Epsom and Ewell Community Safety Partnership

DOMESTIC ABUSE RELATED DEATH REVIEW

Into the death of Winifred

In December 2023

OVERVIEW REPORT

Independent Chair and Author
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Report Completed: 17 December 2024

CONTENTS

1. PREFACE

1.1. The Domestic Abuse Related Death Review (DARDR) Panel wish to express their deepest sympathy to Winifred's[1] family and all who have been affected by her untimely death.

1.2. The Review Chair thanks the Panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review.

1.3. This Domestic Abuse Related Death Review was commissioned by the Epsom and Ewell Community Safety Partnership on notification of Winifred's death in circumstances which appeared to fulfil the criteria of Section 9 (3)(a) of the Domestic Violence, Crime and Victims Act 2004.

1.4. This Review was held in compliance with Legislation and followed Statutory Guidance[2]. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Winifred, Derek[3] and Jo[4] entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Winifred's death in a meaningful way and address with candour the issues that it has raised.

1.5. The term domestic abuse will be used throughout this Review, as it reflects the range of behaviours and avoids the inclination to view domestic abuse in terms of physical assault only.

2. INTRODUCTION

2.1. This Domestic Abuse Related Death Review examines agency responses and support given to Winifred and Jo, residents in an area in Epsom and Derek a resident in an area in Norfolk to the point of Winifred's death in December 2023.

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

2.3. The key purpose for undertaking this Review is to enable lessons to be learned where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for lessons to be learned as widely and thoroughly as possible, professionals need to be able to

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[1] Pseudonym for the deceased.
[2] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews
[3] Pseudonym for the deceased's ex-partner.
[4] Pseudonym for the deceased's child.

understand fully what happened in each case, and most importantly, what needs to change to reduce the risk of such tragedies occurring in the future.

2.4. **The Domestic Abuse Act 2021 defines Domestic Abuse as**:

Behaviour of a person ("A") towards another person ("B") is domestic abuse if-

(a) A and B are each 16 or over and are personally connected to each other, and
(b) the behaviour is abusive.

Behaviour is "abusive" if it consists of any of the following-

(a) physical or sexual abuse
(b) violent or threatening behaviour
(c) controlling or coercive behaviour
(d) economic abuse (see sub-section (4))
(e) psychological, emotional or other abuse

and it does not matter whether the behaviour consists of a single incident or a course of conduct. https://www.legislation.gov.uk/ukpga/2021/17/part/1/enacted

2.5. **The Home Office defines Controlling and Coercive behaviour as:**

- **Controlling behaviour is:** A range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

- **Coercive behaviour is:** An act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

2.6. DARDRs are not disciplinary inquiries nor are they inquiries into how a person died or into who is culpable; that is a matter for Coroners and Criminal Courts, respectively, to determine as appropriate.

3. TIMESCALES

3.1. A referral was made by Surrey Police on 06 February 2024, for a Domestic Abuse Related Death Review (DARDR) to be considered. After an initial advisory meeting held on 22 February 2024, a decision to undertake a DARDR was taken by the Chair and Members of the Epsom and Ewell Community Safety Partnership on 13 March 2024.

3.2. The Independent DARDR Chair was appointed on 14 June 2024 and a pre-meeting of the DARDR was held on 27 June 2024 to agree process, timescales and Terms of Reference. An update was provided to the Home

Office by the Review Chair (the same day) regarding timescales, and the Home Office authorised additional time.

3.3. The first Panel meeting was held at the earliest opportunity on 07 August 2024, during which the Panel Members were instructed to secure their records relating to any contact made with either Winifred, Derek or Jo and appoint an IMR Author.

3.4. The Review considered the contact and involvement that agencies had with Winifred, Derek and Jo from June 2020 to the date of Winifred's death in December 2023. These dates were selected, as it was during this time that Jo's behaviour towards violence became known to agencies.

3.5. After an initial pre-meeting on 27 June 2024, the Panel met formally three times via 'Teams'.

- 07 August 2024
- 15 November 2024
- 13 December 2024

3.6. The Review was concluded on 17 December 2024.

4. CONFIDENTIALITY

4.1. In accordance with Statutory Guidance, the Review has been conducted in a respectful, confidential manner by Panel Members and IMR Authors. The findings of this Review are restricted to only participating Officers, Professionals and their Line Managers until after this report has been approved for publication by the Home Office Quality Assurance Panel.

4.2. As recommended within the Guidance, to protect the identity of the deceased and her family, pseudonyms have been used throughout this report. In the case of Winifred, this name was chosen by her father. Derek, Justin[5], and Jo were selected by the Review Chair and agreed to by the Panel Members.

4.3. Winifred was aged 50 at the time of her death, Derek aged 59, and Jo aged 16. All three were white British nationals.

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

5.1. This Domestic Abuse Related Death Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant statutory guidance for the conduct of Domestic Homicide Reviews.

[5] Pseudonym for the deceased's ex-husband.

Aims of the Domestic Abuse Related Death Review Process

5.2. Establish the facts that led to the death in December 2023, and whether there are any lessons to be learned from the case about the way in which local professionals and agencies worked together to safeguard the family.

5.3. 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.

5.4. Summarise concisely the relevant chronology of events including:

- the actions of all the involved agencies
- the observations (and any actions) of relatives, friends and workplace colleagues relevant to the Review
- analyses and comments on the appropriateness of actions taken
- make recommendations which, if implemented, will better safeguard people experiencing domestic abuse, irrespective of the nature of the domestic abuse they have experienced.

5.5. Agencies that have had contact with Winifred, Derek or Jo should:

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

5.6. **The Review Panel will consider:**

- Each agency's involvement with the following from June 2020 until December 2023, as well as all contact prior to that period which may be relevant to safeguarding, domestic abuse, violence, controlling behaviour, self-harm, mental health issues or substance abuse.

- Winifred who was 50 years of age at date of her death
- Derek was 59 years of age at date of Winifred's death
- Jo was aged 16 at the time of Winifred's death.

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

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

- Whether there was any history of substance misuse and if so whether it was known to any agency or multi agency forum.

- Whether there were any other known safeguarding issues relating to Winifred.

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

- Whether staff who had contact with Winifred, Derek and Jo had sufficient training and knowledge of indicators of domestic abuse, for a victim, child and for a potential perpetrator of abuse; the application and use of the DASH[6] risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC)[7], and to appropriate specialist domestic abuse services.

- Whether there are any lessons to be learned from the case about the way in which professionals and agencies worked individually or together to safeguard Winifred.

- Whether agencies have appropriate commissioned services, policy and procedures to respond to needs of an adult with care and support needs and to recommend and change as a result of the review process.

- Whether agencies have appropriate, commissioned services, policy and procedures to respond to domestic abuse and to recommend and change as a result of the review process.

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

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

- Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DARDR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the COVID pandemic).

- Whether in relation to the family members, were there any barriers experienced in reporting the vulnerabilities, care or support needs of Winifred or the abuse she was subjected to.

- The Review must be satisfied that all relevant lessons have been identified within and between agencies and will set out action plans to apply those

[6] Domestic Abuse Stalking & Harassment (DASH): an evidence-based list of 24 or 27 questions used to assess the level of risk a victim faces – standard, medium or high. High risk indicates referral to MARAC is needed. The threshold for MARAC referral is 14 or above positive answers to the DASH questions.

[7] MARAC a multi-agency meeting to share information to safety plan and allocate actions with the aim of increasing the safety of high-risk victims of domestic abuse.

lessons to service responses including changes to inform national and local policies and procedures as appropriate.

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

- The Review will also highlight good practice to enable wider application to future practice.

6. METHODOLOGY

6.1. Agencies were instructed to search for any contact they may have had with Winifred, Derek, or Jo and asked to secure their records. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR) / Report. This allowed the individual agency to reflect on their contacts and identify areas which could be improved and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Winifred's circumstances in the future.

6.2. The Review Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs)
- Discussions during Review Panel meetings
- Post-mortem

7. INVOLVEMENT OF FAMILY AND FRIENDS

7.1. At the commencement of the Review, the Review Chair contacted Winifred's father by formal letter on 12 August 2024. He was provided with a copy of the Terms of Reference, the Home Office and Advocacy After Fatal Domestic Abuse (AAFDA) leaflets.

7.2. During the first telephone conversation, the Review Chair explained the purpose of the Review and why it was being held. Winifred's father did not wish to participate in the Review and requested that no contact be made with Jo, due to Jo's autism and current mental health. The Review Chair respected his request.

7.3. Due to no contact details being made available to the Review for any of Winifred's friends, the Review Chair requested information from Winifred's father. Unfortunately, he was not able to provide contact details for any of Winifred's friends.

7.4. A letter was sent to Derek (Winifred's ex-partner), on the 14 August 2024, together with the Home Office and AAFDA leaflets explaining DARDRs and available support. At the time of concluding the Review, Derek had not made contact with the Review Chair.

7.5. Due to a delay in receiving updated contact details for Justin (Winifred's ex-husband), the Chair was only able to notify him of the Review on 15 November 2024. The notification was sent by letter, together with the AAFDA and Home Office leaflets. At the time of concluding the Review, Justin had not made contact with the Review Chair.

