



DOMESTIC ABUSE RELATED DEATH REVIEW

Into the death of Grace

In July 2024

OVERVIEW REPORT

Independent Chair and Author
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Report Completed: 30 July 2025

Personal statement written by Emma - Grace's aunt

Grace's childhood was filled with challenges, growing up without her father and later facing increasing criticism from her mother, who had married and started a new family. As she entered her teenage years, this strained relationship deeply affected her sense of self-worth. Feeling isolated from her mother and stepfather, she was pushed out of her home at just 16, left vulnerable and searching for stability during an already turbulent time in her life.

Despite these struggles, Grace found love and became a devoted mother to two beautiful children. However, when her marriage broke down and became destructive, this compounded the pain of rejection from both her parents and her husband which took a profound toll on her health.

Struggling to cope, Grace experienced weight loss and turned to alcohol as a way to numb the overwhelming pain. While she sought help for these issues, a breach of trust occurred when her counselling notes were mistakenly sent to her ex-husband. This devastating error compounded her sense of betrayal, making an already fragile situation worse. Negative judgements from some hospital staff about her drinking condition and being told she wasn't "ill enough" for rehabilitation left Grace feeling unsupported and unheard. Overwhelmed by mental and physical pain, Grace ultimately lost her battle with life.

Throughout her journey, Grace remained a kind and radiant soul, leaving a lasting impact on everyone she met. With a deep passion for music and photography, she was cherished by her friends and family. She wore her heart on her sleeve, bringing warmth and light into every room she entered. Above all, Grace's greatest love was her children and becoming a mother brought her a sense of wholeness, and their love helped mend the absence of parental affection in her own life. Her passing at just 30 years old has left an immeasurable void in the hearts of her children, partner, family, and friends.

We hope that Grace's story serves as a catalyst for change, encouraging better communication and collaboration among support services to protect and uplift those grappling with mental health challenges. It is our deepest wish that other families will be spared the heartbreaking loss of a loved one taken far too soon.

Tribute written by David - Grace's partner

So, Grace, where do I begin. Well, I start with this, what an amazing ray of sunshine you were and what a huge joy you brought to my life along with many others. Not only were you my partner, but you were also a sister, a niece, a granddaughter, a friend and a mother all of which you were amazing at. I met you over ten years ago and I knew then you were special. We did our thing, and it took its time, but I think that made it so much more special. You were the most beautiful human being I've ever met, so loving, caring, sensitive, just you really. Your smile, your laugh just infectious.

I remember when we first started dating you would always say to me you did not want this life for me. At first, I never understood what you meant and just brushed it

away, but as we became closer and you opened up, I realised what you meant. The pain and the suffering you were in was something you did not just want me to experience but others close to you as well. You tried to protect everybody else from your suffering and this just shows the strength you held.

You experienced the most horrible pain throughout your life, things that nobody should ever experience, but throughout all this you still pushed through, still lived life to the full and still raised two amazing little human beings. These two children became your life and what a mother you were to them. You showed them what life is and taught them. You instilled yourself into them and that will guide them for the rest of their lives. I have never seen such amazing parenting, you just had this thing, this knack, this unbelievable connection with them both. You were that loving, special parent that any child could wish for, but also could teach and guide them both so easily.

To try and put into words what you mean is near impossible, you taught me to love and showed me what it was. You were this girl that came into my life and changed it forever. I miss everything about you Grace, the hour-long conversations in the middle of the night, when you couldn't sleep, the silly videos you would send me, your voice, your laugh, I could go on forever. You have left a huge hole in me along with so many others and I can honestly say that will never be filled.

I will hold you close to my heart forever; I was and am blessed to have been able to share part of my life with you and that will never leave me. I shall carry you with me wherever I go, and I promise I shall never stop loving you.

CONTENTS

Section		Page
	Preface	5
1	Introduction	6
2	Timescales	7
3	Confidentiality	8
4	Terms of Reference	8
5	Methodology	11
6	Involvement of Family	11
7	Contributors to the Review	12
8	Review Panel	13
9	Chair and Author of the Review	14
10	Parallel Reviews	14
11	Equality and Diversity	14
12	Dissemination	16
13	Background Information	16
14	Chronology	17
15	Overview	22
16	Analysis	48
17	Key Issues and Conclusions	60
18	Lessons Learned	62
19	Recommendations	64

PREFACE

The Domestic Abuse Related Death Review (DARDR) Panel and members of the Safer Guildford Partnership wish to express their sincere condolences to Grace's¹ family, David², and all those who have been affected by Grace's untimely death.

