EXECUTIVE SUMMARY

of the

DOMESTIC HOMICIDE REVIEW

and

SAFEGUARDING ADULT REVIEW

relating to the death of Mary

FINAL

on behalf of:

REIGATE AND BANSTEAD COMMUNITY SAFETY PARTNERSHIP
and
SURREY SAFEGUARDING ADULTS BOARD

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EXECUTIVE SUMMARY CONTENTS

1.0 INTRODUCTION

This Executive Summary outlines the process and findings of a joint Domestic Homicide Review (DHR) and Safeguarding Adult Review (SAR) undertaken by East Surrey Community Safety Partnership and Surrey Safeguarding Adults Board into the unexpected death of Mary. All the names in this review have been anonymised for the purpose of confidentiality.

2.0 OUTLINE OF THE INCIDENT

2.1 On 29 November 2017 police from the local Safer Neighbourhood team initially attended Mary's home to check on her welfare as she had been identified as a high-risk domestic abuse victim. A neighbour approached the officers flagging concern for Mary.

2.2 The Officers forced entry into Mary's home and found her lifeless body in the bathroom. Mary was found slumped with her knees up against the door with a dressing gown cord around her neck.

2.3 At the time of Mary's death, she was living alone as her three children had been taken into foster care. In the months leading up to her death she had contacted the police on fourteen occasions reporting that her relationship with Gary had become abusive and violent.

2.4 The police undertook a thorough investigation and although the initial examination of the scene did not identify any involvement from another party, Mary's significant and recent domestic abuse history prompted consideration of a manslaughter investigation. Despite Gary being subject to a restraining order in relation to Mary, enquiries revealed that on 28 and 29th November (early hours) Mary had been in Gary's company. The police Domestic Abuse Force Advisor reviewed the domestic abuse suffered by Mary and confirmed it amounted to coercive controlling behaviour.

2.5 The police enquiry found no evidence of another person being involved in Mary's death and concluded that sometime early morning **29 November 2017,** Mary hanged herself. The Home Office pathologist determined that cause of death was hanging and post - mortem enquiries revealed that Mary had high levels of cocaine and alcohol in her system at the time of her death.

2.6 Following two preliminary inquests, the full inquest was held in October 2020. The coroner stated in the Regulation 28 Report, that Mary died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time.

3.0 DOMESTIC HOMICIDE REVIEW

The review considered the issues identified in the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (DHRs), issued under section 9(3) of the Domestic Violence, Crime and Victims Act (2004) and aims to:

a. Establish what lessons are to be learned from the domestic homicide regarding how effectively local professionals and organisations work individually and together to safeguard victims.

b. Identify clearly what those lessons are, how and within what timescales they will be acted upon, and what is expected to change as a result.
c. Apply these lessons to service responses including changes to policies and procedures as appropriate
d. Prevent future domestic violence homicides wherever possible, through intra and inter agency working.

4.0 SAFEGUARDING ADULT REVIEW

4 1 Under the 2014 Care Act, Safeguarding Adults Boards (SABs), are responsible for Safeguarding Adults Reviews (SARs). SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

4.2 The statutory guidance (updated in 2018) to support implementation sets out the purpose of SARs, and principles for their conduct.[1]

Action to safeguard adults should include

a. promoting well-being and preventing abuse and neglect from happening in the first place
b. ensuring the safety and wellbeing of anyone who has been subject to abuse or neglect
c. involving all those who can offer support and impact on reducing risks
d. Acting against those responsible for abuse or neglect taking place
e. learning lessons and making changes that could prevent similar abuse or neglect happening to other people

4.3. The East Surrey Community Safety Partnership[2] and Surrey Safeguarding Adults Board (SSAB) agreed a joint DHR / SCR process for this case. This included representation on the Panel of SSAB manager and the appropriate input from the SSAB, SARs subgroup on the draft and final report.

5.0 TERMS OF REFERENCE

Terms of Reference were agreed by the DHR / SAR Panel on October 2019 and were regularly reviewed and amended as further details of the incident emerged (see Appendix 1).