8. CONTRIBUTORS TO THE REVIEW

8.1. The following agencies contributed as follows:

CAMHS - Information provided
East Surrey Domestic Abuse Services (ESDAS) - IMR
Epsom and St. Helier University Hospitals NHS Trust - IMR
North Surrey Domestic Abuse Service (NSDAS) - IMR
School Jo attended - Report
Surrey and Borders Partnership NHS Foundation Trust (SaBP) - IMR
Surrey County Council Adult Social Care (ASC) - IMR
Surrey County Council Children's Services (CSC) - IMR
Surrey Heartlands Integrated Care Board (ICB) on behalf of GPs - IMR
Surrey Police - IMR

9. REVIEW PANEL

9.1. The Review Panel consists of Senior Officers from statutory and non-statutory agencies who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. Panel Members and IMR Authors were independent of any direct involvement with or supervision of services involved in this case.

Membership of the Panel:

Michelle Baird	Independent Chair and Author
Fran Richiusa	Domestic Abuse Related Death Review Coordinator - Surrey County Council
Jade Talbot	Community Safety and Enforcement Officer - Epsom and Ewell Borough Council
Anne Marie McEntee	Head of Adult Safeguarding (Acute) - Epsom and St Helier University Hospitals NHS Trust
Sarah Mcleod	CEO - North Surrey Domestic Abuse Service (NSDAS)
Claudine Cox	Safeguarding Adults & Domestic Abuse Lead - Surrey & Borders Partnership NHS Trust
Philippa Corney	Senior Manager - Surrey County Council Adult Social Care
Tom Stevenson	Assistant Director | Quality | Practice & Performance - Surrey County Council Children's Services
Helen Milton	Designated Nurse Safeguarding Adults, Surrey Wide - NHS Surrey Heartlands Integrated Care Board (ICB) on behalf of GPs
Andy Pope	Statutory Reviews Lead - Surrey Police
Bridie Anderson	Services Manager - East Surrey Domestic Abuse Services

Nanu Chumber-Stanley	Public Health Lead - Surrey County Council Public Health
Mary Tiley	Safeguarding Children Advisor - Central Surrey Health Children Safeguarding Team

9.2. Bridie Anderson and Nanu Chumber-Stanley attended in an advisory capacity, with Bridie providing expertise on domestic abuse and coercive control, and Nanu offering insights on suicide/prevention.

10. CHAIR AND AUTHOR OF THE REVIEW

10.1. The Independent Chair and Author of this Domestic Abuse Related Death Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Epsom and Ewell Community Safety Partnership and is independent of all agencies involved in the Review. She has had no previous dealings with Winifred, Derek or Jo.

10.2. Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Emotional Freedom Techniques (EFT).

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

10.4. In June 2022, she attended a 2 day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention. She has also attended a number of online courses provided by the Institute for Addressing Strangulation (IFAS).

11. PARALLEL REVIEWS

11.1. Winifred's inquest was held in May 2024 and information from the post-mortem has been used to inform the Review.

12. EQUALITY AND DIVERSITY

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

12.2. Section 4 of the Quality Act 2020 defined 'protective characteristics' as, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

12.3. Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if -
(a) P has a physical or mental impairment, and
(b) The impairment has a substantial and long-term adverse effect on a P's ability to carry out normal day-to-day activities[8]

12.4. The Panel gave due consideration to each of the nine protected characteristics, as to whether they were applicable. The Panel felt there was no evidence to suggest that gender reassignment, pregnancy and maternity, sexual orientation, race, religion or belief were significantly relevant to the circumstances of those involved in this Review. Sex, age, marriage and disability were found to be relevant by the Panel.

12.5. Sex is always regarded as relevant to Reviews, as evidence has shown that domestic abuse is a gendered crime. There is evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2023, an estimated 1.4 million women and 751,000 men aged 16 years and over experienced domestic abuse, a prevalence rate of approximately 5.7% of women and 3.2% of men.[9]

12.6. Women who experience domestic abuse are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse[10]. Winifred made two suicide attempts in 2009 and 2010 following the ending of her marriage with Justin. Within her marriage, Winifred experienced emotional and psychological abuse.

12.7. Disability was relevant as Winifred and Jo were both neurodivergent and experienced mental health concerns that had a substantial and long-term adverse effect on their ability to carry out normal day-to-day activities.

12.8. Winifred received a diagnosis of Post-Traumatic Stress Disorder (PTSD) in 2016 due to her experience of domestic abuse and previous trauma in her childhood. She also had a late diagnosis for Attention Deficit Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD). The former was characterised in Winifred by symptoms of hyperactivity, inattention and restlessness.

12.9. Jo also had recorded diagnoses of ADHD and ASD and was under the Child and Adolescent Mental Health Service (CAMHS). There was mention of Jo having an eating disorder and experiencing depression and anxiety. Jo had episodes of self-harm and suicidal ideation that resulted in hospital admissions.

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[8] Addiction/dependency to alcohol or illegal drugs are excluded from the definition of disability.
[9] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimcharacteristicsenglandandwales/yearendingmarch2023
[10] Agenda Alliance (2023) 'Under-examined and Under-reported: Suicidality and Intimate Partner Violence'.

12.10. Winifred also reported chronic pain that impacted on her daily living and ability to complete tasks such as cooking and cleaning the house. Winifred had a number of recorded physical health needs including fibromyalgia, neurological problems that impacted on her memory and balance, immune deficiency and problems with nerves in her face, which caused slurred speech.

12.11. Women who experience violence often sustain injuries to their head, face and neck. This can present an increased risks of brain injury and associated long term injuries, for example, pain and numbness, loss of memory, nausea and dizziness[11]. The impacts of traumatic brain injury can include non-attendance at appointments, appearing chaotic or unstable, anxiety, impulsiveness, substance use and self-harm and are often misconstrued by agencies as women being non-compliant or difficult to engage with[12]. Winifred had a number of missed health appointments during the Review timeframe, and a number of agencies recorded that Winifred was difficult to engage with.

12.12. Age was considered to be relevant, as Winifred experienced assaults by her adolescent child, Jo. The statutory UK government definition of 'domestic abuse' includes child to parent abuse in cases when the child is aged 16 years or over[13]. However, Jo was aged 13 when the first report of violence towards Winifred was received, and the violence may not have been viewed in the context of domestic abuse. Parents often disclose that the abusive behaviours have been developing for some time before the police become involved, and mothers are more likely to experience child to parent violence than father or male carers[14].

13. DISSEMINATION

13.1. Until this report has been approved for publication by the Home Office Quality Assurance Panel, dissemination of the findings of this Review has been restricted.

13.2. Each of the Panel Members, the Chair and Members of the Epsom and Ewell Community Safety Partnership have received copies of this report. A copy will also be sent to the Coroner, the Surrey Police and Crime Commissioner and the Domestic Abuse Commissioner for England and Wales.

14. BACKGROUND INFORMATION (THE FACTS) [15]

[11] Toccalino et al (2024) 'Exploring the intersection of brain injury and mental health in survivors of intimate partner violence'
[12] Brainkind (2023) 'Too Many to Count: Brain Injury in the Context of Domestic Abuse'
[13] Domestic Abuse Act 2021
[14] Holt (2022) 'Child to Parent Abuse'
[15] This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016)

14.1. Winifred was described as an intelligent and high-functioning woman by her GP who had known her for many years. Winifred's child, Jo lived with her in an area of Epsom. Winifred was supported by her parents who lived in a different area of the country.

14.2. Winifred was married to Justin, with whom she had a child (Jo). Within this relationship she experienced emotional and psychological abuse. Winifred also reported post-separation abuse that escalated during Family Court and Child Protection proceedings. Winifred and Justin's relationship ended in March 2009, and Justin moved out of the family home in August 2009.

14.3. Winifred began a relationship with Derek in 2011, where she experienced physical, sexual, financial, emotional abuse and coercive control. There were occasions where Winifred and Derek informed agencies that Derek was Winifred's 'live in carer' and not her partner. Winifred's relationship with Derek ended in 2016. Derek reported having a diagnosis of paranoid schizophrenia, but this was not confirmed by any agency contributing to the Review.

Incident Summary

14.4. On a day in December 2023, Winifred's father called the police, concerned that he had not heard from Winifred in seven days. Police forced entry at her home address, searched the house and found Winifred in a bedroom in bed with a plastic bag cable-tied around her head. She was pronounced deceased. There was a pestle and mortar on the floor, with medication all across the room, and a bottle of wine next to the bed. A note was found on the floor which stated: *'don't come in, call police, I love you'.*

14.5. An Inquest was held in May 2024 at HM Coroner's Court, where the medical cause of death was recorded as:

i) Cocaine Intoxication
ii) Asphyxia

The conclusion of the Coroner as to death was that Winifred died by suicide.

15. CHRONOLOGY

15.1. The events described in this section explain the background history of Winifred, Derek, Justin and Jo prior to the key timelines under review as stated in the Terms of Reference. Due to no family or friends participating in the Review, the Review relied on information provided in chronologies from agencies.

Summary of relevant contact prior to the period under review

15.2. In March 2009, Winifred reported her marriage to Justin had ended. Winifred was due to undergo an operation and she was worried about who would look after Jo. She contacted Children's Social Care (CSC) for support. Winifred

told CSC she felt suicidal and her and Jo were "*better off dead*". CSC instigated an Initial Child Protection Conference (ICPC).

15.3. In September 2009, Winifred took a paracetamol overdose and was admitted to hospital where she remained for several weeks in intensive care. Adult Social Care (ASC) records indicated that the overdose may have been related to a breach of professional conduct by Winifred's care coordinator at the time, that resulted in a Senior Strategy Meeting being held.

15.4. In February 2010, Winifred took a paracetamol overdose and was admitted to hospital. This was the second overdose in a six month period, and concerns were raised regarding liver damage sustained from Winifred's previous overdose. Jo was placed on a Child in Need plan until November 2011.

