Safer Woking Partnership / Surrey Safeguarding Adults Board

Joint Domestic Homicide Review and Safeguarding Adults Review

Into the death of Alice (pseudonym)

in May 2022

# EXECUTIVE SUMMARY

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Review Completed: 10 January 2024

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## 1. THE REVIEW PROCESS

**1.1.** This summary outlines the process undertaken by the Safer Woking Partnership and Surrey Safeguarding Adults Board Domestic Homicide Review Panel during the Review into the death of Alice (pseudonym) who was a Surrey resident at the time of her death.

**1.2.** The following pseudonyms have been used for the deceased and ex-partner, to protect their identities and those of their family members: Alice (the deceased) and Joe (her ex-partner).

**1.3.** Alice, who had a history of vulnerabilities through poor physical and mental health, alcohol and drug problems, had been the victim of domestic abuse over a number of years. She was found dead in May 2022, in a Surrey hotel room, nearby her, were empty bottles of vodka, wine, cider together with empty packets of codeine and clonazepam. Alice had left several notes in the room that talked about the voices in her head and how she 'could not take it anymore'. The Police and other agencies were aware that Alice was very concerned that Joe, her ex-partner from whom she had suffered a history of domestic abuse was being released from prison in July 2022.

**1.4.** A forensic postmortem was carried out and concluded that there was no evidence of third-party involvement. Whilst the Coroner's Inquest has not yet been held, the Pathologist report stated: "The finding of multiple drugs, many at a level that can be associated with fatalities, mean that death is most likely due to a combined effect of the drugs. In my opinion the **CAUSE OF DEATH** was: Mixed Drug Toxicity."

**1.5.** A decision to undertake a Safeguarding Adults Review and a Domestic Homicide Review was taken by the Chairs of the Surrey Safeguarding Board and the Safer Woking Community Safety Partnership on 21 January 2023 and 31 January 2023 respectively. The Home Office was informed of this decision on the13 February 2023. The Independent DHR Chair was appointed on 27 February 2023 and the first meeting of the DHR Panel was held at the earliest opportunity on 20 April 2023.

**1.6.** Twenty-three of the organisations involved with the Review have completed Individual Management Reviews (IMRs) as they had relevant previous contacts with Alice and/or Joe.

## 2. CONTRIBUTORS TO THE REVIEW

The twenty-seven agencies contacted are:

- **Alpha Extreme Services Limited:** This company had limited relevant contacts with Alice and an Individual Management Review (IMR) report was completed.

- **British Transport Police**: This Police Force had relevant contacts with Alice and Joe and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Byfleet United Charity:** This Charity had relevant contacts with Alice and a report was submitted.

- **Christians Against Poverty:** This Charity had relevant contacts with Alice and a report was provided.

- **Chit-Chat:** This Charity had relevant contacts with Alice and a report was provided.

- **CSH Surrey:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed by the Trust. A member of the Trust who is independent of any contact with Alice or Joe is a Review Panel member.

- **Goldtech Care Services Ltd:** This company had limited relevant contacts with Alice and an IMR was completed.

- **Mascot Community Hub:** This community association had relevant contacts with Alice. A report was provided setting out details of the professional and personal contacts and support provided.

- **Matrix SD&T Ltd:** This Company had relevant contacts with Alice and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Panel member.

- **New Vision Homes:** This Company had relevant contacts with Alice and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.
- **Probation Service:** This Service had relevant contacts with Joe and an IMR has been completed. A member of this Service who is independent of any contact with Alice or Joe is a Review Panel member.

- **South East Ambulance Service NHS Trust:** This service had several contacts with Alice, limited to transferring her to hospital.

- **St Georges University Hospitals NHS:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed.

- **Surrey and Borders Partnership NHS Foundation Trust:** This Trust had relevant contacts with Alice and Joe, and an IMR was completed by the Trust. A member of the Trust who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey Adult Safeguarding Board:** The Surrey Adults Safeguarding Board Manager is a member of the Panel. She had no previous contacts with either Alice or Joe.

- **Surrey County Council Adult Social Care:** This Department had relevant contacts with Alice and Joe. An IMR was completed. A senior member of this agency is a DHR Panel member.

- **Surrey County Council Children and Family Services, Together for Families:** This Department had relevant contacts with Alice and Joe in relation to their children. An IMR was completed. A senior member of this agency is a DHR Panel member.

- **Surrey Fire and Rescue Service:** This service had two contacts with Alice and a report was provided. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey Heartlands Integrated Care Board (ICB) for GPs:** This Board provided an IMR on behalf of the GP Practice where Alice was a patient. A member of the Partnership who is independent of any contact with Alice or Joe is a Review Panel member.

- **Surrey Multi Agency Risk Assessment Conference (MARAC):** The Surrey MARAC Chair confirmed that Alice had been referred to a MARAC meeting and provided a report setting out her review of this referral. He had no previous involvement with Alice or Joe.

- **Surrey Police:** This Police Force had many relevant contacts with Alice and Joe and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

- **Vaughan House:** This Charity for homeless people received a referral in respect of Alice but were unable to assist as they had no facilities suitable for a wheelchair user and no general accommodation had vacancies at the time.

- **Woking Borough Council:** The Council, as part of the Safer Woking Partnership had responsibility for Anti-Social Behaviour issues and therefore had relevant contacts relating to both Alice and Joe and an IMR was completed. A member of the Council is a Review Panel member.

- **Woking Borough Council Housing including Housing Solutions:** These Departments had relevant contacts with Alice and an IMR was completed. A member of Housing Solutions who is independent of any contact with Alice or Joe is a Review Panel member.

- **Women's Support Centre Surrey:** This organisation includes the charity, 'Catalyst'[1] that had relevant contacts with Alice and an IMR was completed. A member of this organisation who is independent of any contact with Alice or Joe is a Review Panel member.

[1] Women's Support Centre Surrey were commissioned by Woking Borough Council (WBC) through Women in Prison until March 2021, then employed by WBC until 1 June 2023 when they were TUPEd to Catalyst.

- **York Road Project:** This service had provided some non-relevant support to Alice prior to the dates of this review. Due to a reorganisation no records are available.

- **Your Sanctuary:** This domestic abuse support service has provided an IMR report in relation to Alice. A member of this Charity, who has had a limited supervisory role in relation to Alice's contact with the organisation is a Review Panel member.

**2.2.** Twenty three of the agencies/multi-agency conference have completed Individual Management Reviews (IMRs) or reports.

**2.3.** Rethink Mental Illness (Surrey Support After Suicide Service) attended Panel and Practitioner meetings to advise and support Panel Members, IMR Authors and Practitioners. The Service had no previous contacts with either Alice or Joe.

**2.4.** The following also contributed to this Review:

- Alice's foster mother and three of her friends provided relevant information which has been included in the Overview Report of this Review.
- HM Coroner provided the DHR Review with papers, including the Pathologist's report, submitted for the purpose of the Inquest.
- Practitioners from statutory, private and charity organisations, who supported Alice with her diverse needs.

## 3. The REVIEW PANEL MEMBERS

**3.1.** The DHR Panel consists of senior officers, from statutory and non-statutory agencies who are able to identify lessons and to commit their organisations to setting and implementing action plans to address those lessons. None of the members of the Panel have had any contact direct or indirect with Alice or Joe.

### 3.2. The Panel Members

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|---|---|
| David Warren | Independent Chair |
| Michelle Baird | Review Administrator - Know More Limited |
| Paul Stanley | Detective Inspector Public Protection and Vulnerability British Transport Police |
| Natasha Coutts | Safeguarding Manager - Catalyst Support |
| Sarajane Poole | Interim Deputy Director of Quality & Deputy Chief Nurse CSH Hospital |
| Ian Grimwood | Director - Matrix SD&T Limited |
| Andy Pope | Statutory Reviews Lead - Surrey Police |
| Thomas Stevenson | Ass. Director \| Quality \| Practice & Performance Quality Assurance & Performance Div. Children, Families & Learning - Surrey County Council |

| | |
|---|---|
| Lynda Marsh | Deputy Head of Service - Surrey Probation |
| Memory Chingozho | Safeguarding Adults and Domestic Abuse Advanced Practitioner - Surrey and Borders Partnership NHS Foundation Trust (SaBP) |
| Sarah McDermott | Board Manager - Surrey Safeguarding Adults Board |
| Gareth Owen | Senior Manager (Countrywide Transition Team) Safeguarding Adults - Surrey County Council |
| Georgia Tame | MARAC Administrator/Domestic Homicide Review Coordinator - Surrey County Council |
| Phillip Stonebanks | Watch Commander - Surrey Fire and Rescue |
| Helen Milton | Designated Nurse, Safeguarding Adults - Surrey Heartlands Integrated Care Board (ICB) For GPs |
| Leanne Spiller | Women's Support Centre Manager - Women's Support Centre - Surrey |
| Camilla Edmiston | Community Safety Manager - Woking Borough Council |
| Catherine Butler | Housing Solutions Manager - Woking Borough Council |
| Gerri Summers | Residents Service Manager - Woking Borough Council |
| Louise Balmer | Adult Community Service Lead - Your Sanctuary |
| Cherisse Dealtry | Chief Executive - York Road Project |

**3.3.** Expert advice regarding domestic abuse service delivery in Surrey has been provided to the Panel by Louise Balmer of Your Sanctuary, which provides the commissioned Independent Domestic Violence Adviser (IDVA) Service in Surrey. Expert advice on Safeguarding Adults, has been provided by Sarah McDermott of Surrey County Council. Specialist advice regarding self-harming and suicide has been provided to the Panel by Annabel Clarke of Surrey Support After Suicide Service. Julie Shaw, Senior Partnership and Programme Manager for Surrey Adults Matter for Public Health provided expert advice on the support that can be provided as part of the Surrey Adults Matter project.