6.0 INDEPENDENCE

The Chair and author of the review is Liz Borthwick, formerly Assistant Chief Executive at Spelthorne Borough Council which she left in 2015. Liz has a wide range of expertise including Services for Vulnerable Adults and Children, housing and domestic violence. She has conducted partnership Domestic Homicide Reviews for the Home Office and has attended Home Office Independent Chair training for DHRs and further DHR Chair training with Advocacy after Fatal Domestic Abuse (AAFDA). Liz has also been involved with a

[1] SARs guidance https://www..gov..uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[2] East Surrey Community Safety Partnership reverted back to individual Borough and District based CSPs in 2020

number of SCRs. She has no connection with the local Borough or any of the agencies in this case.

Liz was supported in this review by Debbie Stitt as DHR / SCR Administrator. Debbie has worked in Community Safety for many years and has a thorough understanding and knowledge of domestic abuse and the processes involved in DHRs. Debbie has attended Home Office training in the running and delivery of DHRs and AAFDA training sessions.

7.0 PARALLEL AND RELATED PROCESSES

7.1 Inquest (see Para 2.5)

Following two preliminary inquests, the full inquest was held in October 2020. The coroner stated in the Regulation 28 Report, that Mary died by hanging, but it was not possible to determine whether she intended to take her own life or she had hoped to be found in time.

7.2 Criminal Trial

Mary's father became a witness for Gary providing evidence that Gary only breached the order out of concern for Mary and the children. As a result, there was only one nominal finding of a breach of the order.

7.3 Care Proceedings

The Care Proceedings agreed that the children would be placed as follows:

- Ashley to live with biological father and partner
- Frankie to live with biological father and partner
- Charlie to live with paternal aunt under a Special Guardianship Order (SGO)

7.4 Police Disciplinary Investigation

Following a formal complaint by Mary's father to the police, the case was referred to the Independent Office of Police Complaints (IOPC). The IOPC referred the case back to Surrey Police who investigated the complaint and concluded that correct procedures had been followed. This view was confirmed by the IOPC. Mary's father appealed the decision, but this was not upheld.

7.5 Surrey Children Social Care Investigation (CSC)

CSC carried out an internal investigation following a breach of inappropriate information sharing. Mary's father lodged a complaint against Surrey County Council (SCC) under the Human Rights Act 1998 and negligence under the Fatal Accidents 1996. Although out of time, SCC and Mary's fathers' legal representative has agreed to defer the investigation until after the results of the inquest are known.

8.0 METHODOLOGY

8.1 The Chair requested proportionate Individual Management Reviews (IMRs) from those agencies identified by the DHR/SAR Panel as potentially having contact with Mary, Gary and the children. The agencies were provided with a framework and guidance for the process including a chronological account of their contact with the victim and / or the alleged perpetrator covering a period from June 2006 (birth of first child) until November 2017(date of death)

8.2 They were asked to feedback on the following in particular:

- Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and perpetrator.
- Consideration of any equality and diversity issues that appears pertinent to the victim or perpetrator
- Were opportunities missed by professionals to routinely enquire about domestic abuse, coercive, controlling and stalking behaviour which should have led to a referral to a domestic abuse support service?
- To review whether there was adequate professional curiosity during engagement with Mary
- Whether there were any barriers experienced by Mary, or her family / friends in seeking support from professional service providers.
- Agencies that had no contact will investigate whether helpful support could have been provided and if so, why this was not accessed.
- Whether there were opportunities for agency intervention or support regarding known perpetrators of domestic abuse /coercive control which were missed.
- Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.
- Whether professionals were aware of confirmation bias when reviewing Mary and Gary's background to ensure scenarios were interpreted from a neutral standpoint.
- What parental support was provided when the children were taken into care
- Consideration of whether Mary's welfare was promoted and protected through timely and effective risk assessment and response to the needs identified (this includes application of thresholds, information sharing, use of assessment tools and timely interventions)

9.0 CONTRIBUTORS TO THE REVIEW

The following agencies submitted IMRs detailing their contact with Mary, Gary and the children

