



DOMESTIC ABUSE RELATED DEATH REVIEW

Into the death of Winifred

In December 2023

EXECUTIVE SUMMARY

Independent Chair and Author
Michelle Baird MBA, BA

Report Completed: 17 December 2024

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1. THE REVIEW PROCESS

- 1.1. This summary outlines the process undertaken by the Epsom and Ewell Community Safety Partnership, in reviewing the death of Winifred who was a resident in their area.
- 1.2. To protect the identity of the deceased and her family, pseudonyms have been used throughout this report.
 - ◆ Winifred - (Deceased)
 - ◆ Derek - (Winifred's ex-partner)
 - ◆ Justin - (Winifred's ex-husband)
 - ◆ Jo - (Winifred's child)
- 1.3. Winifred aged 50 years of age at the time of her death, lived with Jo and died at her home address in an area in Epsom. Derek at the time of Winifred's death was 59 years of age and Jo was 16 years of age. All three were white British nationals.
- 1.4. The process began with an initial advisory meeting of the Epsom and Ewell Community Safety Partnership on 22 February 2024. A decision to undertake a Domestic Abuse Related Death Review (DARDR) was taken by the Chair and Members of the Epsom and Ewell Community Safety Partnership on 13 March 2024.

2. CONTRIBUTORS TO THE REVIEW

- 2.1. 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

3. REVIEW PANEL

- 3.1 The Domestic Abuse Related Death 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. All 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
Nanu Chumber-Stanley	Public Health Lead - Surrey County Council Public Health
Mary Tiley	Safeguarding Children Advisor - Central Surrey Health Children Safeguarding Team
Bridie Anderson	Services Manager - East Surrey Domestic Abuse Services

3.2. 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.

3.3. 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

4. CHAIR AND AUTHOR OF THE REVIEW

4.1. 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 the agencies involved in the Review. She has had no previous dealings with Winifred, Derek, Justin or Jo.

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

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

- 4.3. She has completed the Homicide Timeline Training (five modules) run by Professor Jane Monckton-Smith of the University of Gloucestershire.
- 4.4. In June 2022, she attended a 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).

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.

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 16 years of age 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 DASH¹ risk assessment tool; safety planning; referral pathway to Multi Agency Risk Assessment Conference (MARAC)², 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.

¹ 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.

² 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.

- ◆ 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 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. SUMMARY CHRONOLOGY

- 6.1. The synopsis of the case has been informed by information provided by chronologies of the contact agencies had with Winifred, Derek, Justin and Jo.
- 6.2. Winifred was married to Justin, Jo's father, during which she experienced emotional and psychological abuse. Post-separation abuse escalated during Family Court and Child Protection proceedings. The marriage ended in March 2009.
- 6.3. Following the separation, Winifred faced significant mental health challenges, including two hospitalisations for paracetamol overdoses in 2009 and 2010. Over time, her mental health declined further, compounded by chronic pain, anxiety, and inconsistent adherence to prescribed medication.

- 6.4. In 2011, Winifred entered a relationship with Derek, during which she experienced physical, sexual, financial, and emotional abuse, as well as coercive control. In September 2016, she reported Derek to the police for assault, including incidents of choking and rape. The relationship ended that year, with Derek being arrested for assault and rape. A restraining order was issued against Derek following his acquittal in court.
- 6.5. In August 2019, Winifred reported Justin to police for making false allegations about her parenting. She disclosed ongoing emotional abuse, but due to insufficient evidence, no further action was taken.
- 6.6. In May 2020, Jo (aged 13) was referred to CAMHS after visiting the Emergency Department due to mental health concerns following an argument with Winifred. During this time, Winifred expressed concerns about Jo potentially having ADHD, and it was recommended that Jo undergo a private assessment.
- 6.7. Police responded to an incident in August 2020, where Jo attacked Winifred and threatened to stab her. Jo alleged that Winifred had placed Jo in a chokehold. A joint CSC and police investigation noted Winifred's mental health struggles.
- 6.8. Jo was placed on a Child in Need Plan and following two Child in Need meetings in February and March 2021, the decision was made to close the Child in Need plan in March 2021.
- 6.9. In April 2021, Jo was referred to CAMHS by the GP as Jo was showing traits of ADHD, ASD, anxiety and depression. The 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. As a result, Jo's case was closed, and Jo was subsequently discharged back to the care of the GP.
- 6.10. Between February and March 2022, Winifred's GP referred her to a pain management team for worsening neck and arm pain. MRI results led to ongoing treatment.
- 6.11. In May 2022, Jo disclosed anxiety exacerbated by Jo's relationship with Winifred. Concerns about past abuse by Winifred's ex-partner (Derek) surfaced.
- 6.12. In July 2022, Winifred reported Jo's dissociative behaviour and violent outbursts, including hitting Winifred to confirm that Winifred was "real". Jo disclosed suicidal ideation and trauma.
- 6.13. During August and September 2022, Winifred continued to report anxiety, insomnia and chronic pain. Police received a call from the Samaritans as Jo was experiencing suicidal thoughts and self-harm after having an argument with Winifred. Police took Jo to hospital for a mental health assessment.