**3.4.** The Review Panel met formally five times.

- 20 April 2023
- 10 August 2023
- 10 October 2023
- 23 November 2023
- 10 January 2024

There were additional meetings for:

IMR Authors on 17 May 2023
Practitioners on 13 September 2023

## 4. CHAIR OF THE REVIEW AND REPORT AUTHOR

**4.1.** The Chair of this joint Safeguarding Adults Review and Domestic Homicide Review is legally qualified and is an accredited Independent Chair of Statutory Reviews.

**4.2.** He has no previous connection with the Surrey Safeguarding Adults Board or the Safer Woking Partnership and is independent of all the agencies involved in the Review. He has had no previous dealings with Alice or Joe.

**4.3.** He has an extensive knowledge and experience working in the fields of safeguarding adults and children, domestic abuse and sexual violence at local, regional and national level. Between 2004 and 2011 he was the Home Office Criminal Justice Manager for the Government Office South West. Amongst his responsibilities were the funding and monitoring of the delivery of local services to address domestic violence and sexual crime. He was a founder member of both the South West Regional Safeguarding Children's Board and the Safeguarding Adults Board. He was also a member of a number of Central Government Committees, including those relating to the development of Violence Against Women and Children policies, the national development and implementation of DHRs and the national funding of local domestic and sexual abuse services.

**4.4.** Since 2011 he has chaired numerous Statutory Reviews including Serious Case Reviews, Safeguarding Adults Reviews, Mental Health Homicide Reviews, Drug Related Death Reviews and Domestic Homicide Reviews across the country. He has been a keynote speaker at several National Conferences on domestic and sexual abuse, most recently on the particular issues facing Domestic Homicide Reviews in cases relating to suspected suicides.

**4.5.** For a number of years, he carried out voluntary work as the Chair of a substance abuse Charity and has provided pro-bono legal work for a refuge and its residents.

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

**5.1.** This joint Domestic Homicide Review and Safeguarding Adults Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness, and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant statutory guidance for the conduct of Safeguarding Adult Reviews (SARs) and for Domestic Homicide Reviews (DHRs).

**5.2.** The Review identifies agencies that had or should have had contact with Alice and/or her ex-partner Joe between 1 April 2015 (After the implementation of the Care Act 2014) and the date of Alice's death in May 2022 or any relevant contact relating to neglect, domestic abuse, violence, substance abuse or mental health prior to that period.

**5.3.** Agencies that have had contact with the deceased, Alice and/or her ex-partner, Joe were required to:

- 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 and Safeguarding Adults Reviews.

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

**5.4.1.** Each agency's involvement with Alice and/or Joe, during the period set out in paragraph 5.2.

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

**5.4.3.** Whether COVID restrictions and/or her partner's interventions inhibited Alice's access to agencies.

**5.4.4.** Whether the impact of parenting restrictions including the removal of her children were fully understood by agencies.

**5.4.5.** 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.

**5.4.6.** Whether there were any other known safeguarding issues relating to Alice.

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

**5.4.8.** 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 Alice.

**5.4.9.** Whether agencies have appropriate policy and procedures to respond to needs of a vulnerable adult and to recommend and make changes as a result of the Review process.

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

**5.4.1**1. Whether practices by agencies were sensitive to the ethnic, cultural, religious identity, gender and ages of the respective individuals.

**5.4.12.** Ascertain if any identified family or friends can be traced, who may wish to participate in the Review. If so, ascertain whether they were aware of any safeguarding concerns or abusive behaviour towards Alice.

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

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

**5.6.** 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.

**5.7.** The Review will also highlight good practice.

## 6. SUMMARY CHRONOLOGY

(note: As this is a combined DHR and SAR this is more information provided in this section to indicate the rationale for the lessons and recommendations in this Review than would normally be in an Executive Summary)

**6.1.** Alice, a white single woman, was born in 1983 in South Africa. Her parents had drug addiction problems, and she moved to the United Kingdom with her father a British citizen, when she was 5 years of age. Her mother remained in South Africa.

**6.2.** In about 1993 her mother was killed in a car accident and two weeks later on coming home from school Alice, found her father, he had taken his own life by hanging. Later Alice told a Social Worker that her father was abusive towards her as a child, however her foster-mother told the Review he did care about her and left a substantial Trust Fund for her, which was later 'squandered'by her older half-sister who Alice had initially moved in with. Due to physical abuse from her half-sister, Alice came to the attention of Children's Service and was taken into foster care. 34 pence was all that was left in the Trust Fund when the fraud was discovered. The review was told that the half-sister was sentenced to a term in prison as a result.

**6.3.** After a period of unsuccessful care, Alice was using illegal substances and was a child at risk until at the age of 14. She was then placed in foster care where she was safe and loved by her foster carers. She remained with them until she was 18.

**6.4.** On her 18th birthday she went out with friends to party but was raped by a man who was later arrested in respect of her rape and several others. After this, her foster mother heard nothing from her for some time other than being informed that Alice had returned to using illicit drugs and was often in trouble with the Police. Her foster mother spoke of her joy when in about 2014/2015 Alice visited and introduced them to her 'partner' Joe. She was pregnant, looked well and seemed extremely happy. Sadly, it was not long after that her foster parents were informed Alice was in hospital after being savagely attacked by Joe who was in Police custody awaiting trial for the assault.

**6.5.** There followed a pattern of Joe, a known drug user and suspected drug dealer, being imprisoned for a variety of offences including repeated assaults on Alice and another woman, coming out of prison and returning to Alice in breach of restraint orders, with the cycle repeating itself. When Alice was on her own, she stopped using drugs and drinking too much, only to returning to them when Joe was with her. The Review Panel surmised that this may have been her coping mechanism to Joe's violence.

**6.6.** Both Alice and Joe were well known to Surrey Police Officers. There are 174 occurrences recorded on the Surrey Police Niche crime recording system relating to Alice, and 364 occurrences relating to Joe. These included crime and non-crime incidents and intelligence reports. All four of their children (the youngest two, shortly after birth) were taken into care as they were perceived to be at risk due to Joe and Alice's chaotic lifestyle.

**6.7.** Over the period, 2015-2022 Alice's physical and mental health deteriorated. She was diagnosed with, Hepatitis C, COPD[2], Epilepsy, Thrombosis in right leg, Incontinence, Bi-polar, Anxieties and Depression. By the summer of 2015 she was having to use a wheelchair.

**6.8.** In 2015 due to his anti-social behaviour and drug usage Joe and Alice were evicted and deemed 'intentionally homeless'. Surrey Adult Social Care (ASC) received complaints from members of the public who were concerned about Alice (a woman in a wheelchair) sleeping rough in a multi-storey carpark. Appeals were made by both ASC and Matrix SD&T Advocacy Service to New Vision Homes to provide accommodation for Alice.

**6.9.** On October 2015 Alice wheeled her wheelchair under an oncoming train at a railway station. She survived due to the prompt action of the train driver and the emergency services and was taken to hospital. Two days later Joe visited her and tried unsuccessfully to get her to leave the hospital to get his Benefits money from the bank.

**6.10.** After this incident, New Vision Homes found Alice a ground floor flat to move into after coming out of hospital. It was not adapted for someone in a wheelchair and Practitioners including Occupational Therapists requested adaptions to be made. Although there were occasions when Alice did not respond to offers of support when help was organised. It was only later that it was noted that those occasions usually coincided with Joe staying with Alice on a daily basis. Due to this and costs, little was done to make alterations to the property.

**6.11.** There were numerous complaints made by neighbours that Alice's flat was being used as a drug 'den' where illicit drugs were bought and used. Consequently, after an internal door was damaged, on 27 June 2016, discussion took place at Woking Community Incident Action Group (CIAG) between New Vision Homes, ASC and the Police. Alice was served with an Acceptable Behaviour Contract.

**6.12.** On 18 August 2016 Alice gave birth and procedures were put in place for the baby to be taken into care. Adult Social Services arranged for another round of involvement of an Occupational Therapist which resulted in a recommendation that Alice should be rehoused to a property more suitable for a wheelchair user. They also provided Home Care Services up until November 2017.

**6.13.** On 22 September 2016, following a proactive Police / partnership approach a drugs warrant was executed at Alice's address and Joe was arrested. At the time

[2] COPD -Chronic obstructive pulmonary disease

Alice was in bed in the bedroom of the property. During the search a bag containing £1500 cash was found in the living room, along with multiple cheap throw-away mobile phones. Cocaine and documentation relating to drug dealing were found. This was followed up by the Police arranging unannounced visits and Police patrols which ultimately reduced the number of complaints from neighbours. A 39/24 vulnerable adult report was completed and shared with partner agencies regarding Alice's situation. Joe was convicted of being concerned in the supply of controlled drugs and sentenced to a term of 20 months imprisonment.

**6.14.** By January 2017, in spite of a restraining order on Joe not to contact Alice on his release from prison, there were reports of him again being at the flat with Alice's agreement. Over the following months, Alice repeatedly refused to let carers into her flat, but in April 2017, the Surrey County Council Emergency Duty Team (EDT) received contact from a care agency who advised that Alice had no food or money. EDT agreed for the carers to carry out shopping and for SCC to be billed for the food. This became a pattern, whereby Alice would not allow the carers in, but then there would be further incidents where she would ask for help as she had no food or money.

**6.15.** A friend of Alice's contacted the Police reporting that Alice had told her she had been assaulted, that people were trying to manipulate her into selling drugs and as a result she had self-harmed. Although Alice denied this to the Police, the Officer was concerned by numerous safeguarding issues, including her physical disability and mental health problems and the risk of her being open to manipulation/exploitation in the future. Consequently, he submitted a comprehensive 39/24 vulnerable adult referral, grading Alice as being at medium risk care/ support needs.