- Surrey Police (the police)
- Surrey County Council Adult Social Care Surrey (ASC)
- Surrey County Council Children Social Care Surrey (CSC)
- Health (Surrey GPs)
- Surrey and Borders Partnership Foundation NHS Trust (SaBP)
- Surrey and Sussex Healthcare NHS Trust (SASH)
- Children and Family Health Surrey (CFHS)
- Central Surrey Health (Community Health Provider)
- Epsom and St Heliers NHS Trust
- Registered Social Landlord (RSL)
- SECAMB (Surrey East Coast Ambulance Service)
- Reigate & Banstead Borough Council (RBBC)
- East Surrey Domestic Abuse Service (ESDAS)
- Schools Children Centre
- Catalyst (Substance misuse service)

The IMRs were completed by senior staff who had no direct management involvement with the family or the incident.
The Panel gave detailed consideration and professional challenge to the IMRs submitted by these agencies and the final documents have contributed significantly to this report.
In addition, further information was provided from MARAC minutes and the Agreed Final Threshold for Care of the children.

The following agency confirmed that they had no relevant engagement with the family:

- Sussex and Surrey Health Care Trust

The Independent Chair supplemented the IMR information with telephone conversations with friends. The family were regularly updated on progress of the review but chose not to participate. The Independent Chair and the DHR coordinator also attended the preliminary inquest hearings.

10.0 PANEL MEMBERSHIP

The Panel consisted of senior representatives from the following agencies:

- Surrey Police - DCI Debbie Crouch, Andy Pope, Statutory Reviews Lead
- Surrey Safeguarding Adults Board - Dena Kirkpatrick (Board Administrator) / Sarah McDermott (Board Manager)
- Surrey County Council Children's Social Care - Sam Bushby, Assistant Director SE Quadrant
- Surrey County Council Adult Social Care - Terri Cramer
- Surrey-wide designated GP for Safeguarding Children and Adults- Dr Tara Jones
- Surrey and Borders NHS Foundation Trust - Debra Cole SGA and DA Lead
- Designated Nurse Safeguarding Adults-Surrey Wide CCG-Helen Blunden
- East Surrey Domestic Abuse Service (ESDAS) - Miatta Marke Director of Services
- Housing Association - Sue Young -Tenancy Enforcement & Housing Choice Manager
- Borough Council - Sarah Crosbie, RBBC Community Partnership Team Leader
- East Surrey Community Safety Partnership - Amanda Bird, Tandridge District Council Community Safety Officer
- Independent DHR / SAR Chair - Liz Borthwick
- DHR / SAR Coordinator - Debbie Stitt

11.0 CONTACT WITH FAMILY AND FRIENDS

11.1 Although Mary's family were invited to be part of the review, there was very little contact from them. Despite this, the Chair kept the family updated on progress of the review.

11.2 Two of Mary's friend spoke with the Independent Chair which helped inform the report. Although the Independent Chair tried to obtain contact details for Gary, no up to date details could be sourced.

12.0 SUMMARY OF THE CASE

The DHR / SAR Panel received extensive information from agencies and the DHR / SAR panel utilised the SCIE model 'Learning Together'[3] to identify the Key Practice Episodes (KPEs)in the lives of Mary, Gary and the children.

- **KPE One: Mary's teenage years**

Mary had a difficult relationship with her parents in her teenage years. She also became known to the police due to being described as having "anger management issues. Mary had some mental health issues, was also involved with older men and was using cannabis and cocaine. It would appear that at the time there was no consideration by agencies about grooming of a child or child sexual exploitation.

- **KPE Two: Mary's young adult life and relationship with males (2008-2014)**

Mary met her first partner and became pregnant at 18 with Ashley. There were reports of domestic abuse with Mary being a victim and a perpetrator. Mary then met her second partner. They had a child Frankie and the relationship then ended soon after. Again, it was reported that Mary struggled with the ending of the relationship and caused damage to her ex-partner's house.

- **KPE Three: Mary and Gary's Relationship (including substance misuse, mental health and domestic abuse.**

Mary met Gary who was married at the time. Mary became pregnant by Gary with her third child. Mary and Gary were involved in substance misuse and drugs which appeared to be a dynamic in their relationship. Mary disclosed to a professional that she was experiencing domestic abuse. She was also involved with several incidents relating to Gary's wife. Children Social Care (CSC) became involved as there was concern about the welfare and safety of the children.

