is not sufficient to conclude that the person lacks capacity, however it may be a relevant consideration to consider in determining whether a person is unable to make a capacitous decision,[76] for example if there are many repeated unwise decisions, taking in specific circumstances, a consideration of executive capacity[77] may be appropriate.

15.12.5. The Blue Light Project have developed a Guidance manual[78] for professionals who may encounter people with problematic alcohol issues, who also have complex needs and who are not currently engaged with specialist alcohol services. The manual provides guidance on how to provide assertive outreach[79], along with details of the legal powers available to intervene when it is clear that a person’s chronic alcohol issues may be putting them at high risk.

15.12.6. Taking the above into account, it could be argued that Monro had care and support needs, around her alcohol misuse and her mental health issues – and particularly where these intersected and led to self-harm and suicidal attempts.

15.13. Understanding the effects of domestic abuse and coercive control

15.13.1. Monro’s contact with i-access was very short however appropriate intervention was implemented, and Monro was doing well, although her experiences of domestic abuse were not explored. Monro was deemed to have capacity to make decisions but was often intoxicated when assessments took place: frequent alcohol use contributes to changes in the brain associated with impaired executive functioning. This may impact on the ability to effectively engage with services. In Monro’s situation, alcohol use combined with domestic abuse, and it was possible that her mental capacity fluctuated.

15.13.2. The PLT assessments found Monro to be at low risk of harm from herself, however it was noted that this risk would increase when she was intoxicated. There did not appear to be an assessment of risk of Monro being intoxicated again, which would lead to her being at high risk of harm from herself.

15.13.3. A lot of the language used around the abuse Monro experience indicates that it was non-recent, and a historic issue. There is a lack of awareness of the ongoing and pervasive effects of domestic abuse - from practitioners generally, aside from the social worker and the PLT Nurse who assessed Monro in December 2021. There was also a lack of curiosity and pro-active response to the effects of the family court process on Monro.

[76] Jenkinson, A. and Chamberlain, J., ‘How misinterpretation of ‘unwise decisions’ principle illustrates value of legal literacy for social workers’ Community Care, (28 June 2019)
[77] Executive capacity is the ability to carry out a decision.
[78] The-Blue-Light-Manual.pdf
[79] This is a proactive approach to delivering support and interventions. It is used with people who have difficulties engaging with services. It is a way of organising services to provide an intensive, assertive and comprehensive service, and challenges the idea that a client is always responsible for engaging with services and showing that they want support.

15.13.4. Research highlights[80] how perpetrators of coercive control often use established processes and systems such as family courts, police and children social care, to continue the control of their ex-partners following separation. Monro disclosed to practitioners, including her children's school, that she felt Nojus was monitoring her, and was using these systems to do this. As his behaviours impacted Monro, the behaviour he was raising concerns about worsened, as a direct effect of the ongoing coercive control.

15.13.5. The Coercive and Controlling Behaviour legislation has recently been updated to include ex-partners within the definition – this is in response to the behaviours which Nojus was displaying.

15.13.6. The social worker identified the possible use of the family court to continue control of Monro. The outcome of the court process was to maintain the contact which had already been agreed between Monro and Nojus – and which was happening regularly without the need for a court order. Monro had not refused contact between Nojus and his child –Nojus had commenced the court process with the intention of removing the child from Monro's care, this was a plan which the social worker and the CAFCASS[81] officer involved in the case did not support.

15.13.7. However, this would have impacted on Monro, who had indicated that her children were her protection from taking her own life. The trajectory of her alcohol use, and her self harm/suicide attempts can be plotted against the court hearings – her mental wellbeing had been improving ahead of the court hearing in November 2021, and declined after this took place.

15.13.8. There is some indication of work completed with Monro by the family social worker, however this would have been limited as the social worker's role was to work with both parents. During the scoping period of the review, there were vacancies for the role of domestic abuse link workers in the CSC teams. This role would have worked directly with Monro as a victim of domestic abuse, empowering her to work with domestic abuse services, helping her to understand the effects of coercive and controlling behaviour, which may have reduced her need to use alcohol.

15.13.9. Monro's combined issues of alcohol misuse, mental ill health and domestic abuse were not assessed as intersecting with one another – each exacerbated the other, and when combined would have been identified as posing a much higher risk than when they were assessed as individual issues.

15.13.10. This review highlights the importance of multi-agency working when responding to victim/survivors with co-occurring conditions. It also

[80] See for example: Birchall, J and Choudhry, S "I was punished for telling the truth: how allegations of parental alienation are used to silence, sideline and disempower survivors of domestic abuse in family law proceedings" *Journal of Gender Based Violence* (6) (2022); Hay, C et al "Mother's Post-Separation Experiences of Male Partner Abuse; An Exploratory Study" *Journal of Family Issues* (44) (2021)

[81] Home - Cafcass - Children and Family Court Advisory and Support Service

raises the need for non-domestic abuse practitioners to be trained in both the effects of coercive control, and the completion of DASH risk assessments.