**6.16.** On 5 December 2017, Housing personnel called at Alice's home after reports that someone else was living there with her. On arrival, Joe opened the door to them, and it appeared that it was him that was staying there in breach of Alice's tenancy licence.

**6.17.** Three days later, on 8 December 2017, New Vision Homes were contacted by the Occupational Therapist stating that Alice would benefit from rehousing to a more suitable environment as soon as possible, as due to being a wheelchair user she struggled with accessing bathing facilities and the kitchen. A housing needs assessment was arranged.

**6.18.** In January 2018, Alice was referred to the Enabling Independence Team by her Care Coordinator, however she was not engaging with the worker who was meant to be supporting her with applying for her Personal Independence Payment (PIP). She was also enrolled with Outreach workers to support her with bidding for a new flat, however she was not able to manage as each month she would be requesting a food voucher, and the care agency was reporting that she continued to refuse entry of the carers.

**6.19.** On 17 April 2018 New Vision Homes noted that Alice had still not been entering their bidding process for an adapted property to meet her disability needs and considered that this was probably due to her not having online facilities.

**6.20.** In April 2018, Joe was arrested for the assault on Alice and was remanded in custody. During the safeguarding work that followed, Alice disclosed her history, that she has been in the relationship with Joe for 10 years, they have three children together. The children were no longer in Alice's care, and she had no contact with them. Joe had been jailed for 2 years in 2015 for a violent assault on her. He had more recently been sentenced to imprisonment for another offence and had been released on 24 November 2018 when he then moved back in with Alice. She explained that things quickly became difficult as he returned to using heroin and crack cocaine. Alice said he was very controlling and disrespectful. He would stop her visiting her friend by putting obstacles in the way, such as telling her that she needed to do his shopping before she left or telling her that they had already made other plans for the day when she was due to visit her friend. Alice also advised that Joe did not like her care workers visiting, he would tell her to "get rid of them". Joe would remain in the lounge when care workers attended, which meant that the lounge had become untidy, and she was unable to ask Care Workers to support her with this. Alice was visually upset about the environment of the lounge. There were lots of beer bottles and cans lying around as well as needles scattered around. Alice stated he had been using her place as a "shooting shop," having various heroin users visit to use the property to inject drugs. Alice admitted that although she was a heroin user, she has not taken heroin for 2 months and has been providing fortnightly urine samples which have been clear of heroin. She was currently on 90ml of Methadone daily but also drank 2 to 3 cans of alcohol a day. Alice added that she was receiving regular support from i-access.

**6.21.** Alice went on to say that Joe had attacked her on 31 April 2018. He had wanted her sim card out of her phone, and she did not want to give it to him. Joe smashed her phone up and physically attacked her, punching her in the face several times and attempted to smother her face with a blanket. Alice said that Joe had hit her several times in the past. She admitted that she was more frightened this time as Joe had tried to smother her, she was scared that he would kill her. She remained fearful of him even though she was aware he would be unable to leave the prison. Alice was visually anxious and apprehensive, jumping at sounds from outside. She confided that the care workers were not visiting as often as they should and did not always like to do much when they attended. Her desired outcome was that Joe does not return to her property.

**6.22**. A multi-agency meeting was held on 24 April 2018. This was attended by ASC Locality, WBC Housing, I-access, GP Practice, CMHRS and the Care Agency. The meeting provided some clarity on the roles of the attending agencies; Alice’s needs were no longer felt to relate primarily to mental health, so ASC Locality would lead on case-management and that Alice would remain open to I-access. It was agreed that Alice had capacity to make decisions regarding her own life, but she was just making unwise decisions. Alice was not wanting the carers to support her at home. The plan was to complete a professionals meeting considering discharge from CMHRS.

**6.23.** On 8 May 2018, after neighbours complained to the Police of the numerous people calling at Alice's address at all times of day and night, Community Harm and Risk Management Meeting (CHaRMM) was called regarding Alice, who although a victim of Domestic Abuse was at risk of losing her home due to anti-social behaviour and substance abuse at the premises.

**6.24**. A Specialist Neighbourhood Team Officer working with a Social Worker, made a visit and established that Alice was hiding in the flat and not answering the door through fear of letting in drug addicts who had been friend/associates of Joe, who was then in prison after the assault on her on 31 March 2018. The Specialist Neighbourhood Team Officer, informed Alice that the primary need was to safeguard her and give her respite from the drug addicts attempting to take advantage of her vulnerability, and who were banging on her door at all times of day and night. A Social Worker carried out an assessment of Alice's living conditions as the property was in an appalling state. Subsequently, New Vision Homes put a warning flag on the address, noting that Alice had a Police panic alarm and that the Police visited her daily.

**6.25.** At a second CHaRMM meeting, with representation from Woking Borough Council Housing, Adult Social Care, Police, Your Sanctuary and the care provider, it was noted that Joe remained out of prison on remand and Alice was not engaging with the Home Care Service. The Police had provided her with a mobile phone and a partial closure order was considered.

**6.26.** As a result of agreed actions at the CHaRMM, it was decided that as Alice was engaging well with Adult Social Services, that the closure on the premises was no longer necessary and that there was no requirement for her to remain on CHaRMM.

**6.27.** At the end of May 2018, Joe was sentenced to 4 months imprisonment, and a 5 year protection from harassment order, preventing contact with Alice was put in place on his release. An increased Police presence at Alice's home over the course of a ten-week period led to the number of visits being made by drug users diminishing entirely.

**6.28.** In June 2018, it was found that Alice had no active housing application, as she had been unable to provide the identification information needed and she was unable to get a copy of her birth certificate from South Africa. New Vision Housing notified Alice's Social Worker that as she was in a non-secure tenancy, she could not qualify for a high banding for a move, particularly as she did not wish to move out of the area to flee from Joe. A referral was made for an Occupational Therapist (OT) assessment for equipment to enable her to use the bathroom. By July however, ASC Locality updated CHaRMM that Alice was engaging well with Social Care, had not had any male visitors to her flat and was on the housing register for suitable properties. Alice was later offered a new tenancy in a bungalow.

**6.29.** On 21 September 2018, Probation notified the Police that Joe was to be released from prison on 24 September 2018. Upon Joe's prison release he had no fixed abode. The concerns raised by Probation were, that despite the 5 year non

harassment order upon his release, his relationship may resume with Alice, with him using drug use as a way to control her.

**6.30.** On 6 November 2018, a MARAC meeting was held in respect of Alice. It was noted that Alice was temporarily staying at a hotel until a property was ready for her. The Police suspected that although Joe was claiming to be sleeping in a Woking car park, he was in fact living in Alice's old flat. Although there was a restraining order in place on Joe until 2023, as Alice was known to be engaging with i-access for her drug use and Joe was a Class A drug user, it was believed they would be in contact.

**6.31.** In December 2018, Alice moved into a bungalow. An Occupational Therapist assessment had identified adaptations were needed but it was determined these could be done after she moved in.

**6.32.** On 6 January 2019, a neighbour informed the Police that on 27 December 2019, there were sounds of a disturbance coming from Alice's home. He and his partner went round and found Alice and Joe having a verbal argument. As they arrived, Joe ran to the kitchen and threw a small camping stove gas canister into the oven and switched it on, the suggestion being he wanted to blow the house up. The neighbour had removed the gas canister and secured it to prevent Joe doing it again. Two Officers attended and spoke with Alice. She denied any such incident had occurred. The Officers then spoke with the neighbour who told them that there were regular problems at the house, that he believed Joe 'knocked' Alice about.

**6.33.** A referral was made to the MARAC and on 3 March 2020 at the subsequent MARAC meeting, the following issues were noted, and actions arranged:

- There was a Protection and Harassment order against Joe.
- Welfare check to be done by the Surrey Police Safety Neighbourhood Team (SNT).
- Alice was not supporting the Police at that time.
- MARAC would request an update from Probation.
- It was confirmed that Alice had been supplied with a Domestic Abuse kit.
- If Joe was arrested for any further offending, Your Sanctuary would try and support Alice.
- Alice was now a New Vision tenant living in a partly adapted property.
- Both Alice and Joe were open to i-access.

**6.34.** In April 2019, one of Alice's friends contacted Adult Social Care to inform them that Alice was wheelchair bound and had not been able to access her GP Practice since she was rehoused, therefore she could not get any of her medication. As she had moved out of the GP Surgery area, she needed to sign with a GP Practice somewhere closer, but as Alice did not have a driving licence or passport, she could not register anywhere. Arrangements were promptly made with the closest GP to her home to accept a utility bill as sufficient identification, but there were difficulties in contacting Alice to inform her of this.

**6.35.** The same month, Adult Social Care received a phone call from one of Alice's neighbours who had been helping her throughout the COVID crisis, but for the previous three weeks Alice had been saying that she did not have any money for groceries and had to rely on food banks. Arrangements were made, but a few weeks later a call was received by Adult Social Care from the Woking Family Centre to raise a concern about Alice, who was self-isolating on her own. She has been asking local COVID 19 volunteers to buy her large bottles of cider. On other occasions Alice had also been seen leaving the house to get alcohol herself when she was meant to be at home self-isolating.