- **KPE Four: Child Protection concerns for Ashley, Frankie and Charlie 2014-2016**

The children were suffering neglect due to Mary's drug abuse and mental health issues. Several agencies became involved with Mary and the family, with the children becoming subjects of a Child Protection Plan on the grounds of neglect.

- **KPE Five: Mary Seeking Support 2016**

Mary referred herself to support from the drug and alcohol service Catalyst and was given brief interventions. She stated she wanted to be drug free.

- **KPE Six: Increasing violence and coercive controlling behaviour by Gary**

The relationship between Mary and Gary became very toxic with abuse by Gary and retaliatory abuse by Mary. CSC continued to be involved with the family, Mary was in financial difficulties (rent arrears) and taking drugs again. The police were required to attend many incidents between Mary and Gary during this period.

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[3] www.scie.org.uk/children/learningtogether/
Catalyst: https://www.catalystsupport.org.uk/drug-and-alcohol-services-surrey

- **KPE Seven: Further Child Protection Issues for Ashely, Frankie and Charlie. (July 2017)**

Following further domestic abuse issues between Mary and Gary, a DASH assessment was graded as High Risk (Red). Mary and the children were taken to a Refuge where she stayed only a few days as she felt cut off and alone. CSC became so concerned about the children that a Child Protection Enquiry Commenced.

- **KPE Eight: Gary -A high risk perpetrator. (August 2017)**

In August 2017, the police began the management of Gary as a high-risk perpetrator through its 4P programme. A Children and Family assessment was also completed by CSC which listed the concerns for the children as follows

- Impact of Domestic abuse
- Mary's inability to protect the children in her on/off relationship with Gary
- Mary's drug use and impact on caring for the children
- Neglect of the children e.g. dirty house, no bedding, poor attendance at school.

- **KPE Nine: Police Protection of the Children (September 2017)**

The police were so concerned for the children that, in consultation with CSC, the children were taken into police protection and placed with a foster family. Mary was distraught and again went to the drug and alcohol support service Catalyst, attended parenting support sessions and was trying to move away from the area.

CSC carried out many assessments and the decision was made that the children would not be returning to Mary.

- **KPE Ten: Death of Mary (Nov 2017)**

Late November 2017, the police forced entry into Mary's home and found that she had died in unexpected circumstances.

13.0 KEY ISSUES ARISING FROM THE REVIEW

The review identified several possible instances which may have contributed to Mary's unexpected death

13.1 Better support for parents involved in care proceedings*:* Mary's needs were not considered when the children were taken into police protection despite being identified as being vulnerable, e.g. mental health issues, suffering from domestic abuse and substance misuse. (*KPE 9*)

13.2 Professional curiosity and understanding the need to know the victim better: If agencies had researched historical incidents in Mary's life including domestic abuse, mental health and substance misuse then a pattern could have been established which would have given agencies a better understanding of Mary's needs. This includes the need for professionals to have a trauma base approach when dealing with victims who are suffering from domestic abuse and the impact it has on their life. (*KPE 1 and 2*)

13.3 Access to services and lack of engagement: Many agencies identified that it was difficult to engage with Mary. Professionals need to understand that when an individual is suffering domestic abuse, mental health issues and substance abuse, they need to review how to improve engagement with an individual. (*KPE* 3,4 and 5)

13.4 Information sharing: Information sharing was confused between professionals and there was a lack of communication with health (MARAC) which could have helped better understand Mary's needs. (*KPE 8 and 9*)

13.5 Lack of understanding by professionals of coercive controlling behaviour: Despite coercive controlling behaviour being embedded in domestic abuse legislation, it appears it is the least understood aspect of domestic abuse and safeguarding. (*KPE 6,7 and 8)*

13.6 Domestic Abuse as both Victim and Perpetrator: It is important that professionals understand the complex behaviours of a victim and a perpetrator including retaliatory behaviour. (KPE 5, 6, 7and 8)

13.7 Impact of Children living with domestic abuse- Mary's eldest child was often caring for siblings and all the children saw the abuse which sometimes reflected in their behaviour. (KPE 4.7 and 9)

14.0 CONCLUSION

14.1 Mary's death was unexpected. She said to professionals that although she had felt suicidal at times, she would not do anything as her children were her protective factor. Mary was devastated when Frankie and Charlie were taken into care, especially as she was seeking help for substance abuse and attending the Children's Centre and was "doing what professionals asked".