15.13.11. Throughout the period of the review, it is evident that Monro's children had been present at the scene of incidents of violence and aggression and would have been affected by the power dynamics created by Nojus' behaviour. The Domestic Abuse Act 2021, which was enacted after the period of his review, made provision for children as victims "in their own right." There is no evidence that Monro's children were provided with any specialist support regarding domestic abuse or flagged with the 0-19 team[82] as being at risk from domestic abuse. Although they were subject to Child in Need planning, this did not trigger additional specialist interventions, which may now be available since the introduction of the Domestic Abuse Act.

15.14. Trauma Informed responses

15.14.1. Trauma informed Practice is a strengths-based approach which seeks to understand and respond to the impact of trauma on people's lives. The approach emphasises physical, psychological, and emotional safety for everyone and aims to empower individuals to re-establish control of their lives.

15.14.2. Trauma informed practice includes the ability to identify signs and symptoms of trauma, utilising a strengths-based model which empowers service users to collaborate in the design and delivery of their support – and asks, "what happened to you" instead of "what's wrong with you".[83]

15.14.3. Agencies involved with Monro had limited knowledge of her background and any other support networks she may have had. This review highlighted the importance of understanding a person's past, particularly any adverse childhood experiences – for example, although Monro reported to have a happy childhood, she also disclosed that she self-harmed during her late teenage years, during which time she also left her country and moved to England.

15.14.4. Loneliness can also present as complex in adulthood. In Monro's case, her children were living with their father and grandparents which she was unhappy about and probably felt lonely and isolated. It is important that all staff know as much information as possible to help them make informed choices about signposting, support and choosing the right engagement strategies.

15.14.5. For people living with a mental health diagnosis, trauma informed approaches mean that:

[82] Health Visiting :: Children and Family Health Surrey (sonrenshealthsurrey.nhs.uk)
[83] See Trauma-informed practice: what it is and why NAPAC supports it | NAPAC

"It can be extremely empowering and healing to explore and recognise that many or even all their symptoms are linked to chronic traumatic experiences in childhood rather than innate 'defects' or 'disorders'."[84]

15.14.6. Women and girls' charity AVA provide three key messages for those supporting victims of abuse. First that professionals should work in a way that understands trauma, its impact on the body, and focus on interactions that maximise both physical and emotional safety. Second is that when women use substances is it often as a coping strategy to manage their experiences. They ask that professionals work in a way that acknowledges what women have done to survive and not to blame the women but rather listen to them and believe them. And finally, that professionals must understand behaviour as a form of communication and consider what is going on under the surface for women, take the time to be professionally curious, and focus on building trusting relationships with women that acknowledge their strengths and capabilities.[85]

15.14.7. There is training available at SaBP on Understanding Trauma and Trauma Informed Care, which is delivered face to face. This was most recently delivered in March 2023.

15.14.8. The continuity of the social worker involved with Monro's family allowed a rapport to be built, and Monro opened up to her about Nojus and her other experiences. The social worker displayed a sound knowledge of domestic abuse and was the only professional to identify and record Nojus' behaviours using the language of coercive and controlling behaviour.

15.15. Understanding Risk of Suicide

15.15.1. Suicide is not inevitable, it is preventable. However, suicide prevention is a complex public health challenge and requires close working between the different NHS and partner organisations to build on priorities set out in the National Suicide Prevention Strategy, along with existing and emerging evidence around suicide such as from the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness. Plans should include a strong focus on primary care, alcohol, and drug misuse (NHSE).

15.15.2. Research shows that the risk for a suicide attempt is higher for people who had previously attempted, and higher still for those who also have a mood disorder.[86] Risk factors for suicide include depressed mood, recent loss/bereavement, and alcohol abuse – amongst others.[87] Taking into account the recent loss of Monro's children away from her care – these are all indicators of risk of suicide.

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[84] *ibid*

[85] AVA Project *Breaking Down the Barriers: Findings of The National Commission on Domestic and Sexual Violence and Multiple Disadvantage* (2019) Available: Breaking-down-the-Barriers-full-report-.pdf (avaproject.org.uk) Accessed 30th April 2021

[86] Massimiliano, B and Rosenbaun, J "Risk Factors for Fatal and Non-Fatal Repetition of Suicide Attempts: A Critical Appraisal" *Current Opinion in Psychiatry* July 2010 23 (4) pp.349-355

[87] Hall, R, Platt, D and Hall, RC "Suicide Risk Assessment: A Review of Risk Factors for Suicide in 1—Patients who Made Severe Suicide Attempts: Evaluation of Suicide Risk in a time of Managed Care" *Psychosomatics* (1999) 40 (1) pp.18-27

15.15.3. Assessment of risk of suicide should always be based on the assessment of individual risk, rather on the completion of a checklist. People who have the opportunity to discuss specific stressors in their life, such as domestic abuse, poverty, loss or any other environmental factors which may trigger suicidal ideation. Where possible families and carers should have involvement with assessment processes, including the opportunity to express their concerns about potential risks.[88]

15.15.4. Kent County Council's Suicide Prevention Team[89] have developed a simple assessment tool, to assist professionals in identifying the risk of suicide.[90] The assessment asks three prompts to identify and understand the levels of risk – with the answer options as yes to either "ever", "in this relationship", or "in the past three months".