**6.36.** In July 2020, Adult Social Care received a referral from i-access Drug and Alcohol Service that a visit had been made to Alice at her home, the house was bare and untidy. There was no carpet on the floor and minimal furniture in the living room. Alice was unkempt and did not show signs of maintaining personal hygiene. Alice had disclosed that her neighbour (who helped collect her medication and do shopping) had moved away and this has adversely affected her. With regard to the house, Alice stated that she was unable to afford to lay flooring in the house which was currently concrete flooring - which could cause significant harm if she was to fall. She also only has a small cabinet freezer and was unable to store much food in there. The garden which had several steps, and a platform was a safety risk with the wheelchair. The fence to the garden was also broken and therefore the property was not secure. The property required adapting for wheelchair access. Alice also disclosed that she not been receiving Disability Payment. An Occupational Therapist made several attempts to contact Alice, eventually sending a letter to Alice stating: "…tried to contact you recently without success. If you still require an assessment could you contact us within 2 weeks. After this date we will close this case." As this was never conveyed to the i-access Drug and Alcohol Service Practitioner a reminder was sent in October 2020 to again ask for the help for Alice.

**6.37.** Similar further referrals were made during the following two months emphasising that Alice was alone, wheelchair bound and 'at risk of physical health (having a chest condition), and mental health deterioration and limited ability to seek assistance or help.' After the third referral a Social Worker arranged for a voluntary organisation to do a medicine collection and for a food bank to provide a food parcel. A referral to be made for an electric wheelchair.

**6.38.** The GP Practice who had been copied into to these referrals, noted the regular good communication from the i-access key worker. A result of which was the GP contacted Alice by phone, but in spite of all reasonable advice and safety netting being given, Alice declined an appointment/COVID test/medication for her chest symptoms. The GP accepted there was no reason to consider she did not have capacity to make these decisions.

**6.39.** On receiving a referral from ASC in January 2021, a manager from the Byfleet Unity Charity visited Alice at home. They agreed to arrange for a new fridge freezer, clothing and bedclothes. They advised her to contact Citizens Advice Bureau about getting her PIP restarted and dealing with £1750 utility debt. At the same period Adult Social Care commenced a S9 Care Act assessment (which was completed in March).

**6.40.** On 5 February 2021, CSH Surrey received a referral to their Continence Service from Alice's GP. A telephone consultation from the Continence Service was made due to Alice's overactive bladder and stress incontinence. A plan was agreed - refer to the pelvic physiotherapist, send some leaflets and samples of incontinence pants then to follow up in 3 months."

**6.41.** Later that month, the ASC Locality team were contacted by a neighbour of Alice, who asked if her Social Worker could make contact with her to check on her welfare." Subsequently an ASC Locality Worker made contact with Alice via telephone and with a home visit. It was revealed that Alice was falling about 2 times per month and was also experiencing cognitive / memory problems.

**6.42.** On 29 March 2021, Alice was referred to CSH Surrey by the ASC Locality Team and the Community Nursing Team was asked to assess Alice's pressure sores. They attended Alice on 14 April with the physiotherapist and a plan was agreed with her that the physiotherapist would speak to her Social Worker regarding the visit and to discuss:

- Provision of carers to help with washing and dressing
- Refer to Occupational Therapist (OT) for rails and chair raisers
- Refer for a pendant alarm and key safe

**6.43.** This meeting was followed up two days later on 16 April 2021, when the Occupational Therapist visited Alice to complete the assessment. During this, she was informed that the Wheelchair Service had confirmed she was on their waiting list for a new electric wheelchair which was estimated for June 2021. While an assessment was being completed, Alice briefly mentioned her history with suicide attempts, addiction, domestic abuse, etc, but said she was now in a better place mentally but generally frustrated. It was arranged for regular community nurse visits to check and dress her pressure sores. In the following weeks Alice reported being in significant pain and that her incontinence had got worse. She was given a bladder scan and advice regarding pads.

**6.44.** The Reablement Service was in contact with Alice once a day, but Alice complained to her GP that the work she was being asked to do was increasing her pain levels. Due to Alice's history of drug misuse, her GP was very cautious about adding in more medication without specialist input but agreed to her increasing codeine and epilepsy medication as an interim measure until the Pain Clinic could see her.

**6.45.** A Reablement worker recorded "I am very concerned about Alice. She said to me that she is very close to doing something. She used her fingers to demonstrate how close it is. She was in tears. She declined for me to contact her GP or paramedics. She is very low at the moment, and I am very concerned."

**6.46.** A Safeguarding referral was also received by Adult Social Services from the Scope National Helpline stating Alice had called the national helpline because she was really struggling. She claimed she was in a lot of pain and was not receiving the support that she needed from the support worker or carers and was not able to eat

properly due to her disability and access to the kitchen. She said she was struggling with a lot of things like benefits and debt.

**6.47.** A Reablement review took place, and reported that (Alice) was in tears when expressing her pain and her frustration with how her case was being handled:

- She had not been able to see the GP for her pain.
- She was finding life 'very complicated and difficult'.
- Her Social Worker was leaving, and he could not tell her who was going to take up her case.
- She could not get through to anyone for help.
- She was scared for her life.
- She said she needed a key safe but could not afford that or Careline.
- She wanted help with shopping and cleaning and laundry because she was struggling.
- She could only move around in a wheelchair which she found difficult and that is why she slept on a sofa.

The report concluded that (Alice) needed help and recommended that she receives the help she needs urgently as she thinks she is struggling and there is no way out. She feels she is close to doing something to herself which might be to end her life.

**6.48.** On 5 May 2021 a Reablement worker found Alice unconscious, she had cut marks on her left arm and after rousing her, the worker ascertained Alice had taken all of her pain medication/epilepsy medication. Every packet was empty. At the hospital Emergency Department, Alice denied having any suicidal ideation stating the medication was taken for pain. After a discussion with the Psychiatry team, it was decided that as there was no suicidal ideation there was no need for an assessment. It was noted that she was awaiting a Package of Care (POC) under the Reablement Team and they were contacted to ensure the package of care restarted the next morning. She was also referred to i-access for follow up.

**6.49.** On 17 May 2021 Alice attended a hospital with back pain. She was examined but there were no new acute findings, pain management was undertaken, and she was referred to the Chronic Pain Team. However, on 1 June 2021 she failed to turn up to her appointment. She was later given two telephone appointments but again did not attend several planned face-to-face appointments.

**6.50.** On 17 June the Occupational Therapist was told by Alice that the equipment the Therapist had ordered for her had arrived. A discussion took place around further equipment needs and Alice agreed to have a profiling 'hospital' type bed, which the Occupational Therapist ordered. Alice said she had been seen by the Pain Team and Mental Health Team and her medications had been adjusted. The Occupational Therapist noted that Alice sounded to be in better spirits. Subsequently the Occupational Therapist and the Continence Team continued to visit her at her home throughout June and July.

**6.51.** On 2 July 2021 Police attended at Alice's home after receiving information that Joe was visiting her. A neighbour who knew Joe well, confirmed that he was regularly visiting and staying over at Alice's address. The Officers completed a DASH, assessing Alice as being at high risk based on their observations and information known. It was decided that Joe was to be arrested for breaching the Restraining Order. Alice however was unsupportive, although this seemed to the Officers to be due to her fear of Joe and her concerns about repercussions. An Outreach referral was completed, and a SCARF/VAAR high risk was shared with partner agencies.

**6.52.** Adult Social Care received a referral from a Social Prescribing Link Worker, who explained that during a visit to Alice, she was told that Alice had already been visited by an Occupational Therapist and that a report had been drawn up as to required modifications to the property, as she was a wheelchair user. Alice had asked what the next steps would be and when they would be completed. Adult Social Care responded that in 2018 the Occupational Therapist had completed a report for home adaptations which had been sent to New Vision Homes, who had advised that Alice had declined for the work to be completed. Therefore, due to the time gap, an updated assessment would be required. This was later completed and sent to New Vision Homes.

**6.53.** An i-access worker made a safeguarding referral that on 6 July 2021. Alice had disclosed that Joe, had turned up, with a dog about a week ago, he had nowhere to go, so she let him in. He 'switched on her' and she had retaliated. She then told him to leave her house. The Police attended and she disclosed that Joe had been at her property. However, she was worried that he would find out as he had breached his restraining order, and he had read her key safe number. The I-access worker explained that he would make a MARAC referral and arrange for the key safe number to be changed. It was only after Joe had been arrested and was in Police custody on 12 July 2021, that Alice gave a statement to the Police. In the statement she referred to the incident in December 2019 which she had previously refused to speak to Police about, she confirmed that she and Joe had been arguing all day and that during the evening, he had grabbed her hair and punched her in the head several times.

**6.54.** In September 2021, Surrey Police received a message from Alice which raised concerns for her welfare, as she stated she could not go on anymore, her head was all over the place, and that she was nailing her own coffin. She was upset and very stressed. She said that she was feeling very low as she was worried about going through with Police action in relation to Joe. She was scared he was to come out of prison and get to her again. It was explained the Police would support her.
She said that she had no plans to self-harm and would speak to her GP as she is not sleeping well. The Police contacted Your Sanctuary and ASC regarding their concerns about Alice. ASC Locality considered this incident against s.2 of the Care Act criteria but decided this did not meet the threshold for a Safeguarding Adults Enquiry. The contact outcome stated that a referral to the GP / Mental Health Services was the appropriate action.

**6.55.** Surrey Fire and Rescue Service visited Alice and completed a full safety visit. It was noted that Alice 'is a wheelchair user who lives in a bungalow, but she cannot exit the bungalow in an emergency situation, when she does try and exit, she states the wheelchair tips and falls backward. She did explain she did have contact with Occupational Therapy and others who are helping with her situation, but it is concerning that she is not able to exit. Her home is also cluttered around her living areas, she would need assistance with clearing this and general house tidying, but her care staff will not assist her. The cooker also needs some attention, but once again she is unable to access this to clean. There is a reach pole in the property to assist her to close the windows, but she also struggles with this and doesn't find it easy to use. Fire alarms all tested, no gas in the property.'