While nothing can ease the profound loss felt by the family, it is hoped that the findings of this Review will support their wish for meaningful learning - learning that may help prevent similar traumatic experiences for other families.

The Independent Chair and Author of the Review would also like to express her appreciation for the time, commitment, and valuable contributions of David, Emma³, Lisa⁴, the Review panel members, and the authors of the Individual Management Reviews (IMRs), which form the foundation of this Overview Report.

Additionally, the Review Panel Members would like to thank Emma for sharing a cherished photograph of Grace and her children. This heartfelt contribution was displayed at Panel meetings as a poignant reminder of Grace's life and the vital importance of our collective efforts to prevent future tragedies.

The key purpose for undertaking a DARDR, is to enable lessons to be learnt where there may be links with domestic abuse. In order for these lessons to be learnt as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each death, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

In accordance with Section 9(1) of the Domestic Violence, Crime and Victims Act 2004, Grace's death met the criteria for a statutory review. Whilst this report is presented as a DARDR, the Review has been undertaken in line with the current Domestic Homicide Review (DHR) statutory guidance⁵, pending publication of national guidance for DARDRs.

The Act states that there should be a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

- (a) a person to whom he/she was related or with whom he/she was or had been in an intimate personal relationship,
- (b) a member of the same household as himself/herself; held with a view to identifying the lessons to be learned from the death or
- (c) where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour

¹ Pseudonym for the deceased.

² Pseudonym for Grace's partner.

³ Pseudonym for Grace's aunt.

⁴ Pseudonym for Grace's friend.

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

in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted.

The Home Office defines domestic violence as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial and emotional.

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

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

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

1. INTRODUCTION

1.1. This DARDR report examines the responses of agencies and the support provided to Grace, a resident in an area in Guildford, prior to her death in July 2024.

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

1.3. The circumstances that led to a Review being undertaken in this case:

1.3.1. Grace, who had a history of vulnerabilities through poor physical and mental health and alcohol misuse, had been a victim of domestic abuse over a number of years. She was found deceased at her home in July 2024. (See Section 13.5. for further details).

1.4. The Review has considered all known contact/involvement agencies had with Grace and Daniel⁶ during the period between March 2022 and Grace's death in July 2024, as well as contacts prior to that period which could be relevant to neglect, domestic abuse, violence, substance abuse or mental health issues. This timeframe was agreed by all panel members to be appropriate, as it encompasses the period when Grace separated from Daniel and self-referred to a domestic abuse service.

⁶ Grace's ex-husband.

1.5. The Review is conducted in compliance with legislation and followed statutory guidance. It was carried out in an open and constructive manner, engaging both voluntary and statutory agencies that had contact with Grace, Daniel, Ashley⁷, and Charlie⁸. This approach enabled the Review panel to meaningfully examine the circumstances surrounding Grace's death and candidly address the issues raised. Any actions taken to enhance services as a result of this Review will serve as part of Grace's legacy.

1.6. DARDRs are not disciplinary proceedings, nor are they inquiries into how a person died or who is culpable; those are matters for coroners and criminal courts, respectively.

2. TIMESCALES

2.1. On 24 September 2024, Surrey Police submitted a referral for a DARDR to be considered. A scoping meeting was held by the Safer Guildford Partnership on 25 October 2024, during which the Panel was unable to reach a unanimous decision on whether the case met the criteria for commissioning a DARDR. Subsequently, on 03 December 2024, the Chair and members of the Safer Guildford Partnership agreed to proceed with the Review. The Home Office was formally notified of this decision on 04 December 2024. The coroner was informed of the commissioning of the DARDR by the Partnership on 24 February 2025.

2.2. The Independent Chair was appointed on 20 January 2025, and a pre-meeting of the DARDR was held on 17 February 2025, to agree on the process, timescales, and Terms of Reference. On the same day, the Review Chair provided the Home Office with an update on the timescales, noting that the six-month statutory timeframe for completing the Review would not be met, due to reasons already noted in paragraph 2.1. An extension was subsequently approved to enable the thorough completion of the Review process.

2.3. The first panel meeting was held at the earliest opportunity on 12 March 2025. During this meeting, panel members were instructed to secure any records relating to contact with Grace, Daniel, Ashley or Charlie, and to appoint an Individual Management Review (IMR) author.