15.5. Winifred began a relationship with Derek in 2011, although this does not appear to have been known by agencies at the time. In April 2015, Winifred informed ASC that Derek was her sole carer. ASC had concerns, that Derek had no formal identification documents and no Disclosure and Barring Service (DBS) checks completed. When the DBS checks returned in October 2015, Winifred advised there was historical information, but that she was not concerned with the content. She told ASC she was not in a relationship with Derek.

15.6. In March 2016, Winifred reported to police that Derek who she described as her 'live in carer', had been accessing inappropriate imagery which may have included child pornography. Information shared amongst agencies indicated Winifred and Derek were in a relationship, but they stated they were not so that Derek could claim carer's allowance. Winifred told police that Derek had moved out of her property.

15.7. A Local Authority Designated Officer (LADO) referral was made to ensure Derek was not undertaking caring responsibilities for other vulnerable adults or children. Police completed a DASH risk assessment, this was graded standard risk and shared with CSC. A Vulnerable Adult at Risk (VAAR) was completed for Winifred and shared with ASC.

15.8. Later that month, Winifred reported a concern to police that Derek was grooming a child online. Derek was arrested, he provided a no comment interview and was released on conditional bail. Police enquiries identified the female who lived outside of the UK and reported she was an adult.

15.9. During the police investigation, Winifred reported she had been thrown onto a bed by Derek resulting in her banging her head. Winifred reported she was passing blood in her urine and had concussion type symptoms. Winifred did not wish to support a police investigation, and this concluded with no further action.

15.10. In September 2016, Winifred reported to police that she had been assaulted by Derek, whom she referred to as her ex-partner. Winifred reported Derek had got her in a chokehold and raped her. Derek was arrested and charged

with two counts of rape and one count of Actual Bodily Harm (ABH) but was found not guilty at Court. A Restraining Order was issued preventing contact with Winifred and Jo.

15.11. A DASH risk assessment was completed, graded high risk and raised for a Multi-Agency Risk Assessment Conference (MARAC) in December 2016. Winifred disclosed significant experiences of coercion and control by Derek since 2011.

15.12. In 2018, agency records indicate animosity between Winifred and Justin around child contact. In June 2018, the school raised concerns regarding Winifred and Justin's acrimonious relationship, Winifred's mental health and that she appeared intoxicated whilst attending the school for a meeting. CSC initiated a S47 investigation.

15.13. In July 2018, Winifred contacted ASC requesting an assessment. She was due to have an operation and felt she would struggle with this. Winifred reported that she had experienced years of psychological abuse by Justin. Police made numerous attempts to contact Winifred, when they were able to, Winifred did not disclose any criminal offences but wished for someone to mediate for her during Family Court.

15.14. In September 2018, Jo was placed on a Child Protection Plan under the category of emotional abuse, due to concerns of parental acrimony over child contact and concerns Winifred appeared intoxicated.

15.15. In November 2018, CSC received information from a third party that Jo (aged 12) was finding things difficult at home, and disclosed Winifred had assaulted Jo by grabbing and throwing Jo across the room. Winifred and Jo informed CSC this had not happened.

15.16. In December 2018, Family Court concluded with a Child Arrangements Order setting out contact with Justin. In January 2019, the Child Protection Plan was stepped down to a Child in Need Plan, and in April 2019, ASC closed Winifred's case as no contact had been received from her.

15.17. In August 2019, Winifred contacted police to report Justin was making false allegations about her and her capacity to parent. Police noted that Winifred appeared confused and was not able to focus on one issue. An officer visited Winifred and Winifred described emotional and psychological abuse by Justin during Family Court and Child Protection proceedings. Police contacted CSC, however CSC declined to provide information for data protection reasons, but informed police they had looked into the allegations relating to Justin and considered that Jo's needs were being met. Police were unable to progress an investigation without supporting evidence and the matter was filed.

15.18. In May 2020, Jo (aged 13) was referred to CAMHS after Jo was admitted to the Emergency Department for concerns around mental health following an argument at home. Jo screamed, shouted and was aggressive and violent towards Winifred. Winifred reported that Jo was not allowed to stay at a

friend's house overnight which had triggered the conflict. A multi-disciplinary meeting was held between CAMHS and CSC. It was agreed Winifred would explore a private ADHD assessment for Jo due to the long waiting list under the NHS. Jo was discharged from CAMHS two days later with a risk management plan in place and a referral for Jo to talking therapy.

16. OVERVIEW

16.1. This section documents the key contacts agencies and professionals had with Winifred, Derek, Jo and Justin during the timeframe of the Review.

16.2. On 14 June 2020, police received a report that Jo (aged 13) had arranged a fight with a peer at a local park. The report stated Jo intended on using a key between the knuckles and had broken glass to use as a weapon. Jo confirmed slapping the peer and that Jo had intended to use weapons to perpetrate harm. Jo was issued with a Community Resolution[16].

16.3. On 04 August 2020, police received a report that Jo was attacking Winifred and made threats to stab her. Officers attended and reported Jo had hit Winifred in the eye. Winifred reported she felt that Jo had Attention Deficit Disorder (ADD). No offences were reported, and subsequently no further action was taken.

16.4. A SCARF[17] was completed by police and shared with CSC. Jo reported feeling low in mood and not wishing to live. It was noted that police had been called three times within a 24 hour period.

16.5. Following the police incident, Jo went to stay with a friend, whose mother reported to CSC that Jo had an eating disorder and Jo did not feel Winifred understood how Jo felt. Jo believed Winifred blamed Jo for the deterioration in their relationship.

16.6. A strategy discussion was held on 06 August 2020, where health agencies reported that Jo had disclosed that on 04 August 2020, Winifred had placed Jo in a strangle hold. A joint visit took place between CSC and police as part of a S47 investigation[18]. Jo reported not wanting to live at home anymore. It was recorded that Winifred appeared to be struggling with her own mental health concerns as well as Jo's mental health. It was noted that tensions in the home may have been exacerbated by periods of COVID lockdown in 2020.

16.7. Jo was placed on a Child in Need plan in August 2020. Following two Child in Need meetings on 10 February 2021 and 09 March 2021, the decision was made to close the Child in Need plan on 20 March 2021.

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[16] Community resolutions are frequently used by police to deal with low level offending.
[17] Single Combined Assessment of Risk Form (SCARF) used to notify agencies of an identified risk involving a child.
[18] A Section 47 is initiated to decide whether and what type of action is required to safeguard and promote the welfare of a child.

16.8. On 30 April 2021, Jo was referred to CAMHS by the GP as Jo was showing traits of ADHD, ASD and anxiety and depression. Jo's GP requested an assessment for ASD, however due to insufficient documentation, CAMHS could not accept the referral. CAMHS requested a closing letter from a clinician that had been treating Jo privately, but this was not received, and Jo was subsequently discharged back to the care of the GP.

16.9. Between February 2021 and August 2021, Winifred missed a number of health appointments which resulted in letters being sent to Winifred's GP. In August 2021, Winifred underwent an operation relating to these appointments and was discharged from hospital the following day.

16.10. Between August 2021 and October 2021, Winifred did not respond to letters requesting contact for routine follow up after her operation. On 15 October 2021, Winifred was removed from the consultant's waiting list as no pre-assessment had taken place. Winifred was discharged back to the care of her GP in January 2022.

16.11. In February 2022, Winifred's GP referred her to the pain management team at a named hospital, as she had reported worsening pain in her neck and left arm. An MRI was completed in March 2022, with medication prescribed and agreed follow up reviews.

16.12. On 20 May 2022, SaBP received a referral from a named hospital following a disclosure from Jo (aged 14) that Jo had argued with Winifred. Their relationship was deteriorating, and Jo was becoming increasingly anxious in the context of Jo's privately diagnosed ADHD. CAMHS recorded that the relationship between Jo and Winifred was a trigger for Jo's anxiety.

16.13. Winifred disclosed concerns that Jo may have been sexually assaulted by an ex-partner of Winifred's in which a Restraining Order was in place. Whilst it was not explicit, it was surmised this was Derek. Jo did not disclose sexual abuse, but informed Winifred of being a victim of a sustained physical assault by Winifred's ex-partner. Jo was placed on a waiting list for youth mental health service Mindworks.

16.14. Winifred attended an arranged telephone appointment on 20 June 2022. She reported mislaying her prescription and declined any further outpatient follow up. Winifred's GP was contacted on 29 June 2022 and the GP agreed to manage Winifred symptomatically.

16.15. On 12 August 2022, Winifred was referred to the General Practice Integrated Mental Health Service (GPIMHS) by her GP for treatment regarding her ADHD. Winifred reported worsening anxiety, insomnia, inconsistent compliance with medication, chronic pain and a history of multiple stressors including Family Court, abusive relationships and situational anxiety that impacted on her ability to attend appointments and socialise.

16.16. On 24 August 2022, Winifred attended a face-to-face appointment with the pain management team. Winifred reported she was in a lot of pain which left her debilitated. Winifred was unable to leave the house, cook for herself and was having difficulties sleeping. A further face-to-face appointment on 14 September 2022, resulted in a referral for a surgical opinion regarding Winifred's neuropathic pain symptoms.

16.17. On 17 September 2022, police received a call from the Samaritans as Jo was experiencing suicidal thoughts. Police located Jo, who reported having an argument with Winifred as Jo was not allowed to go out until Jo's homework had been completed. Jo reported leaving the home address and self-harming (cuts to the arms). Police took Jo to hospital for a mental health assessment.

16.18. Winifred attended the hospital and confirmed Jo was open to CAMHS and had a youth support worker. Winifred told police that Jo was diagnosed with ADHD and ASD. A SCARF was completed and shared with CSC. No offences disclosed and subsequently no further action taken by police.