**6.56.** Adult Social Care tried unsuccessfully to contact Alice by numerous telephone and visits to her home throughout January 2022, and it was not until early February that she was seen at her home. Alice admitted that she has been struggling with depression. She was not taking medication for this, and she said this may be something she is interested in. Adult Social Care contacted Alice's GP to request a GP appointment to review her mental health.

**6.57.** On 25 January 2022, Alice had a telephone consultation with her GP Practice. She confirmed that she had stopped taking 'recreational' drugs. Her medication was reviewed as she was in a lot of pain and feeling depressed; but had no immediate thoughts of self-harm. It was noted that she had missed her appointment with Pain Management but agreed to make another appointment. The same day after the call, the GP wrote to Mental Health Services regarding medication changes. A letter was received back regarding this (recommending a trial of venlafaxine) but numerous attempts to contact Alice were unsuccessful.

**6.58.** The Occupational Therapist noted that contact had been made with New Vision Homes to chase up the adaptations in Alice's home. The repairs team advised that it required authorisation from a project manager and that the Project Manager would be contacted to get an update on the adaptation. The Therapist also called to chase up the application for an electric wheelchair but received no answer. The Police had made an assessment on the installation of some domestic abuse safety measures to Alice's home and were waiting for the Council to implement the work on the property.

**6.59.** Surrey Police contacted agencies working with Alice to give notice that Joe would be released from prison in the next few months, and that they wanted to inform professionals involved about the situation as Alice had a restraining order against Joe.

**6.60.** On 21 March 2021, Alice was admitted to hospital following taking an overdose and having a cardiac arrest. A Psychiatric review was undertaken following a capacity assessment being completed and documented and Alice was discharged on 25 March 2021. A referral was made back to her GP for a community team referral, as Alice refused further testing for possible medical issues.

**6.61.** On 1 April 2022, Alice health was reviewed by her GP in a telephone consultation. A Paramedic home visit was arranged, and she was diagnosed with a

lower respiratory tract infection and treated with a course of antibiotics. It was recommended that she should go to hospital, but she was adamant that she did not want to go. She was referred urgently to the mental health team for review, after previously declining their intervention when they had contacted her. Alice again declined support but stated she would phone 999 if she deteriorates.

**6.62.** In April 2022, Woking Borough Council responded to the Occupational Therapist's request for an update regarding the major adaptations to Alice's kitchen/bathroom/doors as she had been waiting almost ten months for these adaptations and would like to know how long she may have to wait. The OT was informed that New Vision Homes' contract had ended on 31 March 2022 and due to a backlog of adaptions, the work on Alice home had not been completed. Woking Borough Council were in the process of appointing a new major adaptations contractor with a view to starting works from May 2022 onwards.

**6.63.** Alice's allocated worker on the Adult Social Care team wrote to the Community Mental Health Recovery Services (CMHRS) stating that Alice 'had been seen by Psychiatry Liaison in hospital, following an admission regarding an overdose. Prior to this a request had been made several times to her GP to make a referral to CMHRS. Alice had confirmed that CMHRS had been trying to get hold of her, but she had not been answering their calls. She was very low and not as engaging as she used to be. A risk assessment was being completed with Alice, but she was not engaging therefore the risk assessment would be completed without her input and would be sent to her in the post.'

**6.64.** On 23 May 2022, i-access contacted Alice for a telephone consultation. It was recorded that she had been getting on well, she stated that she continued to receive support from the Byfleet United Charity. They were helping her with her garden and with getting furniture for her flat. When her mental health was discussed however, she reported being frustrated and paranoid. She felt something was not right in her head; she was hearing voices. Alice added she was anxious as Joe would be released from prison in July 2022. The Police are aware of this. When discussing drug and alcohol use, she reported that she had the occasional drink and cannabis. However, this was not something that she viewed as a problem. She denied any heroin use and stated that she would never go back to that. Alice then requested that she be removed from Recovery mode as she was still abstinent from heroin and would work with CMHRS and her GP. The Worker agreed but also informed her that should she require any support to get in touch. She said thank you to the Service for the support received.

**6.65.** On 25 May 2022, Alice's GP Practice telephoned and texted Alice to make a GP appointment for 30 May but received no response.

**6.66.** Later that month, Surrey Police found Alice deceased in a hotel room.

## 7. KEY ISSUES AND CONCLUSIONS

### 7.1. Key Issues:

### 7.2. Domestic Violence and Alice's fear of Joe

**7.2.1.** In November 2014 Alice told her Probation Officer that her father had been physically and emotionally abusive towards her when she was a child. At 18 she was raped. It was recorded by her Probation Officer that Alice had described a history of damaging and destructive personal relationships. She had married a previous partner who was abusive to her and who received a life sentence for offences against other women. The Officer concluded that Alice presented as a young woman who was vulnerable to exploitation.

**7.2.2.** From the very commencement of their relationship, Alice had suffered physical and mental abuse from Joe for many years, yet because of her fear of him, she still allowed him into her home when he turned up, in spite of the court order restraining him from contacting her. The Review has alluded to a number of the vicious assaults he inflicted upon her, including whilst she was in her wheelchair when she would not or could not do his bidding. The assaults summarised are too savage to be detailed in this report and it is perhaps not surprising that she bore a lasting sense of injustice that his prison sentences did not always reflect the injuries she suffered and had to live with. The Police although hampered on occasions, by her reluctance through fear to support proposed actions against him, nevertheless, took positive action against Joe when they had evidence to do so. Although this is a matter for the Coroner's Inquest, the fear of Joe's pending release from prison appears to have been a major factor in Alice's decision to take her own life. Her friends and foster mother who were with her not long before her death, have separately recounted, that although she was unhappy about the inadequacies of her living accommodation and the lack of action in addressing her needs, particularly the absence of any work on the promised sanctuary scheme safe room; it was that fear of Joe coming out of prison which terrified her.

**7.2.3.** There is considerable research evidence, (some of which is highlighted in the Overview Report) that Domestic abuse has significant psychological consequences for victims, including anxiety, depression, suicidal behaviour, low self-esteem, inability to trust others, flashbacks, sleep disturbances and emotional detachment.

### 7.3. Substance Abuse

**7.3.1.** Alice and Joe both had/have chaotic lifestyles, both used/use illegal drugs and were/are alcohol dependent. Joe has a long list of convictions for drink and drug related assaults and anti-social behaviour. Alice's parents were allegedly involved in the sale and use of illicit substances when Alice was born, and her foster mother has told the Review that she had been using heroin prior to her coming to live with her family when she was only 14 years of age. Alice was drug free by the time she came out of care at the age of 18. However, after being raped at 18 years of age, she went through a difficult time and is believed to have returned to using heroin and cocaine as well as cannabis. Other than during her pregnancies, she continued to use illegal drugs while Joe was with her; either because of his influence or as a coping mechanism against the violent assaults she suffered at his hand. Whenever Joe was in prison, she worked hard to be drug free.

### 7.4. Physical and Mental Problems

**7.4.1.** Alice was wheelchair bound and suffered from a number of life-defining physical and psychiatric disabilities including Hepatitis C, COPD[3], Epilepsy, Thrombosis in right leg, Incontinence and Bi-polar. The anxieties and depression she suffered were aggravated by her life experiences of; finding her father after he had taken his own life by hanging when she was about 10 years of age, being raped on her 18th birthday, living in fear of the recurring violence from Joe, her poverty and inadequate accommodation.

**7.4.2.** Being bereaved by suicide as a child, placed Alice at an even higher risk of self-harming. Research considered in the Overview report indicates that if a child had lost a parent due to an unnatural cause, the risk of the child attempting suicide was twice as high as that of a non-bereaved child, however children who had lost a parent to suicide had an 82% higher risk of attempting suicide compared to children who had lost a parent in an accident.

**7.4.3.** Women with severe mental illness are up to five times more likely than the general population to be victims of sexual assault and two to three times more likely

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to suffer domestic violence.[4] The study, found that 40% of women surveyed with severe mental illness had suffered rape or attempted rape in adulthood, of whom 53% had attempted suicide as a result.

### 7.5. Homelessness

7.5.1. At one stage both Alice and Joe were homeless. Adult Social Care received notice of this from members of the public concerned that a woman in a wheelchair was having to live on the streets. As she had been deemed to be intentionally homeless and therefore not eligible for care and support, ASC and Matrix Service Development & Training Ltd. appealed this decision, however it was only after Alice attempted to take her own life by pushing her wheelchair in front of a train, that the decision was rescinded, and a flat was found for her.

### 7.6. Inappropriate equipment and accommodation

**7.6.1.** Practitioners from several agencies identified problems in her living conditions. She could not easily get in or out of either the flat or bungalow she had been provided, because of poor wheelchair access. She had difficulty getting to a bath, she had to sleep on a sofa for long periods, kitchen equipment included sink and work services which were too high for her to use from her wheelchair.

**7.6.2.** Several times from 2018 until the time of her death in 2022 it was advocated that she should be given an electric wheelchair, due to the state of her manual one - nothing happened.

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[3] COPD -Chronic obstructive pulmonary disease

[4] *Psychological Medicine* 2023 research led by UCL and King's College London funded by the Medical Research Council and the Big Lottery.

**7.6.3.** In September 2021, Surrey Fire and Rescue Service carried out a safety inspection of her bungalow, reporting that the premises had not been adapted for someone in a wheelchair and highlighted the risks Alice faced with access and egress to/from the building. These issues were regularly brought to the attention of the correct agencies by practitioners, yet her housing needs were never properly addressed due to the high cost of adapting the accommodation she had and the lack of purpose-built wheelchair accommodation being available in the area she wanted to live.

### 7.7. Conclusions

Considered within the context of the six principles of the Care Act 2014 ie. Empowerment, Prevention, Proportionality, Protection, Partnership and Accountability.