14.2 The review has highlighted the tragic cost of domestic abuse including coercive control, mental health issues and substance abuse. The numerous agencies involved with Mary did not always consider the 'bigger picture' of all the issues she was experiencing. If this had been recognised, it may have led to more comprehensive and appropriate support for Mary, especially during the time when the children were taken into care. As a result, Surrey Police have recommended that an experienced investigator reviews the historical as well as current Police involvement with the individuals, to inform risk management

14.3 Health agencies were not given information about Mary and what she was experiencing in 2017. Sharing information from the MARAC with the GP and mental health services could have enabled a better picture of Mary's support needs during the period when Mary was very vulnerable.

14.4 Although Mary was seen as a victim by some agencies, there is evidence to indicate that professionals were judgemental about Mary, Gary and what was perceived as "their lifestyle choices", which indicated "professional bias". Professionals used the words "did not engage" "missed appointments" and did not explore the reasons behind this lack of engagement. Sometimes professionals do need to have challenging conversions with victims, but this needs to be carried out in a compassionate and supportive way.

14.5 The breakdown of an abusive relationship is a key indicator of increased risk of serious harm. Although some professionals are more aware of such risks, this review also highlights the risks relating to separation of a mother from her children. Feedback from

friends highlights that Mary loved her children and wanted them back. There is evidence to indicate that Gary used the separation from himself and the children to control and coerce Mary. During the time that care proceedings were taking place, professionals focused on the children and the domestic abuse that Mary was experiencing. The high risk of separating Mary from her children was not identified and the support she needed during this period was not considered.

14.6 When Mary was referred to ASC as an adult safeguarding concern, a decision should have been made as to whether the criteria in s42 Care Act 2914 had been met. By not identifying that Mary met the criteria (and should therefore have been subject of a safeguarding enquiry), support could have been made available for Mary. This may have helped her through the period of increased domestic abuse and separation from her children.

14.7 It is imperative that agencies work together to ensure that they understand fully the issues a person in experiencing and to understand what has happened in the past. This will enable professionals to "know the victim" better in order to provide the essential support that they may need.

15.0 RECOMMENDATIONS

The CSP submits a quarterly monitoring report to the Surrey DHR Oversight Group. The report is compiled from updates from each of the agencies with responsibility for recommendations, who are required to provide evidence of progress. Progress is also discussed at the quarterly CSP meetings.

15.1 TRAINING - LOCAL

Recommendation One
Professionals must understand the increased risks when children are removed, especially when a parent is experiencing domestic abuse, has other risks and has increased vulnerability. Support for the parent should be provided both before the children are removed and afterwards. Individual agencies such as Police, ASC & CSC to ensure their staff are trained understand and support the parent including the management of risk. This will be scrutinised by. the SSAB and SSCP, giving assurance to the SAB/ SCP that the agencies have implemented this training
Ownership: individual agencies such as Police, ASC & CSC

Recommendation Two
The Surrey Children Services Academy, SSCP and SSAB will develop a training programme and guidance information on Professional Curiosity which will be available to all agencies including the charity, community and faith sectors. Agencies to review improved understanding and use of professional curiosity in reflective supervision with practitioners.
Ownership -Surrey Children Services Academy, SSCP and SSAB

Recommendation Three
The Children Service Academy, SSCP and SSAB to ensure that staff working with vulnerable adults, children and families have an in depth understanding through DA training of coercive controlling behaviour, including the trauma impact of CCB, the increased risks of stalking, grooming of family members and professionals, retaliatory violence / resistance and an understanding of the links between substance abuse, mental health issues and domestic abuse.
Professionals working in adult social care must have the tools to understand the needs of a victim suffering from domestic abuse, substance abuse and mental health issues.
Ownership: Surrey Children Services Academy, ASC, SSCP and SSAB

Recommendation Four
DASH training to be available to all agencies when assessing risk.
Ownership: Police, ASC and Surrey Children Academy

Recommendation Five
ASC professionals to be reminded through Safeguarding Training and supervision about the importance of timeliness in decision making on receipt of a safeguarding enquiry referral.
Ownership: ASC.