16.19. On 18 September 2022, Jo attended the Emergency Department for treatment for superficial cuts and suicidal ideation following an argument with Winifred. Jo was discharged with a support plan in place and ongoing work with targeted youth support.

16.20. On 30 September 2022, Winifred self-referred for participation in a research study with SaBP. The study trialled Winifred on Sertraline to determine whether it was an effective medication in the treatment of adults with symptoms of anxiety and a diagnosis of ASD.

16.21. On 09 October 2022, Winifred attended a telephone appointment with GPIMHS, during which she reported issues with sleep and social anxiety. She reported not finding previous experiences of NHS counselling helpful and declined support for therapy or coping skills. Winifred wanted help to eradicate white noise, background noise and a heightened awareness of her surroundings when she was trying to sleep. She described herself as "*always consciously aware*" and found it "*exhausting*". Winifred was offered amber tinted glasses to block out blue light, a prescription for Quetiapine[19] and a referral to the ADHD service.

16.22. On 10 October 2022, Jo shared with the school that Jo and Winifred had argued throughout the weekend. When Jo became emotionally dysregulated, Winifred repeatedly followed Jo, which exacerbated the issue.

16.23. On 13 October 2022, during a phone appointment with CAMHS, Winifred described the advocacy she was putting in for Jo as "*a constant battle*".

16.24. On 18 October 2022, Winifred disclosed to a research assistant on the research study she was involved in, that Jo had assaulted her and left her

[19] Quetiapine is an atypical antipsychotic medication used for the treatment of schizophrenia, bipolar disorder and major depressive disorders.

with bruises. Winifred reported this left her feeling low in mood. Winifred was advised that her disclosure amounted to adolescent to parent violence, and Winifred was given contact details for domestic abuse support services.

16.25. On 22 November 2022, Winifred and Jo attended a virtual appointment with CAMHS. Winifred reported feeling blamed by professionals and that she and Jo were "*desperate for support*". Winifred reported wanting to feel listened to by professionals and was working tirelessly to keep Jo safe. Winifred asked for more specific expectations as to what CAMHS expected from her. CAMHS responded that Jo wanted to feel listened to by Winifred. A referral to the national autistic society was recommended, however it was not clear if this was for Winifred or for Jo.

16.26. In late November 2022, Winifred attended appointments for treatment for her pain and further review appointments were scheduled for December 2022 which Winifred attended. Following one of these appointments, plans for examination under general anaesthesia were made and a referral was made for acupuncture to help with the desensitisation in Winifred's neck that caused her headaches.

16.27. On 23 December 2022, CAMHS recommended that Jo undertake a course of cognitive behaviour therapy (CBT). However, before CBT could begin, it was suggested that Winifred complete the Freedom Programme through ESDAS to address trauma from a previous abusive relationship. Completing this programme would then help determine the suitability of CBT for Jo, as Winifred would be better equipped to support Jo through therapy. In the interim, it was recommended that Jo explore courses offered by a named children's charity, and the National Autistic Society. Initially, Winifred was resistant to completing the Freedom Programme[20] but later agreed to review information about it at home. Jo was discharged from CAMHS on 23 December 2022.

16.28. On 09 January 2023, Winifred reported to a research assistant in the SaBP study she was participating in that she felt disconnected mentally and physical, was feeling flat in mood and detached. She reported high levels of anxiety. Winifred rearranged her next follow up appointment and then postponed further appointments, reporting she was unsure if she wanted to continue due to the potential risk of hair loss and discolouration of teeth.

16.29. On 30 January 2023, Winifred attended a telephone appointment for a review with the pain management team. Winifred reported finding it difficult to manage her pain on a daily basis and it was causing her to experience low mood. A letter was sent to Winifred's GP outlining these concerns.

16.30. Further medical interventions were discussed with Winifred in February and March 2023 during telephone review appointments. It was recorded in April

[20] Freedom programme - a 12-week support group for women fleeing domestic abuse or who have experienced domestic abuse.

2023, that Winifred did not attend a pain education programme and was discharged. In June 2023, it was confirmed that Winifred's nerve remained compressed with no change since the last test in 2022. In July 2023, Winifred missed two further schedule telephone appointments for her physical health.

16.31. On 19 May 2023, CAMHS received a referral from Jo's GP requesting a review of ADHD medication. The referral noted that Jo had been referred in February 2021 but was not placed on the ADHD waiting list due to missing paperwork from the private clinic where the initial ADHD diagnosis was made. The GP included a comprehensive assessment confirming Jo's ADHD diagnosis. Jo began a new prescription for ADHD medication on 01 December 2023.

16.32. On 05 September 2023, Winifred attended the Emergency Department on advice of her GP as she reported experiencing a sudden loss of consciousness and a fall. This happened on 01 September 2023, and Winifred reported being unable to recall full events. Winifred had bruising under her left eye, a persistent headache and poor balance.

16.33. A CT scan of her head, face, pelvis and abdomen were completed with no concerns noted. An incidental finding relating to Winifred's liver was noted for further investigation. Winifred reported worsening pain in her left elbow and arranged a face-to-face appointment to review this.

16.34. On 24 September 2023, Winifred reported to police that she had been punched numerous times by Jo (aged 16) and told to kill herself. Winifred took refuge in the bathroom and Jo broke down the door to get to her before leaving the home address and calling Justin to pick Jo up. Winifred reported Jo had been trying to find a bag of medication that Winifred had hidden because of the danger of Jo taking an overdose. Winifred felt Jo was not getting the right level of support from CAMHS.

16.35. Jo informed the police that Winifred was "mentally unstable," claiming she failed to keep the house tidy, neglected to feed Jo, and withheld Jo's medication. However, when Justin arrived to pick Jo up, Winifred handed him the medication.

16.36. Winifred did not wish to provide a statement or support a police investigation as she did not want to criminalise Jo. A SCARF was completed for Jo and shared with CSC. A DASH risk assessment was completed and graded standard risk. Winifred did not wish to complete the DASH risk assessment with officers, and it was completed based on professional judgement. Police Multi-Agency Safeguarding Hub (MASH) assessed the DASH and could not find evidence of care and support needs for Winifred and it was not shared further with partner agencies.

16.37. On 26 September 2023, Jo informed the school that following the fight with Winifred on 24th September, Jo returned home from school to find Jo's belongings on the doorstep, and Winifred refused to let Jo into the house. Jo's

father collected Jo and Jo stayed with him while the situation was being resolved.

16.38. Winifred attended a telephone appointment with the hospital on 05 October 2023, to discuss the results of her liver ultrasound and an MRI was scheduled for the following week. Winifred missed a face-to-face appointment on 17 October 2023, to discuss the results of her nerve treatment and she was discharged to the care of her GP.

16.39. On 26 October 2023, Winifred attended a face-to-face gastroenterology appointment. The consultant noted that Winifred was not very well following her fall in September 2023. Winifred reported she had been vomiting and had a lot of upper abdominal pain. There was suggestion that Winifred's experience of dizziness may have been due to an infection, but tests completed had not indicated any sign of infection or explanation for her symptoms.

16.40. On 20 November 2023, the gastroenterology consultant attempted to call Winifred three times during her scheduled telephone appointment, but Winifred did not answer. Winifred had also declined further suggested medical tests on 26 October 2023. Blood tests had been pre-booked with her, but not completed. Winifred's record was marked for patient initiated follow up for the next nine months and a letter confirming this was sent to Winifred's GP.

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16.41. Jo raised concerns with the school regarding Winifred's erratic behaviour. Jo had seen messages that made Jo suspect that Winifred might be using drugs. The school discussed the matter with Jo's grandparents, who confirmed they had already spoken to Jo about their shared concerns.

16.42. Jo and Winifred were involved in a physical altercation. The school intervened, speaking with both Winifred and Jo's grandmother. Winifred stated that Jo would not leave her alone, which contributed to the conflict. Jo went to stay with the grandmother.

16.43. Two attempts were made to contact Winifred for her scheduled gastroenterology telephone appointment, but Winifred did not answer. A voicemail was left, asking her to contact her GP if she had ongoing symptoms and Winifred could be re-referred.

16.44. Winifred's father contacted police as he had not heard from Winifred. Winifred was meant to collect Jo from her parent's address but had not arrived. Police attended Winifred's address and sadly found Winifred deceased.

17. ANALYSIS

17.1. The Review Panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone

or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

17.2. Nine agencies/organisations have provided Individual Management Reports (IMRs) detailing relevant contacts with Winifred, Derek, Justin and Jo. The Review Panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

17.3 The lessons learned and recommendations / action plans to address them, are listed in Section 19 in this report.

17.4 The following is the Review Panel's analysis of the agencies' interventions:

East Surrey Domestic Abuse Service (ESDAS)

17.5. ESDAS had no contact with Winifred, Derek, Justin or Jo in the Review timeframe. The only contact had was extremely limited and administrative only as it related to a referral for IDVA support for Winifred July 2017, for the Court case involving Derek that was subsequently adjourned.

No recommendations were made by the IMR Author.

Epsom and St. Helier University Hospitals NHS Trust

17.6. Winifred was known to Epsom and St. Helier University Hospital NHS Trust from April 2009, for a number of ongoing and longstanding health issues.

17.7. Winifred's health conditions were investigated and treated by the relevant specialties. Letters were sent to Winifred's GP to update them at each consultation. When Winifred did not attend appointments, voice messages were left when possible, appointments were rebooked, or letters sent to Winifred's GP to inform them of the outcome.