**7.7.1.** Alice had to manage an incredibly challenging range of needs and adverse circumstances, over a number of years; recurring, and persistent, difficulties that included childhood upheaval and abuse, unsettled accommodation, homelessness, ill-adapted accommodation, ongoing financial difficulties, lack of food, security, physical impairment, mental health challenges, cycles of addiction - recovery and relapse, chronic, unbearable pain and having 4 children removed from her care. Throughout, there were numerous incidents of physical and emotional abuse from Joe.

**7.7.2.** The range, persistence, complexity, and interrelated nature of these difficulties necessitated Alice receiving support from a range of agencies. The Review identified 23 different organisations that had contacts with her between 2015 and 2022. Their visits, telephone calls and letters were rarely coordinated and on occasions resulted in her being swamped with well-meaning practitioners trying to contact her. It is perhaps not surprising that on occasions she became frustrated and just did not respond to them. This was particularly so when there was a rapid turnover of personnel or if Joe was on the scene. Gradually the practitioners themselves realised this, and organised joint contacts with her at times which suited her best. It did not help that although Occupational Therapists and other practitioners identified her essential needs, to her it appeared that there was little resulting action. Individual agencies have told the Review that there was no overall ownership or co-ordination.

**7.7.3.** Until 2020 one agency could not force another to act on a recommendation to take a particular cause of action and partnerships such as MARACs, CHaRMM, CIAG could only coordinate not direct. Yet in January 2020 Surrey Adults Matter (SAM)[5] was launched with a Strategic Steering Group attended by senior leaders from Public Health, Adult Social Care; Housing; Probation Service; Community Safety and Surrey Police among others and also from the charity and voluntary sector.

[5] SAM's aim is to 'design and deliver better coordinated services for people facing multiple disadvantage, facilitating a shift to crisis prevention for those with complex needs who are often hard to reach'. The intention being 'to look at how things are operating at individual, system and service level, with a view to improving outcomes.'

**7.7.4.** In spite of this, Alice was never referred and agencies during the Review never mentioned its existence nor that in 2021 Surrey also became a Changing Futures Area which allowed the creation of an Alliance of Trauma Informed Outreach workers to compliment the multi-agency strand of their multiple disadvantage work.

**7.7.5.** The Review found that during the first few years after the implementation of the Care Act 2014, there appeared to be a little evidence of a working knowledge of Care Act 2014 responsibilities, although informally practitioners (as has been mentioned above) did share information well with others for the benefit of Alice. Care Act referrals improved considerably after people became more familiar with the legislation and the Review acknowledges the diversity of the agencies making appropriate Safeguarding referrals from 2018 onwards.

**7.7.6.** The review noted many examples of good practice and in particular the Panel highlights the small Byfleet Unity Charity which, when informed of Alice's situation, promptly spent thousands of pounds of the charity's scant budget to cloth her, provide clean bedding, kitchen equipment including a fridge/freezer, laminate flooring for her concrete floor garden care and a companionship cleaning service.

**7.7.7.** The Review concludes that whilst practitioners from the different professions, recognised her vulnerabilities and correctly reported that her basic needs[6] were not being met, other than the above-mentioned Charity, no one Agency or Partnership took ownership of expeditiously actioning those needs. The Review Panel is nevertheless satisfied that the lessons from Alice's horrendous experiences will be addressed, if the recommendations agreed during this combined Review are properly implemented. That will be Alice's legacy.

**7.7.8.** The Review Chair and Panel acknowledge that the scope of the review has been limited by Joe's decision not to engage with the Review.

## 8. LESSONS LEARNED

**8.1.** The following summarises the lessons agencies have drawn from this Review together with those identified by practitioners and the Review Panel during their deliberations. The recommendations made to address these lessons are set out in the Action Plan template in Section 20 of this Report.

### 8.2. CSH Surrey

**8.2.1.** Domestic abuse routine enquiry and history taking were not embedded in the initial assessment. Despite Alice disclosing that she has been a victim of domestic abuse, had suffered from drug addiction and suicidal attempts, there was no further enquiry to understand the impact this had had and was currently having on Alice. It was not known if she was still drug taking, was experiencing domestic abuse from a new partner or her previous partner or what her current mental health was. Her physical health needs and her disclosure about her lived experiences all indicated

[6] Maslow described the human basic needs as: Psychological needs - The needs for survival ie. Food, shelter, water etc. Safety needs: These include our need for personal, emotional and financial security as well as physical wellbeing.

that she was a vulnerable adult with safeguarding needs. Further explorative conversations following her disclosure may have engaged Alice and enabled her to share further information. Alice was discussed at MARAC in July 2021 due to Joe repeatedly breaking the restraining order and attending Alice's home, if domestic abuse had been explored with her by practitioners who were providing services prior to this, earlier intervention would have been possible.

**8.2.2.** There appears to have been little professional curiosity, particularly around rescheduled visits and the comment regarding the adverse effect of incontinence to her quality of life. There is no evidence of practitioners exploring with Alice why she refused some visits or rebooked them and how she could be supported to engage more with the service. There is no understanding of what her daily lived experience was or of the impact of her history which she disclosed to clinicians and the understandable impact that this would have on her mental health and current health. It is not known if Alice had a wider support network or any family, what her day-today life was like or what other support services she had. Had this been undertaken she may have felt comfortable to disclose that she had given birth to 4 children who had been removed from her care and the subsequent impact this would have on her and an understanding of her increased vulnerability, especially her mental health. There is no evidence of a holistic assessment of Alice's life and needs.

**8.2.3.** Good practice was identified, practitioners were responsive to Alice's requests and clinical needs, making appropriate changes as required to try to improve her quality of life. Practitioners offered further visits / alternative dates when Alice declined to engage, to try to ensure she received the help she needed, reassuring her when she became distressed, and signposted to her GP for an assessment of her pain. CSH Wound Assessment and Management guidelines and Bladder Scanning and Assessment of Residual Urine Policy were in place and were followed. Community Continence Assessment and Reassessment Policy were also in place at the time of intervention and were followed. Level 3 adult safeguarding training which is delivered face-to-face includes how to ask explorative questions about relationships, how to respond and access support, to listen and understand the client's lived experiences.

### 8.3. Goldtech Care Services Ltd

**8.3.1.** Information sharing could have been better, as personnel working with Alice were totally unaware of her history of mental health difficulties, domestic abuse or self-harming. If they had known they could have been more vigilant and been able to structure support more appropriately. (This is being addressed by the commissioning agency.)

### 8.4. Matrix Service Development & Training Ltd

**8.4.1.** Recording systems at the time (2017) were an extension of an existing pdf system that existed for ward-based interactions as the primary work was IMHA. These only allowed short entries and although these could be extended to the next available section, the compartmentalised nature discouraged this. The introduction of

new word templates that allow unlimited system entries. This allows for more detailed information to be recorded than the PDF system in use 2017.

**8.4.2.** Prompts around safeguarding concerns had been omitted on latest case notes systems.

### 8.5. New Vision Homes

**8.5.1.** The delay in responding to the request for Sanctuary works, NVH could have been better in regard to its response time. However, there are now better procedures in place and a Repairs Team inbox, so that the whole team can monitor and progress these kinds of works and ensure that they are completed in a timely manner.

**8.5.2.** Level of the response, to the requests made by Occupational Therapists, the Fire & Rescue Service and other Agencies practitioners, for Alice's flat, then bungalow to be adapted to meet her needs as a wheelchair user, was not given sufficient priority.

**8.5.3.** Whilst attempts were made to communicate with Alice this was inhibited due to her difficulties as a wheelchair user being able to attend meetings and as she often did not have/or would not answer a mobile phone. Other methods of communication could have been explored.

**8.5.4.** As New Vision Homes no longer exists, there are no improvements to discuss regarding the service they would provide. However, as the service is back in- house, it has been recognised there is a need for updated policies and procedures. This is being undertaken as part of a service improvement plan for the housing service within Woking Borough Council.

### 8.6. Probation Service

**8.6.1.** The assessment made in the pre-sentence report was clear and thorough. Points were made to be followed up on after sentence to guide whoever the case was allocated to.

**8.6.2.** Lack of pre-release work, change of Officers when staff move on, evidences the need for handovers to be conducted and recorded and show management oversight. Given Joe's history of violent offending, there should have been consideration of a referral to MAPPA and the decision making in relation to this recorded on NDelius. There are other missed opportunities in relation to referrals for Joe - for example, he could have been considered for the IOM scheme. IOM is the joint and intensive management of offenders by Police, Probation and other partner agencies (including local authorities, drug and alcohol support services, mental health services, accommodation providers and voluntary sector organisations). Joe could also have been considered for MATAC (multi-agency tasking and coordination), a proactive method of identifying and tacking the most harmful domestic abuse perpetrators which commenced in July 2021.

**8.6.3.** There was no contact with Joe before release - good practice would have been to arrange a video-link to discuss his release plans and gain a sense of his attitude towards Alice. No safeguarding referrals were made in relation to Alice or Joe's new partner. It would have been helpful to find out more about Joe's new partner as well as who was visiting him in prison and who he had been contacting.

**8.6.4.** A focus on safeguarding, liaison with the Police information sharing and prerelease work may have opened up opportunities for agencies to make contact with Alice so that she was better informed about Joe's release from prison.

### 8.7. Surrey Adult Social Services

**8.7.1.** From an Adult Social Care practice perspective, given the timespan of this chronology, some of the learning identified has already been learned. However, the Author views the outstanding learning points as follows:

**8.7.2.** Understanding and implementation of Care Act 2014 s.9 duties to assess and s.13 Eligibility Criteria - the chronology has shown that eligibility decisions may have been made without reference to the outcomes and wellbeing considerations required by the Care Act. Whilst practice has undoubtedly moved on within the organisation since the Care Act was implemented, and any new legislation invariably brings a natural learning period for workers and organisations alike, this chronology does show the adverse outcomes that can occur if this is not understood.