Recommendation Six
Learning from this DHR to be disseminated via a workshop organised by RRBC/SSAB and the Independent Chair.
Ownership: RBBC and SSAB

15.2 INFORMATION SHARING / REFERRAL PROCESS

Recommendation Seven
The MARAC process to be reviewed to ensure that information regarding relevant risks for a service user is passed safely and promptly to any involved service including Primary Care e.g. GPs. This was also a recommendation in the Coroner's Inquest Report October 2020.
Ownership: Surrey Domestic Abuse Management Board (DAMB)

15.3 ASSESSMENT REFERRAL PROCESS

Recommendation Eight
SSAB and SSCP to produce Safeguarding Referral Guidance (adult and children) for organisations whose sole purpose is not safeguarding e.g. housing associations, drug and alcohol services, and to raise awareness of its availability.
Ownership: ASC MASH and Children C-SPA.

15.4 TRAINING-NATIONAL

Recommendation Nine
R&B CSP to highlight the need for the Home Office to consider whether the Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews 2016 should be updated to include specific guidance where a person may have taken their own life**.**
Ownership: R&B CSP

Recommendation Ten
R&B CSP to request that the Home Office promotes the Domestic Abuse Housing Association Accreditation principles as best practice for housing associations[4].
Ownership; R&B CSP

15.5 AGENCY-SPECIFIC RECOMMENDATIONS

15.5.1 POLICE RECOMMENDATIONS (original numbering from police report)

Recommendation 2: It is recommended that all police officers and police staff involved in the response to / investigation of incidents of domestic abuse are reminded that it is vitally important accounts are obtained from the children involved/witnessing incidents with the appropriate expert advice and assistance.

Recommendation 3: It is recommended that once incidents of DA have been referred to the Safeguarding Investigation Unit, an experienced investigator reviews the historical as well as current Police involvement with the individuals. This will help inform investigative and risk management strategies.

Recommendation 4: It is recommended that where possible, incidents that are linked (same individuals, same domestic situation) are allocated to one investigating OIC. This will ensure single oversight of all reported incidents and help inform risk management strategies.

[4] www.daalliance.or.uk

APPENDIX ONE

REIGATE & BANSTEAD DOMESTIC HOMICIDE REVIEW and SAFEGUARDING ADULT REVIEW
Updated February 2020 *(vrs 6)* – Mary

TERMS OF REFERENCE

1. This is a joint Domestic Homicide Review (DHR) and a Safeguarding Adult Review (SAR)

2. *The Domestic Homicide Review (DHR)* is being conducted in accordance with Section 9(3) of the Domestic Violence Crime and Victims Act 2004.

3. *The Safeguarding Adult Review (SAR)* is being conducted in accordance with the Care Act 2014 which states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adult Review (SAR) when an adult in its area dies as a result of abuse or neglect (whether known or suspected) and there is concern that partner agencies could have worked together more effectively to protect the adult.

4. This legislation places a statutory responsibility on organisations to securely share confidential information, which will remain confidential until the panel agrees the level of detail required in the final report for publication.

5. *Parallel investigations*: The following were investigated separately to this Review:
i) Children's Services; complaint from father
ii) Police; criminal trial for breach of Non-Molestation Order and driving offence
iii) IOPC; in response to officer conduct
iv) JL's father complaint to the IOPC about Police conduct.

6. The DHR will strictly follow the East Surrey Community Safety Partnership (ES CSP) DHR protocol, which is based on Home Office guidance[5]

7. *The statutory purpose of the DHR is to*:

a) Establish what lessons can learned from Mary's unexpected death regarding how the local professionals and organisations worked individually and together to safeguard the victims of domestic abuse.

b) Identify clearly what those lessons are, both within and between agencies, how they will be acted on, and what will change as a result through a detailed Action Plan.

c) Apply these lessons to service responses including changes to policies and procedures as appropriate

[5] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

d) Prevent domestic homicides where possible in future through improved intra and inter-agency responses for all domestic abuse victims and their children.