17.8. Between April 2009 and December 2023, no safeguarding or domestic abuse referrals were recorded on the electronic records system, iCM (Clinical Manager).

17.9. There were missed opportunities during Winifred's pain management appointments in August 2022 and January 2023, to thoroughly explore the impact of her pain. In 2022, she reported being severely debilitated, unable to leave her home, cook, or sleep properly, and shared that the pain was significantly affecting her mood. Following her January 2023 consultation, she was referred to a pain management programme but did not attend.

17.10. The pain management team could have further investigated the broader impact of her pain, which might have resulted in additional referrals, such as to adult social care, given her difficulties managing daily activities. It could

have also led to consideration for GP or mental health support to address her mood in relation to her ongoing pain.

17.11. There was a further missed opportunity at Winifred's Emergency Department attendance in September 2023, where her social circumstances were not explored beyond noting that she lived with Jo. Professional curiosity to enquire further into the events leading to her attendance could have provided valuable insights.

17.12. Winifred's diagnoses of mild ASD and ADHD, as reported by her GP, were not addressed during subsequent appointments or hospital visits. As a result, potential reasonable adjustments to accommodate and support her needs was not considered.

Named School that Jo attended

17.13. There was a significant history of events highlighting the challenges that Winifred and Jo faced in communicating effectively with each other. When conflicts arose, Jo's grandparents often acted as mediators, providing both Jo and Winifred with time apart to de-escalate and regain composure. While the relationship between Winifred and Jo was occasionally warm and supportive, their similar neurodiverse traits frequently led to clashes. As Jo grew older, these disagreements increasingly escalated into physical altercations.

17.14. In Jo's earlier school years, it was primarily Winifred's behaviour that instigated or worsened their disputes. However, as Jo matured, she began to assert herself and challenge Winifred's actions, which unfortunately led to more frequent and intense physical confrontations.

17.15. The report writer acknowledged, that Jo was exposed to and learned certain responses from Winifred's behaviour. Over time, Jo began to replicate these behaviours, not as a perpetrator of domestic abuse, but as a victim who adopted these patterns during her formative years.

17.16. Targeted Youth Support were involved during 2022-2023 and had some positive effects, but progress was limited by Winifred's disguised compliance, making it difficult to achieve lasting changes. Jo once shared video evidence of the home environment, which revealed signs of neglect, including hoarding behaviour. The footage showed dirty dishes throughout the kitchen, mouse droppings, and piles of unwashed clothes scattered around the house. In contrast, Winifred presented a different image on video calls with the school, curating a clean and stylish background.

North Surrey Domestic Abuse Service (NSDAS)

17.17. NSDAS had no contact with Winifred, Derek, Justin or Jo in the Review timeframe.

17.18. NSDAS were in contact with Winifred from October 2016, following a referral from police. Winifred told NSDAS, that Derek used to be in the military police

and was deployed to active war zones which caused him to experience PTSD. Winifred reported that Derek had no money and nowhere to live so he moved in with her in 2013 and became her carer. She described Derek as a father figure to Jo and considered him part of the family unit.

17.19. Winifred told NSDAS that Derek took advantage of her, taking £10,000 from her and taking money from her parents. She felt isolated and had no local support. Following the ending of the relationship, Winifred reported receiving letters from His Majesty's Revenue and Customs (HMRC) regarding a debt of £14,000 in council-tax, as the council had become aware that Winifred and Derek were cohabiting.

17.20. Winifred told NSDAS she felt unable to leave her home address as she had nowhere else to go and Jo was at a critical point in education.

17.21. NSDAS worked with Winifred for a period of six months, referring her to the Sanctuary Scheme during that time. Winifred and Derek were heard at MARAC on 20 December 2016. There was a noted gap in communication between NSDAS and Winifred following the MARAC with no apparent contact. Due to length of elapsed time, it was not possible to find out why this was. NSDAS contacted Winifred in March 2017, to confirm work with Sanctuary Scheme had been completed and Winifred's case was closed.

No recommendations were made by the IMR Author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

17.22. Winifred's first contact with SaBP was in 2009. She had disputed a diagnosis of Emotionally Unstable Personality Disorder (EUPD) and in 2011, it was noted there was no evidence of a mental illness. Winifred was mainly under the care of her GP, although it was understood she had explored treatment privately.

17.23. In September 2022, Winifred self-referred for participation in a research study for adults with symptoms of anxiety and a diagnosis of ASD. Winifred remained a participant of the study until her death, however for the months leading up to her death her engagement was poor.

17.24. In October 2022, whilst participating in the study, Winifred disclosed to a research assistant that Jo had assaulted Winifred and left Winifred with bruises. Following this disclosure, the research assistant consulted with the Safeguarding Adults and Domestic Abuse Lead. It was felt that a safeguarding concern under the Care Act 2014 was not required, as Winifred did not appear to have care and support needs. Winifred was advised that her disclosure amounted to adolescent to parent violence and abuse and Winifred was given information on available support.

17.25. During October 2022, Winifred reported worsening anxiety, insomnia, inconsistent compliance with medication, chronic pain and a history of multiple

stressors including Family Court, abusive relationships and situational anxiety that impacted on her ability to attend appointments and socialise.

17.26. Winifred reported hiding the extent of her own difficulties from Jo and described the advocacy she was putting in for Jo as "*a constant battle*" and she was "*desperate for support*". There was no exploration as to what Winifred's needs were, and no consideration given to whether Winifred had unmet care and support needs herself. If CAMHS had obtained permission from Winifred to share information with adult support services, information sharing may have informed a plan which accommodated Winifred's needs as a parent with ADHD and ASD.

17.27. In November 2022, a meeting was held with CSC, CAMHS and Jo's school. CAMHS confirmed they were unable to support Jo until Winifred had completed some work on her own needs. Winifred felt blamed by professionals and asked CAMHS for specific expectations she could achieve which were emailed to Winifred, but there was no record of what these were to consider if they were achievable.

17.28. The SaBP IMR Author noted unhelpful language in some of the CAMHS records, that amounted to victim blaming when Winifred asked for clarification about what specifically was asked of her. There was reference to Winifred "*triggering*" Jo with no consideration to Winifred's neurodiversity, and the impact this may have had on Winifred and Jo's relationship dynamics and social interaction.

17.29. There was a significant delay in Winifred receiving treatment for ADHD. GPIMHS had made a referral for Winifred to the ADHD service on 24 October 2022. There were some delays in the service accepting the referral as it was necessary to request further information from GPIMHS. However, the referral was accepted on the 19 April 2023 and the ADHD service wrote to Winifred on the 19 June 2023 to advise her that her name had been placed on the waiting list for a first appointment. The letter advised of a significant waiting list for the service, and the service were contacting people referred to them from the start of 2019.

17.30. Such a delay may have impeded positive outcomes for Winifred, however this delay occurred in the context of a notable rise in referrals to the ADHD services and this had placed significant pressure on the national system in terms of timeliness of response. Variations are reported across the country in the length of waiting lists for both a first appointment for assessment and for ongoing medication review however, across the system, all providers have reported extended wait times and delays. Consequently, the Trust and its commissioners of service have recognised and acknowledged the risk that the system delays may present to patients and the risk (which has been assessed as high) has been reported, mitigated and is monitored on the Trust Corporate Risk Register.

17.31. Following Winifred's death, a Patient Safety Incident Investigation (PSII) was undertaken by SaBP. The investigation concluded that direct communication

with CAMHS could have been initiated after Winifred disclosed to a research assistant in October 2022 that Jo had assaulted her. This communication would have informed CAMHS of Winifred's involvement with SaBP and facilitated information sharing to mitigate risks, in line with the 'Think Family' approach to care[21].

Surrey County Council Adult Social Care (ASC)

17.32. ASC had no contact with Winifred, Derek, Justin or Jo in the Review timeframe.

17.33. Winifred had a total of nine assessments with ASC. She had received support over a number of years for various physical conditions and mental health concerns. She had also received reablement services and direct payments to purchase personal care.

17.34. During their involvement with Winifred, the ASC Locality Team appropriately met their duties under the Care Act 2014, completing assessments and reviewing Winifred's Support Plan. The IMR Author noted that Winifred did not have annual reviews, these were attempted but not completed in a timely way due to difficulties in contacting and engaging with Winifred.

17.35. Winifred's social worker felt that Winifred did not wish to engage with support from ASC or accept any changes following her assessments. Winifred received direct payments from the Local Authority instead of care services, giving her greater flexibility and control over her support package. It was recorded that Winifred was reluctant to take responsibility for the management of direct payment for her care. The social worker was unable to confirm if this was the case, or due to Winifred having difficulties in managing this arrangement as a result of her mental and physical health needs.

17.36. There was evidence of liaison between ASC and Winifred's GP following assessments. Winifred's GP was surprised at the level of care package being offered to Winifred by ASC, and it was recorded by ASC that Winifred's GP felt that Winifred had psychological concerns rather than physical disabilities.

17.37. There was evidence of conversations between ASC and Winifred's GP regarding onward support for Winifred via mental health services, but no referrals were made by her GP. ASC closed Winifred's case in 2020 without doing a reassessment, therefore leaving her with potentially unmet eligible social care needs. Had the case remained open with regular monitoring and review, there might have been greater potential to identify mental health issues or risks to Winifred's wellbeing.

17.38. The concerns around Winifred's relationship with Derek were evident in ASC records. In April 2015, ASC noted Winifred had not sent in any direct payment reconciliations and so it was not clear how this money was being spent. Derek

[21] The Think Family approach urges adult services to think about the people who use their services as parents and to consider the needs of the whole family. It also guides staff to consider that what affects the parent will affect the child, and what affects the child will affect the parent.

did not have a DBS clearance, yet was referring to himself as a carer for Winifred and Jo who lived with her.