- 6.14. In September 2023, Winifred visited the Emergency Department on the advice of her GP after experiencing a fall and sudden loss of consciousness. She had bruising under her left eye, a persistent headache, and poor balance but could not recall the full details of the incident.
- 6.15. In 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 called Justin to collect Jo. Winifred reported Jo had been trying to find a bag of medication that she had hidden because of the danger of Jo taking an overdose. Winifred felt Jo was not getting the right level of support from CAMHS.
- 6.16. 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. The DASH was not shared further with partner agencies.
- 6.17. On a day in December 2023, Winifred failed to collect Jo from her parent's home. Her father contacted police, who found Winifred deceased at her home.

7. KEY ISSUES AND CONCLUSIONS

Recognising and responding to the risk of suicide

- 7.1. 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.
- 7.2. 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.
- 7.3. 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

- 7.4. 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.
- 7.5. 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.
- 7.6. 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

- 7.7. 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.
- 7.8. 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.
- 7.9. 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).
- 7.10. 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

- 7.11. 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.
- 7.12. 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.
- 7.13. 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.
- 7.14. 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

- 7.15. 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.
- 7.16. 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.
- 7.17. 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 processes³. 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.
- 7.18. Changes to the Domestic Abuse Act 2021, recognise how various forms of domestic abuse and coercive controlling behaviour can play out in Family

³ [Harm Report \(2020\)](#) 'Assessing Risk of Harm to Children and Parents in Private Law Children Cases'

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

- 7.19. There were a large 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.
- 7.20. 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.
- 7.21. 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.
- 7.22. 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.
- 7.23. 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

- 7.24. 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.

- 7.25. 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.
- 7.26. 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 symptoms⁴. The individual experiences the symptoms as real and may repeatedly seek medical care. This can be further accentuated in women with PTSD⁵.
- 7.27. 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.

8. LESSONS LEARNED

East Surrey Domestic Abuse Service (ESDAS)

- 8.1. 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

- 8.2. 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.
- 8.3. 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.

⁴ [Pemberton and Loeb \(2020\)](#) 'Impact of Sexual Violence and Interpersonal Violence and Trauma on Women'

⁵ [Coleman, Arthur and Shelby \(2023\)](#) 'Psychological Distress and Pain Related to Gynaecological Exams Among Female Survivors of Sexual and Physical Violence'

- 8.4. 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)

- 8.5. 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)

- 8.6. 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.
- 8.7. 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)

- 8.8. 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.
- 8.9. 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.
- 8.10. There was a narrative in ASC records around Winifred's 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)

- 8.11. 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.
- 8.12. 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.
- 8.13. 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

- 8.14. 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.
- 8.15. 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

- 8.16. 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.

9. RECOMMENDATIONS

Epsom and St. Helier University Hospitals NHS Trust

- 9.1. An anonymised case study will be created based on Winifred, which will be included within training sessions and shared with outpatient's services.
- 9.2. To continue to embed professional curiosity within level 3 safeguarding adult training using case scenarios.
- 9.3. To continue to progress roll out of Oliver McGowan's training.
- 9.4. To continue to progress the implementation, of the Reasonable Adjustment Digital Flag Information standard.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

- 9.5. To build upon existing work to embed the 'Think Family' approach into everyday practice across the organisation.
- 9.6. To promote awareness of young carers in all teams within SaBP.

Surrey County Council Adult Social Care (ASC)

- 9.7. A S9 assessment should have been undertaken before Winifred's case was closed to ensure there were no unmet eligible social care needs.

Surrey County Council Children's Services (CSC)

- 9.8. Where a parent has a significant profile of physical and mental health vulnerabilities, any Child and Family Assessment should seek to gain consent and gather information about the impact on parenting capacity from any involved services supporting the parent.
- 9.9. 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.

Surrey County Council Public Health

- 9.10. Embed the Surrey Suicide Prevention Strategy 2025 - 2030.
- 9.11. All partners to sign up to and embed the Alison Todd Suicide Prevention protocol.
- 9.12. Embed a suicide safer community approach in Surrey.

- 9.13. 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.
- 9.14. Increase awareness of mental health crisis support available for individuals in caring roles.

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

- 9.15. 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).

Appendix A - 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