8. The statutory purpose of the SAR is to:

a) To direct the Safeguarding Adults Board (SAB) to review the circumstances where an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
b) Identify and promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. This will include useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.
c) Explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

9. The agreed timeframe for information to be secured and reviewed is **date of birth of the first child** unless there have been significant events prior to this. *Significant events will include engagement due to mental health and other noteworthy medical issues, domestic abuse, other wellbeing issues etc.*

10. The DHR / SAR will not seek to apportion blame to individuals or agencies from the information it receives. However, it is recognised that other parallel procedures (e.g. SAR, IPCC referral, internal agency disciplinaries) may use information from the DHR process to support their investigations.

11. In addition, the following areas will be addressed in the Individual Management Reviews (IMRs) and through wider enquiries:

a) Awareness of the potential presence of coercive control and how this impacts on the behaviour of the victim and perpetrator.

b) Consideration of any equality and diversity issues that appear pertinent to the victim or perpetrator[6]

c) To consider whether opportunities were missed for professionals to routinely enquire about domestic abuse, coercive, controlling and stalking behaviour which should have led to a referral to a domestic abuse support service.

d) To review whether there was adequate 'professional curiosity' during engagement with Mary

d) Whether there were any barriers experienced by Mary or her family / friends / colleagues in seeking support from professional service providers.

[6] e.g. age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

e) Agencies that had no contact will investigate whether helpful support could have been provided and if so, why this was not accessed.

f) Whether there were opportunities for agency intervention or support regarding any known perpetrators of domestic abuse / coercive control which were missed.

e) Identification of any training or awareness-raising requirements required to ensure a greater knowledge and understanding of the impact of domestic abuse and availability of support services.

f) Whether professionals were aware of 'confirmation bias' when reviewing an individual's background?

h) What parental support was provided when the children were taken into care?

i) Whether Mary's welfare was promoted and protected through timely and effective assessment including risk assessment and response to the needs identified (this includes application of thresholds, information sharing, use of assessment tools and timely intervention).

12. The Panel will critically evaluate and approve the Overview Report, Executive Summary and Action Plan produced by the Independent Chair at the end of investigation prior to it being passed to the Chair of ES CSP.

13. These Terms of Reference may be varied by the DHR / SAR Panel as new information emerges.

APPENDIX TWO

GLOSSARY OF ABBREVIATIONS AND TERMS USED IN THIS REPORT

ABBVTN	FULL NAME
AAFDA	Advocacy after Fatal Domestic Abuse
ASC	Surrey Adult Social Care
CAADA	Co-ordinated action against domestic abuse. Risk assessment tool
C&F	Child and Family
CFHS	Children & Family Health, Surrey
CCB	Coercive Controlling Behaviour
CCG	Clinical Commissioning Group
CFH	Child & Family Health
CSC	Children's Social Care Surrey
CSH	Central Surrey Health
DAMB	Surrey Domestic Abuse Management Board
DASH	Domestic Abuse Stalking and Honour-based Violence Safeguarding Risk assessment
ESCSP	East Surrey Community Safety Partnership (CSP) - now reverted to the standalone Reigate and Banstead CSP
IMR	Individual Management Review
IO	Police Investigating Officer
IOPC	Independent Office for Police Conduct
FSP	Family Support programme
MARAC	Multi-Agency Risk Assessment Conference
MARF	Multi-Agency Referral Form
MASH	Multi Agency Safeguarding Hub (now C-SPA)
OIC	Officer in Charge
PACE Interview	Interview carried out under caution under the Police and Criminal Evidence Act
Police	Surrey Police
RBBC	Reigate & Banstead Borough Council
SSAB	Surrey Safeguarding Adults Board
SDAC	Surrey Drug & Alcohol Care
SECAMB	South East Coast Ambulance Service
SIU	Surrey Police Safeguarding Investigation Unit
SSCP	Surrey Safeguarding Children Partnership