17.39. A face-to-face visit was completed with Winifred in July 2015, but it was not recorded if Derek was in attendance. The first recorded contact ASC had with Derek was not until November 2015, after he had seemingly undertaking a 'caring' role for Winifred for around seven months. The IMR Author notes this was a challenging meeting in which Winifred did not wish to comply with employer responsibilities, and Winifred and Derek denied they were in a relationship.

17.40. Despite their concerns about Derek, ASC did not raise a safeguarding concern until March 2016, when Derek was suspected of accessing inappropriate imagery.

17.41. There were missed opportunities to assess the suitability of Derek's role as a carer, and a lack of professional curiosity into whether Winifred's apparent non-compliance with employer responsibilities was because she was being subjected to financial abuse, violence and coercive and controlling behaviour by Derek, which she later reported to police in March 2016. There was also a missed opportunity by ASC to complete safeguarding referrals to CSC in light of Derek's contact with Jo and his position as a 'live in carer'.

17.42. ASC held no information regarding Winifred's experience of domestic abuse after 2016, when she reported her relationship with Derek ended.

Surrey County Council Children's Services (CSC)

17.43. Winifred, Justin and Jo were known to CSC from October 2008. Involvement with CSC at this time was primarily due to Winifred's emotional and mental health during the period when her relationship with Justin was ending.

17.44. Support was provided via Child Protection Plans and Child in Need Plans, and Winifred was able to respond to the expectations of these plans to the level that formal support from statutory services was not felt to be needed. The last period of Child in Need support ended in April 2021, and there was no further recorded involvement with CSC after this date.

17.45. There was no involvement with CSC between March 2010 and March 2016, despite the police referral to CSC in September 2016, providing a history of violence and coercive and controlling behaviour by Derek towards Winifred during this period of time. CSC were not aware of Winifred's relationship with Derek, that he was living with Winifred and Jo, and referring to himself as Winifred's carer until March 2016, when Winifred informed police that her then partner, Derek, was accessing inappropriate imagery, which may have included child pornography. Winifred ended the relationship, although CSC recorded that the level of manipulation from Derek made this difficult for her.

17.46. In 2018, CSC were aware of increased parental acrimony between Winifred and Justin over child contact. There were ongoing Family Court proceedings

and Jo was made subject to a Child Protection plan in September 2018 until January 2019, which was stepped down to a Child in Need plan until this ended in June 2019.

17.47. In August 2019, Winifred reported to police that she had experienced psychological abuse by Justin, undermining her parenting ability and making frequent complaints about her. This was in the context of Family Court and police contacted CSC for information to support a criminal investigation. It was recorded in the police IMR that CSC declined to provide any information about the Family Court case due to the Data Protection Act. Police were subsequently unable to determine if any potential offences had taken place and the police investigation was filed.

17.48. CSC reported to police that they were satisfied that Jo's needs were being met. Whilst Family Court is a civil proceeding, agencies have an obligation to report any criminal offences to the police to investigate. Evidence provided in one set of proceedings could be used in the other proceedings. As such a collaborative approach between agencies is essential to ensure coordination.

17.49. The rationale for not providing information to police to investigate Winifred's report of psychological abuse by Justin in August 2019, on the basis that Jo's needs were met, failed to recognise Winifred as a potential victim of crime and did not allow for an investigative, multi-agency approach to understanding her situation.

17.50. Support from CSC focussed on Winifred's ability to safely and effectively parent Jo. Whilst her physical and mental health needs were recorded, there was no evidence of liaison with ASC or other health agencies involved with Winifred, to explore how her health needs and experience of domestic abuse may have impacted on her parenting ability.

Surrey Heartlands Integrated Care Board (ICB) on behalf of GPs

17.51. Winifred was well known to her regular GP who had the majority of contact with her before and during the timeframe for this Review. Winifred was a frequent attender at her GP practice, with seventeen direct contacts in 2021, nineteen in 2022 and twenty-nine in 2023.

17.52. Winifred's GP went to significant lengths to support Winifred, calling her back when she had missed phone calls and provided her with longer consultations than would normally be the case.

17.53. Winifred had a close and supportive relationship with her GP, who appeared to have a good understanding of Winifred's history and the reasonable adjustments required to support her. Her GP was aware of Winifred's experiences of domestic abuse and recalled Derek often attended Winifred's appointments between 2014 and 2016 and could be quite controlling. Winifred's GP reflected that the practice would now offer to see Winifred alone, but at the time, knowledge of coercive and controlling behaviour was much more limited.

17.54. Winifred faced long waits for a review with the ADHD service, spanning two years and had not been seen prior to her passing. The IMR Author noted this was a reflection of very long waits across the country for specialist neurodiversity assessment and support.

17.55. Winifred had a number of missed health appointments. Her GP felt that Winifred's ADHD and ASD led her to frequently request referrals which she then assigned lower priority to on several occasions. Winifred made it clear that she saw other conditions as more pressing or wanted to address one issue before another. The IMR Author also noted, that a number of the hospital letters indicating missed appointments were for failed telephone reviews (during the COVID pandemic). These were marked as 'did not attend' and were rescheduled and followed with successful telephone contact.

17.56. The IMR Author noted that non-attendance of adults is not routinely mapped, and hence the pattern of non-attendance at appointments was much harder to identify. Winifred's GP noted difficulties in keeping track of non-attendance letters from other health providers. There was potential for patterns of non-attendance to go unnoticed.

17.57. During the Review timeframe, Winifred presented with symptoms of anxiety, social withdrawal and insomnia. Winifred felt her problems had been situational and did not seem to be improving with time. She had stopped her ADHD medication, and felt this could be a factor as she was also struggling with concentration and organisation.

17.58. Winifred was prescribed anti-depressant medication, but there was no recorded prior history of self-harm or suicidal ideation in GP records, despite two significant overdoses in 2009 and 2010. Winifred's GP reported her death by suicide to be "*completely unexpected*". During Winifred's last contact with her GP on 01 November 2023, and during an attendance at the practice with Jo on 08 November 2023, Winifred "*appeared well with good eye contact, well dressed and with normal speech and mood*".

17.59. Winifred's GP had no knowledge of the physical abuse Winifred had experienced by Jo until after Winifred's death. The IMR Author noted that Winifred's family subsequently reported, that in the weeks leading to Winifred's death, she had become more erratic. Jo believed Winifred was stockpiling her medication, and the family felt Winifred may be using illicit drugs. This was not shared with the GP prior to Winifred's passing and does not appear to have been reported to any other agency.

Surrey Police

17.60. Winifred, Derek, Justin and Jo were known to police. Winifred had warning markers for being a vulnerable adult at risk of harm from Derek and Justin. There were other warning markers in relation to her health needs, including

short term memory loss, ADHD, fibromyalgia, slurred speech and balance issues.

17.61. The police IMR Author noted that all responses and actions within the Review timeframe were appropriate and conformed to policy and procedure.

17.62. Safeguarding notifications were completed to relevant support agencies, and Winifred and Jo's diagnosed physical and mental health issues were well documented and taken into consideration, where commensurate with the nature and circumstances of the occurrences responded to by police.

17.63. Surrey Police recognised and responded to Winifred's reports of physical and sexual violence by Derek, non-recent domestic abuse allegations, child to parent domestic abuse and abuse played out in the context of Winifred's acrimonious divorce and Family Court proceedings with Justin.

18. KEY ISSUES AND CONCLUSIONS

18.1. The Review Panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contact with Winifred, Derek, Justin and Jo.

Recognising and responding to the risk of suicide

18.2. Winifred endured domestic abuse from Justin and Derek, as well as child to parent violence from Jo. She experienced ongoing trauma, leading to a PTSD diagnosis. Following the end of her relationship with Justin, she attempted suicide in 2009 and 2010, both requiring hospitalisation and a period in intensive care.

18.3. There was little evidence amongst agency records of the risk of suicide being identified or of support services in place to mitigate the risk, despite the two previous significant suicide attempts and Winifred reporting throughout the Review timeframe that she was struggling.

18.4. Understanding a person's mental health history and whether they have experienced repeated trauma is important for assessment, support and intervention. All agencies should routinely ask people who have a history of self-harm, suicidal ideation and/or previous suicide attempts if they are experiencing domestic abuse. Agency policy and procedure on domestic abuse and suicide prevention should align with each other to support practitioners in understanding the intrinsic links between domestic abuse and suicide.

Understanding Winifred's lived experience

18.5. There was little enquiry by any agency into Winifred's lived experience. Some agencies were aware that she was living with Jo but did not always know about the violence and abuse within this relationship.

18.6. CAMHS and CSC were aware of previous violence perpetrated by Jo on Winifred in the early stages of the Review timeframe, but services quickly withdrew. Winifred would later describe her chronic frustration in obtaining support for Jo from NHS mental health professionals.

18.7. Winifred and Jo were both neurodivergent, but there was little exploration by agencies into Winifred and Jo's relationship dynamics, communication styles and how they interacted with each other. Social misconceptions and stigmas around neurodiversity, particularly for Winifred, who had a late diagnosis, can exacerbate feelings of isolation and helplessness. Winifred reported being "*desperate for support*" for herself and Jo and described that constantly advocating for Jo while also trying to manage her own needs was "exhausting". Greater understanding by agencies to tailor support services and understand the dynamics of Winifred's caring role for Jo (and possible Jo's caring role for Winifred) may have improved outcomes for Winifred.