**8.7.3**. Understanding and implementing of Care Act 2014 Safeguarding Adults Criteria and Threshold. The chronology showed that there were opportunities when the Surrey Adults Safeguarding Procedures might have applied but were not considered - doing so could have strengthened the multi-agency network, working in a more co-operative, preventative way and, potentially, raising cognisance amongst the whole network of concerns regarding coercion and control.

**8.7.4.** Understanding of fluctuating needs, in relation to Care Act Assessments.

**8.7.5.** Awareness and understanding of fluctuating mental capacity, in relation to Mental Capacity Act 2005. The chronology showed numerous instances where capacity was believed / assumed, and this assumption appears to have persisted regardless of how Alice was presenting. There were reasons, by way of mental health, substance use and coercion / control where a disturbance of the mind or brain could have been reasonably considered to be affecting ability to make choices (even if only temporarily).

**8.7.6.** Awareness of coercion and control, what it is, how it looks and multi-agency best practice; the chronology did not reveal any persistent consideration of this area of practice.

**8.7.7.** There is no indication that Alice was ever asked if carers, employed at her home by other agencies could be warned of the inherent risks of harm from drugs, syringes, other paraphernalia or of the dangers if Joe was at or arrived at the premises whilst they were present.

**8.7.8.** Agencies appeared to have been confused about their duty of care to staff and/or the client by sharing information without consent, due to their belief that to do this may contravene Data Protection Legislation.

**8.7.9.** Data sharing agreements as recommended in the Surrey Multi-Agency Information Sharing Protocol, did not appear to have been in place with those non statutory commissioned services employing carers in Alice's home.

**8.7.10.** There was a lack of knowledge regarding the 'Surrey Data Sharing Handbook' amongst the professionals involved with Alice between 2015-2022.

**8.8. Surrey & Borders Partnership NHS Foundation Trust (SaBP)**

**8.8.1** Re **Information sharing**: Prior to the s75 NHS Act 2006 agreement ending in November 2019, both the CMHRS and i-access were integrated health and social care teams. Therefore, any safeguarding concerns should have been discussed with ASC staff within the teams and/or the ASC Safeguarding Advisors and Managers that covered the CMHRS and I-access at the time. They would have then decided if further enquiries were required under s42 Care Act 2014.

**8.8.2.** Post s75 agreement, all teams now report safeguarding concerns to MASH in line with all other Trust services. In addition, domestic abuse forms a significant part of the Trust safeguarding adults training and DASH training has been provided on an ad hoc basis in partnership with Domestic Abuse Outreach services in the Trust. MARAC and DASH are discussed as part of safeguarding training as well as coercion and control.

**8.8.2.** There is currently good practice as domestic abuse is now part of the safeguarding adult's policy, and a workforce domestic abuse policy is in place. The Trust's intranet includes a specific page on domestic abuse which provides a range of information, including domestic abuse services contact details. Domestic abuse is an integral part of the Trusts safeguarding adults training and learning from Domestic Homicide Reviews and Safeguarding Adults Reviews are shared through governance arrangements.

- Domestic abuse and Domestic Abuse Stalking and Harassment (DASH) training to be further embedded across the Trust.
- Audit of safeguarding adult enquiries in relation to domestic abuse across directorates with a specific focus on the routine enquiry.
- All people supported by SaBP services can be seen without their partners.

**8.8.3.** Although there is good evidence of recording and comprehensive assessment with the teams, there are gaps of information sharing when Alice was known to a variety of professionals. The teams would stop involvement but follow up by a care coordinator was not arranged.

**8.8.4.** There were also opportunities to speak to Alice on her own when she would attend i-access service for prescription collection without Joe. Discussions to address domestic abuse were missed, particularly when two different workers saw

her black eye but did not believe the explanation that she gave. Staff noted that Alice and Joe appeared to have a volatile relationship but did not attempt to speak to Alice separately from Joe.

**8.8.5.** There is good information sharing when the new Care coordinator was allocated and would arrange the professionals' meetings effectively so that relevant professionals would support with different tasks. However, there were times where there were inconsistencies with mental health and substance misuse services outcomes. The dual diagnosis policy was not utilised effectively. At present the Use of the Triangle of care is being implement in the Trust with regular training and discussion in team meeting to ensure effective practice.

### 8.9. Surrey Heartlands Integrated Care Board (ICB) for GPs.

**8.9.1.** There was good inter-service working**.** The GP contributed to the initial child protection conference for Alice's unborn baby in the summer of 2016, and subsequently provided a medical report for her Family Court solicitor.

**8.9.2.** No information was received by the GP practice regarding any MARAC attendances; this would have been the case at the time, but as a result of an earlier Surrey DHR, a GP/MARAC information sharing process was agreed at the end of 2021. Following a pilot in the first half of 2022, this process was rolled out countywide from September 2022. Surrey GPs are now contacted in advance of the MARAC, asking them to share any relevant information, and informing them that their patient is due to be discussed and is hence a victim of high-risk domestic abuse. Training of clinical and non-clinical staff has supported this development, and there are very good levels of returns from Surrey GP practices, and improvements in DA clinical record keeping. (See Appendix D: Surrey GPs and MARAC Information Sharing Guide)

**8.9.3. Good practice**: Reviewing the detailed records for the 3 years that Alice was registered at her last medical practice, shows robust attempts to contact and engage with her. Alice's documented non-use of voicemail on her mobile phone was fully acknowledged by both clinical and non-clinical staff, and when Alice did not answer her phone (which was frequently the case), text messages were sent instead. These have proven advantageous in this Review, as they provide an objective record of what messages were sent and when. A missed phone call resulting in a voicemail may be recorded as "no reply, voicemail left". The use of texts linked directly to the electronic GP record is now widespread.

### 8.10. Surrey Multi Agency Risk Assessment Conference (MARAC)

**8.10.1.** Whilst the MARAC Chair was satisfied that the MARAC meetings in respect of Alice were well attended and that the actions set and delivered were appropriate, it was pointed out the MARAC process in Surrey has continued to develop with a number of administrative changes having been implemented which are better supporting the MARAC referrals, information sharing and agency accountability.

### 8.11. Surrey Police

**8.11.1.** There were some occasions where intelligence was recorded but not acted upon. In 2017 information that Alice had been seen with bruises on her chest was not followed up. Police had responded to a report of a domestic incident the day before, yet no injuries were disclosed / seen. This should have been explored.

**8.11.2.** Intelligence recorded in 2019, indicated that Alice was being assaulted by Joe and bruises had been seen on her arms. The report also mentioned that there was a Restraining Order preventing Joe from contacting Alice. There was no further research completed. This was a missed opportunity which should have been followed up.

**8.11.3.** There has been a lack of basic training for Officers/Staff in connection with the submission of intelligence, and this has contributed to issues regarding reports being submitted when there is no requirement and reports not being submitted when they ought to be.

**8.11.4.** In this case, the Officer submitting the report graded the intelligence as low risk based on the fact that the information was provided by a member of the public. This was an incorrect assessment and may well have been due to lack of training and appreciation of enhanced risk levels relating to domestic abuse.

**8.11.5.** There were a few occasions where breaches of the Restraining Order could have been pursued / investigated more robustly by police.

**8.11.6.** In high-risk DA cases consideration should be given to a multi-agency enforcement strategy, especially where a victim is open to different agencies. This could be agreed at MARAC.

### 8.12. Surrey Women's Support Centre

**8.12.1. Good Practice:** Women's Support Centre (WSC) provided Alice with a laptop in an attempt to enable her to engage with substance misuse support.

**8.12.2.** WSC was told in May 2021 that Alice had not opened the Tablet box, but it was unclear what further support was provided or what encouragement was offered at this time.

**8.12.3.** Documentation could have been more detailed as it is unclear what, if any encouragement was given to Alice when her non-engagement with the SMART group and with WSC as a whole became known.

8.12.4. Subsequent to WSC initial involvement with Alice it has introduced a dedicated domestic abuse service and employs a DA worker who is a qualified IDVA.

### 8.13. Woking Borough Council

**8.13.1.** The criteria for which Alice was referred to both the CIAG and ChaRMM Partnership meetings had been met on both occasions and therefore was suitable for discharge at that time. However, this happened when there were still outstanding actions, albeit not necessarily relevant to the original referral. Once discharged from CIAG/CHaRMM there was then no oversight on whether the actions were completed.

**8.13.2.** At the time of the CIAG involvement, there was no IT that would support onward monitoring being used at Woking Borough Council, (This is no longer the case). The use of the information sharing platform, 'Ecins', allows for an individual to be discharged from the meeting, however the outstanding actions would then still be monitored. If an action is then incomplete in the agreed timescale after discharge, then it can be addressed under AOB as part of the CHaRMM to ensure update/outcome is provided.

**8.14. Woking Borough Council Housing**

**8.14.1.** A particular lesson learnt is to ensure that vulnerable people are bidding for suitable, settled homes regularly so that their housing needs can be met as soon as possible.

**8.14.2.** Although Alice had support from various agencies, closer working from housing might have made a difference to timescales but would still have been subject to a suitable property becoming available.
**8.14.3.** The need for a more suitable home for Alice was identified following an Adult Social Care assessment as the bathroom and kitchen had become increasingly inaccessible to Alice.

**8.14.4.** There are no records of representations being made by ASC and Matrix Service Development & Training Ltd in June and July 2015 relating to Alice sleeping in a public carpark as unfortunately, there are no homelessness notes for the time period as they were input into a different IT system which is no longer in use. The notes on the relevant system were input retrospectively by the IMR author as they had previously been in the email inbox of a member of the Options Team. The IMR Author took immediate action by informing all staff that notes must be input in a timely manner into the correct IT system in accord with policy.