- Have you self-harmed?
- Have you ever felt suicidal?
- Have you ever made a suicide attempt?

15.15.5. These prompts should not be considered as a risk assessment tool by themselves, rather they are prompts which will help professionals open up a full conversation about mental health and should promote confidence in asking questions about suicide. Without the answers to these questions, any safety plan that is developed around keeping the individual safe from suicide will be based on incomplete information.

15.15.6. Completion of suicide prevention training remains the most effective way of ensuring that professionals are able to safely identify and support people at risk of suicide.

15.15.7. SaBP, have an Internal Suicide Prevention Strategy and have co-produced training that is delivered through the Recovery College. It is open to anyone and helps people feel confident to talk about suicide. They are also members of the Zero Suicide Alliance.[91]

15.15.8. SaBP have plans to introduce training around the Joiners Model[92] of suicide risk. This Interpersonal Psychology Theory of Suicide requires the identification of both "perceived burdensomeness" (perception of being a burden to others) and "thwarted belongingness" *a social disconnection to something larger than oneself) – along with the "capability" of completing suicide – which combined result in a high-risk state for suicide.

15.15.9. SaBP are currently reviewing their suicide policy and risk assessment approach, and intend to align both to the newly introduced NICE guidance[93] which requires services to move away from a low, medium and high risk approach to suicide risk assessment.

[88] https://sites.manchester.ac.uk/ncish/
[89] suicideprevention@kent.gov.uk
[90] https://padlet.com/SuicidePrevention/suicide-prevention-team-resources-zuu4rhjasoll5b01/wish/2298134888
[91] Zero Suicide Alliance (ZSA)
[92] Republic of Ireland Suicide Risk Model — Construction Working Minds
[93] Overview | Preventing suicide in community and custodial settings | Guidance | NICE

15.15.10. Police showed good practice by including a suicide indicator on Monro's Niche record.

15.15.11. Monro was not identified as being at high risk of suicide at any time, including when she was discharged from Hospital A on Christmas Eve, after attending with belongings seeking admission to a psychiatric ward. It is difficult to fully understand why further options were not explored in terms of finding an alternative emergency bed or making sure that when Monro left the hospital, follow up was made as to where she went and who was able to support her. Police or her family should have been contacted to raise the concerns.

15.15.12. This review identifies gaps, across all services, in understanding suicide risk, and responding to those who are at risk of suicide.

16. Conclusions

16.1.1. 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.

16.1.2. 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.

16.1.3. 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.

16.1.4. 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.

17. Lessons to be Learnt

17.1 Surrey Police

17.1.1. 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.

17.1.2. 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.

17.1.3. 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."

17.1.4. 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.

17.2 GP Practice A

17.2.1. 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.

17.2.2. 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.

17.2.3. 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.

17.3 Hospital A

17.4.1. 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.

17.4.2. 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.

17.4. Surrey and Borders Partnership Trust

17.4.1. 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.

17.4.2. 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.

17.4.3. 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.

17.4.4. 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.

17.4.5. 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.

17.5 Children Social Care

17.5.1 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.

17.5.2 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.

17.6 Your Sanctuary

17.6.1. 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.

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

17.6.3. Your Sanctuary Outreach workers have recently been trained in the use of the Homicide and Suicide Timeline[94] and this will further improve practice.

17.6.4. 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.

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

17.6.6. 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.

17.6.7. 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.

[94] Professor Jane Monckton-Smith

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

18. Recommendations

18.1. Multi-Agency Recommendations

18.1.1. 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.

18.1.2. 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.

18.1.3. 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.

18.1.4. 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.

18.1.5. 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.

18.1.6. 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.

18.2 Surrey and Borders Partnership Trust

18.2.1. 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.

18.2.2. 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.

18.2.3. 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.

18.2.4. SaBP will develop an agency specific Professional Curiosity Resource Pack, which will be available on the Trust's intranet.

18.3 Your Sanctuary

18.3.1. 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.

18.3.2. 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.

18.4. Surrey County Council

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

18.5. Adult Social Care

18.5.1. A learning tool will be developed and shared with social worker in reflective practice sessions, specifically addressing identification of care and support need and appropriate referrals, assessment, signposting and collaborative work with partner agencies, to ensure early information sharing and prevention.

18.5.2. The legal team will produce guidance for social workers engaged with the coronial process.

Appendix A