Identifying child and adolescent to parent violence

18.8. Child and adolescent to parent violence is not always recognised as domestic abuse, particularly when a child is under 16 (and outside of the Domestic Abuse Legislation). Parents can experience shame in reporting their child as a perpetrator of violence and abuse, fearing that doing so could lead to their child being criminalised or removed from the family.

18.9. There was evidence that Jo's violence towards Winifred was minimised, particularly when Jo was younger. Episodes of violence and abuse were referred to as "*incidents*" or "*arguments,*" which provided little context and sought to minimise the severity of harm. Winifred was made to feel responsible for managing Jo's violence towards her, with CAMHS and CSC withdrawing support with the expectation that Winifred needed to work on her own needs first and listen more to Jo.

18.10. There was little evidence that agencies considered Jo's violence could be symptomatic of Jo's own exposure to abuse and violence in the family home, despite Jo disclosing experiencing harm perpetrated by Winifred's ex-partner (Derek).

18.11. Adult and child support services should work in conjunction with each other to promote a family-centred approach to addressing child and adolescent to parent violence, which identifies and recognises the support needs of both the child and parent.

Caring responsibilities and domestic abuse

18.12. Winifred experienced financial abuse, physical abuse, sexual abuse, coercion and control, and possible economic abuse within an intimate relationship with Derek, which was framed as Derek having caring responsibilities for Winifred.

18.13. Winifred reported that Derek would use her past against her. This included shaming Winifred about her previous mental health care coordinator, who, in 2009, breached his position of trust by attempting to form an intimate relationship with Winifred at a time of immense vulnerability for her.

18.14. Domestic abuse has additional impacts on people with care and support needs, who require support from their abusive partner. Perpetrators can use a victim's vulnerability and dependency to assert and maintain control.

18.15. Additionally, Winifred's own experiences as a carer for Jo left her feeling increasingly isolated, as she felt she was not getting the practical or emotional support she required. There was evidence that Winifred was experiencing carer stress and did not appear to have much opportunity or ability to access a safe space outside of the family home.

The use of civil proceedings to perpetrate harm

18.16. Whilst outside of the Review timeframe, there was a notable withdrawal of support services during a time of immense stress for Winifred in 2018 and 2019. Winifred and Justin were going through Family Court proceedings, and in August 2019, Winifred reported experiencing psychological abuse by Justin within Family Court.

18.17. CSC were contacted by police investigating the allegations made by Winifred, but CSC declined to provide information to police under the Data Protection Act. CSC reported to police that they felt that Jo's needs were met but made no reference to Winifred as a potential victim of abuse.

18.18. The Ministry of Justice Harm Report (2020) highlights the need for agencies involved in Family Courts and private law children cases to be aware and take account of other proceedings concerning the same family, and that relevant information is shared between processes[22]. Agencies should work in coordination with connected systems, procedures and services. Procedures must be safety-focused and trauma aware, conducting an open enquiry into what is happening for the child and their family. As well as ensuring that children's needs and wishes are at the centre of private law children proceedings, the needs of litigants must also be given central consideration.

18.19. Changes to the Domestic Abuse Act 2021, recognise how various forms of domestic abuse and coercive controlling behaviour can play out in Family Court proceedings. The Act has extended the scope of "personally connected" to include ex-partners who do not live together, to better recognise post-separation abuse.

Perceived non-engagement

[22] Harm Report (2020) 'Assessing Risk of Harm to Children and Parents in Private Law Children Cases'

18.20. There were a number of agencies involved with Winifred, with her being repeatedly open and closed to services over many years. There was evidence of agencies withdrawing based on perceived non-engagement by Winifred, rather than professional curiosity into why she was not attending appointments or engaging in support. There was little recognition of the increased risk to Winifred that non-engagement presented, which may have required agencies to escalate this as a safeguarding concern.

18.21. Some agencies, namely Winifred's GP, recognised Winifred's pattern of non-attendance but reported finding it difficult to keep track of non-attendance letters from other health providers. Non-attendance from adults without identified care and support needs are not routinely mapped, and there is potential for patterns of non-attendance to go unnoticed.

18.22. It is not unreasonable to consider that Winifred may have felt overwhelmed by the volume of appointments, follow up reviews, and various suggested treatments. She reported being in considerable pain and struggling to manage this on a daily basis. Winifred reported difficulties with attending appointments and leaving the house on multiple occasions during the Review timeframe. She had documented difficulties with her memory, as well as her intersecting mental health concerns and role as a carer and parent to a child with mental health difficulties.

18.23. Winifred had physical health needs that impacted on her memory and had experienced assaults to the head and face, as well as non-fatal strangulation. This can present an increased risk of traumatic brain injury and can present in a loss of memory, appearing chaotic or unstable, increased anxiety, and non-attendance at appointments. Professionals may perceive this as someone who is non-compliant or difficult to engage with.

18.24. In addition, there were two references within the Review timeframe to Winifred being intoxicated, which triggered safeguarding concerns for Jo. There was no evidence of further exploration by any agency into whether Winifred's perceived presentation was due to substance use or symptomatic of her prescribed medication or physical health needs. It is important to note that Winifred experienced neurological problems that resulted in slurred speech, which was not apparent to all agencies.

Intersecting health needs

18.25. Towards the end of the Review timeframe, Winifred was open to SaBP. There were multiple occasions where Winifred was discharged back to the care of her GP. Frequently discharging patients with complex needs to their GP adds an unnecessary barrier for patients and increases the chances of disengagement.

18.26. During the Review timeframe, it appears agencies were responding to Winifred's most presenting need at the time of agency contact and not considering her experiences of abuse, her physical and mental health needs, her chronic pain, and her late diagnoses of ADHD and ASD. The number of

coexisting needs Winifred had may have met thresholds of S9 and S42 assessments.

18.27. Winifred experienced a high number of gynaecological issues during the Review timeframe, including undergoing a hysterectomy in an attempt to alleviate her symptoms. Survivors of rape and sexual violence commonly present with high levels of somatic concerns, such as pain from different parts of the body, gastrointestinal, sexual and pseudo-neurological symptoms[23]. The individual experiences the symptoms as real and may repeatedly seek medical care. This can be further accentuated in women with PTSD[24].

18.28. For patients seeking care for medically unexplained symptoms, especially pain, professionals should include questions about previous trauma and consider different treatment pathways that incorporate physical and psychological intervention, rather than responding to these as separate entities.

19. LESSONS LEARNED

East Surrey Domestic Abuse Service (ESDAS)

19.1. ESDAS had no contact with Winifred, Derek, Justin or Jo in the Review timeframe. The only contact had was extremely limited and administrative only.

No recommendations were made by the IMR Author.

Epsom and St Helier University Hospitals NHS Trust

19.2. There was no routine enquiry into whether Winifred was experiencing domestic abuse when she presented with a loss of consciousness after a reported fall. Winifred had facial injuries and was experiencing pain, but there was no exploration into whether Winifred was safe from harm.

19.3. There was a lack of professional curiosity into Winifred's lived experience which may have resulted in additional referrals to external support agencies. Winifred reported being in chronic pain which was causing her to experience difficulties managing daily living. There was also no referral to mental health services when Winifred reported feeling low in January 2023.

19.4. The IMR Author also identified the need for reasonable adjustments for neuro-diverse patients accessing Trust services.

Recommendations have been made by the IMR Author.

North Surrey Domestic Abuse Service (NSDAS)

[23] Pemberton and Loeb (2020) 'Impact of Sexual Violence and Interpersonal Violence and Trauma on Women'

[24] Coleman, Arthur and Shelby (2023) 'Psychological Distress and Pain Related to Gynaecological Exams Among Female Survivors of Sexual and Physical Violence'

19.5. NSDAS had no contact with Winifred, Derek, Justin or Jo in the Review timeframe. Whilst there was a noted gap in communication between NSDAS and Winifred following the MARAC in 2016, it has not been possible to find out why this was.

No recommendations were made by the IMR Author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

19.6. Winifred and Jo were known to multiple services within SaBP, but there was no consideration given to the 'Think Family' approach. There was little evidence that practitioners were exploring whether Winifred and Jo's identified support needs were impacting on each other. This included how each of them were communicating with the other given their neurodiversity and the dynamics of the relationship, where both may have been undertaking forms of caring responsibilities for the other.

19.7. Child and adolescent violence towards a parent were not always recognised. There may have been barriers for Winifred in reporting abuse by Jo due to shame and a perceived risk of criminalising Jo. Other barriers included a history of poor experience of statutory mental health services by Winifred, both as an adult at risk and a parent advocating for Jo's needs.

Recommendations have been made by the IMR Author.

Surrey County Council Adult Social Care (ASC)

19.8. ASC closed Winifred's case without doing a reassessment, therefore potentially leaving her with unmet eligible social care needs. Had the case remained open with regular monitoring and review, there might have been greater potential to identify mental health issues or risks to Winifred's wellbeing.

19.9. There were conflicting records from agencies as to whether Winifred had care and support needs. ASC record that Winifred had self-diagnosed ADHD and her GP felt that Winifred had psychological issues as opposed to physical disabilities.

19.10. There was a narrative in ASC records around Winifred' perceived non-engagement, but it was not established whether this was due to not wishing to engage or feeling unable to as a result of her mental health, physical health and social care needs.

A recommendation has been made by the IMR Author.

Surrey County Council Children's Services (CSC)

19.11. The focus of CSC involvement was on Winifred's ability to safely and effectively parent Jo. CSC assessments acknowledged the external factors which may have impacted on Winifred's parental ability such as her health

vulnerabilities and the impact of domestic abuse, but largely focused on the impact of all these on Jo.