**8.15. Your Sanctuary**

**8.15.1. Good Practice**: Persistence with contact attempts when calls went unanswered. This was reasonable, proportionate and in line with policy. It demonstrated a willingness to try and engage and multiple requests were made for alternative contact methods through other professionals involved with Alice.

**8.15.2. Learning**: For follow up actions from a MARAC or any other Professional meeting to be clearly documented and recorded on the Client Case Notes, positive or negative.

**8.15.3.** Inter-agency responses identified as a potential missed opportunity when YS did not appear to have actioned contact with Alice's Adult Social Care Worker. Otherwise, there is evidence of good practice in terms of Professionals meetings being attended as well as MARACs, despite having little input to offer due to lack of contact between Alice and YS.

**8.15.4.** As it had been hard to engage with Alice from the first contact in 2012, an opportunity where she was willing to speak, expressing her genuine fear and asking for support could have been optimised so as to learn more about her needs and situation. However, it is noted that at that time, Alice preferred to speak to a Police DA Worker, with whom she had established a rapport. This may have been why further exploration and risk assessment was not completed, because Alice was likely to have done so with the Police DA case worker.

### 8.16. Cross Agency Practitioners

**8.6.1.** There was a lack of knowledge of the Surrey Multi-Agency Information Sharing Protocol amongst practitioners, several of whom were working at Alice's home without having been warned of the risks to either themselves or Alice.

**8.6.2.** There was no formal co-ordination of the many practitioners who needed to have contact with Alice; this resulted in Alice becoming confused by the many different agencies contacting her. It was practitioners themselves who identified the problem and informally arranged joint visits at times suitable to Alice. There was a lack of knowledge regarding the Surrey Adults Matter programme.

**8.6.3.** Some non-statutory organisations working with Alice were never invited to multiagency forums meeting to discuss her care.

**8.6.4.** Some funding streams created barriers for example health funding could not be used for social care.

## 9. RECOMMENDATIONS

### 9.1. National Recommendations

**9.1.1.** In this joint Review the Review Chair and Safeguarding Lead met with 17 practitioners who had worked with Alice in relation to her diverse and complex needs health (physical and mental), housing, drugs/alcohol, children being taken into care, in addition to violent domestic abuse over number of years. The meeting allowed those practitioners who came from both statutory and non-statutory organisations, to express their views openly in a safe environment. After being reminded of the confidentiality of the Review, the practitioners gave key information that had not previously come to light in the IMRs, and which now features in the lessons and recommendations of this Review. It is the view of the Review Panel that the participation of the practitioners has added immensely to the quality of the Review's findings, and they therefore recommend that the Home Office team currently drafting the new statutory guidance for the conduct of DHRs consider adding such engagement with practitioners as good practice.

### 9.2. Cross Agency Recommendations

**9.2.1.** To reduce the risk of individuals with severe multiple needs falling through gaps between services or being faced with a plethora of service providers, participating agencies should utilise the Surrey Adults Matter (SAM) programme to work together in a more coordinated way with the client at the heart of the process with a view to improve outcomes. This would enable joined-up support to individuals with multiple needs and reduce the number of professionals individually contacting them.

**9.2.2.** Agencies have a duty of care to staff and commissioned services, who are expected to carry out work in environments/situations where there is a high risk of serious harm. It is therefore recommended that such agencies participating in this review, should rely on legitimate interests as the sole lawful basis for collecting and sharing the relevant information that would need to be given to the front-line workers. This will always need to be clearly documented, to allow the consent to share to be valid reason basis for sharing.

**9.2.3.** Participating agencies working with members of the public should ensure that front line professionals understand the Surrey Gold Standard Coercive and controlling behaviour framework so as to enable them to identify and deal appropriately with people who may be experiencing controlling or coercive behaviour (CCB).https://www.healthysurrey.org.uk/domestic-abuse/professionals/surrey-goldstandard-coercive-and controlling-behaviour-framework

**9.2.4.** All agencies involved with this review should ensure that they have an escalation policy to assist staff to know pathways for escalation. All agencies should be aware and utilise as appropriate, the Surrey Safeguarding Adults Board Inter–Agency Escalation Policy and Procedure - Resolution of professional disagreements and oversight of risk in work relating to safeguarding adults.

### 9.3. Agency Recommendations

#### 9.3.1. CSH Surrey

a) Clinicians to have access to regular and ad hoc safeguarding supervision.

b) The introduction and use of a holistic tool would enable practitioners to complete a robust assessment of a client's needs and how to address them whilst also further safeguard any vulnerable adults. In the community health children services a family health needs assessment is used and could be adapted to support this.

#### 9.3.2. Probation

a) To improve the quality of pre-release work in custody cases to ensure effective risk management and safeguarding

b) Probation staff to be aware of their responsibilities under the Care Act where there are safeguarding concerns.

### 9.3.3. Surrey County Council Adult Social Care

a) In relation to cross agency information sharing appertaining to the safety of frontline workers, agencies going forward, need to actively seek the individual/data subjects' consent where there is the potential high risk to others and staff working on the case. If the individual is able to give consent at the earliest opportunity, this opens up the gateway to share the relevant detail on this matter with appropriate parties who could be affected. This will always need to be clearly documented, to allow the consent to share to be a valid reason basis for sharing. If individuals do not give consent, then a best interest decision in line with the Health and Social Care (Safety and Quality) Act 2015, will need to be considered as the potential risk to others, who maybe directly affected if not to share, is just as important as the risk to the data subject if we were to share information.

b) ASC workforce will be supported to understand and implement Care Act 2014 s.9 duties to assess and s.13 Eligibility Criteria.

c) ASC workforce will be supported to be confident in understanding and implementing implement of Care Act 2014 Safeguarding Adults Criteria.

d) ASC workforce will be supported to be confident in understanding and considering fluctuating needs, in relation to Care Act Assessments.

e) ASC workforce will be confident in understanding and considering fluctuating Mental Capacity, in relation to Mental Capacity Act 2005.

f) To ensure that ASC workforce understand all aspects of coercion and control and what multi-agency best practice is in place in this area.
g) ASC Workforce supported to be confident in assessing risk and recording assessment / risk management.

### 9.3.4. Surrey Integrated Care Board (for GP Practice)

a) Learning from this case is shared and used to support practices in developing clinical and safeguarding supervision for patients with multiple complex long-term problems.

b) That Level 3 update sessions in 2023 include high-risk DA and response.

c) That Information sharing processes are established between Surrey GPs and MARAC.

### 9.3.5. Surrey Police

a) Bespoke training to improve the quality of intelligence report submissions should be provided to all public facing officers and staff.

### 9.3.6. Surrey Public Health

a) Increase awareness amongst the Public and practitioners of the links between domestic abuse and suicide, as this can be hidden by a perfunctory classification such as ‘deceased suffered from depression or mental health problems.

### 9.3.7. Surrey Support After Suicide Service

a) Drive awareness among frontline professionals of Suicide bereavement as significant risk factor for suicide. Include suicide bereavement as a potential risk factor when assessing for suicide risk.

### 9.3.8. Woking Borough Council - Safer Woking Partnership

a) To better use the available information sharing platform Ecins (Data System) to ensure that all actions are completed. To ensure that all actions have a visible audit trail from assigning to closing.

b) Encourage wider use of ‘Ecins’[7] amongst partners to ensure all those that attend the CHaRMM are able to access and update cases and can be accountable for assigned actions.

c) Introduce into the ToR for CHaRMM that under AOB all outstanding actions that have expired in time to complete, to be addressed on all cases discharged to CHaRMM. The agenda can then provide in advance of the meeting those actions and who they were assigned to so that they can come prepared to answer.

### 9.3.9. Woking Borough Council Housing (Incorporating recommendations from New Vision Homes)

a) To review all current policies and procedures that are relatable to domestic abuse and mental health.

b) Initial domestic abuse training to be delivered by an external provider. To have regular training provided on an ongoing basis.

c) Mental health training to provide in line with the mental health protocol. To continue training in line with any relevant legislation.

d) To update data information via a bolt on to the existing system within WBC.

e) For a member of the Resident Services team to attend MARAC when a tenant is on agenda meetings alongside Woking Borough Council’s Housing Team. This should be a manager from Housing options and resident services accompanied by Housing Options Officer as a training opportunity.

[7] Collaborative case management system

f) To ensure that there is a process in place so that vulnerable people who need to move into suitable, settled homes are monitored regularly so that their housing needs can be met as soon as possible.

g) The Rough Sleeper Team to work with other support agencies and other organisations to assist vulnerable people to access a suitable property as they become available.

h) That properties are inspected by an Occupational Therapist (OT) before a tenant moves in to ensure the needs of people with mobility challenges can be addressed at the property where possible before the new tenant moves in.

i) All case notes to be input in a timely manner.

j) Homelessness Policies and procedures to be reviewed/updated.

**9.3.10. Women Support Centre - Surrey (WSC)**

a) To improve record keeping through the completion of training and skills workshops around case notes and what to include.

b) To ensure all avenues are explored by personnel to encourage client engagement and retention.

c) To ensure all key WSC personnel have a sound working knowledge of the Mental Capacity Act and how/when it should be utilised to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment.

**9.3.11. Your Sanctuary**

a) A management review/dip sample of MARAC actions being documented on client case notes and follow up records being made to include outcomes and whether MARAC/MODUS has been updated.

b) For follow actions for MARAC or any other professional meeting to be clearly documented and recorded on the client case notes.

c) A need has been identified for a more consistent approach to MARAC and record keeping.