19.12. There was no evidence of liaison with ASC or health services Winifred was accessing, which given the number of physical health issues Winifred reported should have led to consultation with adult support agencies.

19.13. In 2018 and 2019 Winifred and Justin were going through Family Court proceedings and in August 2019, Winifred reported experiencing psychological abuse by Justin within Family Court. CSC were contacted by police investigating the allegations made by Winifred, but CSC declined to provide information to police under the Data Protection Act. CSC reported to police, that they felt Jo's needs were met but made no reference to Winifred as a potential victim of abuse.

Recommendations have been made by the IMR Author.

Surrey Heartlands Integrated Care Board (ICB) on behalf of GPs

19.14. Winifred's diagnosis of ADHD and ASD allowed for Winifred's GP to have a better understanding of Winifred's needs and respond accordingly. However, the delay in her accessing the ADHD service resulted in the majority of support for Winifred coming from her GP via prescribing advice. Winifred would frequently attend her GP, which was viewed positively, but the long wait times for specialist neurodiversity assessment and support is likely to place increased pressure on GPs nationally.

19.15. Winifred had a large number of missed secondary healthcare appointments. When the individual is neither a child, nor an adult with identified care and support needs, missed appointments are not usually identified and responded to. However, consideration should be given as to how GP practices flag repeated non-attendances and when non-attendance becomes a safeguarding concern.

A recommendation has been made by the IMR Author.

Surrey Police

19.16. The IMR Author submitted that all responses and actions within the Review timeframe were appropriate and conformed to policy and procedure.

No recommendations were made by the IMR Author.

20. RECOMMENDATIONS

20.1. The Domestic Abuse Related Death Review Panel's up to date action plan, at the time of concluding the Review is set out in Appendix A of this report.

Appendix A - Action Plan

Recommendation	Scope of recommendation i.e. local or regional	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
An anonymised case study will be created based on Winifred, which will be included within training sessions and shared with outpatient's services.	Local	Creation of anonymised case study. Dissemination of the case study with outpatient's services.	Epsom & St. Helier University NHS Trust	Improved awareness of the importance of professional curiosity and the importance of identifying needs for reasonable adjustments for neuro-diverse patients accessing our services.	March 2025	
To continue to embed professional curiosity within level 3 safeguarding adult training using case scenarios.	Local	Professional curiosity already features within our level 3 safeguarding adults training, and the use of case scenarios emphasising its importance and applies the concept to practice embed learning.	Epsom & St. Helier University NHS Trust	Improved awareness of the importance of professional curiosity and how this is applied in practice.	June 2025	
To continue to progress roll out of Oliver McGowan's training.	Local	Training in Learning Disability and Autism is now mandatory for all staff working in CQC regulated professions. All staff working at ESTH have been enrolled in Oliver McGowan's training at the appropriate level with a focus on completion of	Epsom & St. Helier University NHS Trust	Increased knowledge and confidence in identifying needs for reasonable adjustments for neuro-diverse patients.	September 2025	

		e-learning. Further detail is awaited on the roll out of the interactive aspects for staff within Surrey Heartlands ICB footprint.				
To continue to progress the implementation, of the Reasonable Adjustment Digital Flag Information Standard.	Local	A reasonable adjustment policy is in place for staff. Currently there is ongoing work in motion within the Trust with regards to the Reasonable Adjustment Digital Flag Information Standard which was published by NHS England in September 2023.	Epsom & St. Helier University NHS Trust	Ensuring that patients requiring reasonable adjustments are identified, clear plans are put in place and accessible within digital records.	May 2025	
Surrey GP practices are encouraged to review their internal processes for patients with repeated or persistent patterns of missed appointments (outside of those covered in existing “was not brought” policies).	Local	Learning from this review to be shared and practices encouraged to review their internal processes.	Health (Surrey GPs)	At submission of IMR report to DARDR process, key learning points to be shared with all Surrey GP practices.	January 2025	
To build upon existing work to embed the ‘Think Family’ approach into everyday practice across the organisation.	Local	Review and promote current SaBP ‘Think Family’ resource and ensure that it continues to be reflected in training. Develop a domestic abuse policy for service users and include	Surrey and Borders Partnership NHS Foundation Trust	Resource would be included in Quarterly Learning Event, e-Bulletin and on safeguarding pages on Intranet. Policy developed in partnership with Surrey	April 2025	

		information and guidance on 'Think Family'. The Policy would also distinguish domestic abuse from 'child and adolescent to parent violence and aggression' (CAPVA) and provide guidance on where families can obtain support from. To develop stand-alone training on domestic abuse.		DA Services and available to all staff. Training in place and compliance being monitored.		
To promote awareness of young carers in all teams within SaBP.	Local	To distribute a 7-minute briefing about Young Carers, based on information found via the link Being a young carer: your rights - Social care and support guide - NHS To distribute a 7-minute bulletin about CAPVA.	Surrey and Borders Partnership NHS Foundation Trust	Briefing distributed and available on Trust intranet.	November 2024	**Completed**
A S9 assessment should have been undertaken before Winifred's case was closed to ensure there were no unmet eligible social care needs.	Local	Care Act training - Introduction to the Care Act as well as refresher courses - this is already being rolled out.	Surrey County Council Adult Social Care	Staff at all levels will have received training to ensure they have a minimum level of awareness of good practice appropriate to their role.		**Ongoing**
Where a parent has a significant profile of physical and mental health vulnerabilities, any Child and Family	Local	To ensure that adult services are consulted during child and family assessments to enable a holistic approach and	Surrey County Council Children's Social Care	Ongoing implementation.		**Ongoing**

Assessment should seek to gain consent and gather information about the impact on parenting capacity from any involved services supporting the parent.		strengthen overall analysis of risk.				
Where information comes to light that a parent has suffered coercive, controlling and violent behaviour from a partner, this should be fully explored as part of any Child and Family Assessment and its impact on parenting capacity fully assessed.	Local	As above but also to ensure that MARAC discussions feed into child and family assessments to ensure holistic risk analysis to the children as well as the adults involved.	Surrey County Council Children's Social Care	Ongoing implementation.		**Ongoing**
Embed the Surrey Suicide Prevention Strategy 2025 - 2030.	Local	Support the delivery of the Surrey Against Domestic Abuse Strategy	Surrey Suicide Prevention Partnership Board	By April 2025, a DA and suicide prevention strategy action plan will be developed.	April 2025	**Ongoing** Strategy action plan to be reviewed on an annual basis.
All partners to sign up to and embed the Alison Todd Suicide Prevention protocol.	Local	Presentation on protocol to all partners. Strategy leads to sign up to protocol. Support process to complete action plan for protocol.	Surrey Suicide Prevention Partnership Board	By June 2025, presentation to all NHS partners, VCSEs, community services B&Ds in Surrey.	June 2025	**Ongoing** Strategy action plan to be reviewed on an annual basis.
Embed a suicide safer community approach in Surrey.	Local	Target people working in grassroots community groups and VCSEs training to be suicide alert.	Surrey Public Health Team	Ongoing training	Ongoing	**Ongoing**

		Raise awareness of mental health support in Surrey. Raise awareness of positive relationships in local communities.				
Raise awareness of suicide prevention by ensuring that suicide safety plans are shared with trusted next of kin and relevant professionals involved in supporting the individual.	Local	Surrey to develop a process to share safety plans with trusted next of kin/professionals supporting the individual.	Surrey Suicide Prevention Partnership Board	Online development of safety plan.	Ongoing	**Ongoing** Strategy action plan to be reviewed on an annual basis.
Increase awareness of mental health crisis support available for individuals in caring roles.	Local	Comms messages / local support. Training and education for carers.	Surrey Suicide Prevention Partnership Board	By April 2025, a carers suicide prevention strategy plan will be developed.	April 2025	**Ongoing** Strategy action plan to be reviewed on an annual basis.

Appendix B - Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ABH	Actual Bodily Harm
ADD	Attention Deficit Disorder
ADHD	Attention Deficit Hyperactivity Disorder
ASC	Autism Spectrum Disorder
CAMHS	Child and Adolescent Mental Health Service
CBT	Cognitive Behavioural Therapy
CPS	Crown Prosecution Service
CSC	Children's Social Care
CT	Computed Tomography scan
DARDR	Domestic Abuse Related Death Review
DASH	Domestic Abuse Stalking and Harassment and Honour Based Violence risk assessment
DBS	Disclosure and Barring Service
EFT	Emotional Freedom Techniques
ESDAS	East Surrey Domestic Abuse Services
EUPD	Emotionally Unstable Personality Disorder
GP	General Practitioner
GPIMHS	General Practice Integrated Mental Health Service
HMRC	His Majesty's Revenue and Customs
ICB	Integrated Care Board
ICPC	Initial Child Protection Conference
IFAS	Institute for Addressing Strangulation
IDVA	Independent Domestic Violence Adviser
IMR	Individual Management Review
LADO	Local Authority Designated Officer
MARAC	Multi-Agency Risk Assessment Conference
MASH	Multi-Agency Safeguarding Hub
MRI	Magnetic Resonance Imaging
NHS	National Health Service
NSDAS	North Surrey Domestic Abuse Service
PSII	Patient Safety Incident Investigation
PTSD	Post -Traumatic Stress Disorder
S9	Section 9 of the Care Act 2014
S42	Section 42 of the Care Act 2014
SaBP	Surrey and Borders Partnership NHS Foundation Trust
SCARF	Single Combined Assessment of Risk Form
VAAR	Vulnerable Adult at Risk