2.4. Following the initial pre-meeting on 17 February 2025, the Review panel met formally four times via Microsoft Teams: 12 March 2025, 04 June 2025, 09 July 2025 and on 30 July 2025.

2.5. David and Emma attended the final panel meeting on 30 July 2025, which enabled them to ask any questions of the Panel. Lisa was unfortunately unable to attend.

2.6. The Review was concluded on 30 July 2025.

⁷ Grace's older child.

⁸ Grace's younger child.

3. CONFIDENTIALITY

3.1. In accordance with statutory guidance, the Review has been conducted in a respectful, confidential manner by panel members and IMR authors. The findings of this Review are restricted to only participating officers, professionals and their line managers, David, Emma and Lisa until after this report has been approved for publication by the Home Office Quality Assurance Panel.

3.2. As outlined in the guidance, the following pseudonyms have been used throughout this report to protect the identities of the deceased, her family, partner, friend and former partner:

- ◆ Grace (the deceased) and David (her partner) - chosen by David.
- ◆ Emma (Grace's aunt) - chosen by Emma.
- ◆ Ashley and Charlie (Grace's two children) - chosen by Emma.
- ◆ Lisa (Grace's friend) - chosen by herself.
- ◆ Daniel (Grace's ex-husband) and Kevin (Grace's ex-partner) - selected by the Review Chair and agreed by the Panel.

3.3. Grace, who was a mixed race British national, was 30 years old at the time of her death. Daniel, who is a white British national, was also 30 at that time. Their children, Ashley and Charlie, were 9 and 6 years old, respectively, and were also of mixed race. Their dates of birth, along with the exact date of Grace's death, have been redacted from this report to protect their identities and to respect the privacy of Grace's family.

4. TERMS OF REFERENCE

4.1. This 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 statutory guidance.

4.2. Statutory Guidance Section 2(7) states the purpose of the Review is to:

- a) Establish what lessons can be learned from the death regarding the way in which local professionals and organisations work individually and together to safeguard victims;
- b) Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
- c) Apply those lessons to service responses including changes to policies and procedures as appropriate;
- d) Prevent domestic abuse, domestic homicides and suicides, and improve service responses for all domestic abuse victims and their children by developing a coordinated, multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

- e) Contribute to a better understanding of the nature of domestic violence and abuse;
- f) Highlight good practice.

4.3. Agencies that had contact with Grace, Daniel, Ashley and Charlie should:

- ◆ Secure all relevant documentation relating to those contacts.
- ◆ Produce detailed chronologies of all referrals and contacts.
- ◆ Commission an Individual Management Review (IMR) in accordance with the respective Statutory Guidance Reviews.⁹

4.4. Summarise concisely the relevant chronology of events including:

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

4.5. The Review panel will consider:

- ◆ Each agency's involvement with the following from March 2022 until July 2024, as well as all contact prior to that period which may be relevant to safeguarding, domestic abuse, violence, controlling behaviour, self-harm, mental health issues or substance abuse. This timeframe was selected, as it encompasses the period when Grace separated from Daniel and self-referred to a domestic abuse service.
- ◆ Grace who was 30 years of age at date of her death.
- ◆ Daniel was 30 years of age at date of Grace's death.
- ◆ Ashley was aged 9 at the time of Grace's death.
- ◆ Charlie was aged 6 at the time of Grace's death.
- ◆ Whether the agencies or inter-agency responses were appropriate leading up to and at the time of Grace's death.
- ◆ Whether there was any history of mental health problems, self-harm or substance misuse, and if so whether they were known to any agency or multi-agency forum.
- ◆ Whether there were any other known safeguarding issues relating to Grace.
- ◆ Whether there was any history of abusive behaviour towards Grace and whether this was known to any agencies.

⁹ The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7).

- ◆ Whether staff who had contact with Grace, Daniel, Ashley and Charlie had sufficient training and knowledge of indicators of domestic abuse, for a victim, child and for a potential perpetrator of abuse; the application and use of the DASH¹⁰ risk assessment tool; safety planning; referral pathway to Multi-Agency Risk Assessment Conference (MARAC)¹¹, and to appropriate specialist domestic abuse services.
- ◆ Whether there are any lessons to be learned from the case about the way in which professionals and agencies worked individually or together to safeguard Grace.
- ◆ Whether agencies have appropriate commissioned services, policy and procedures to respond to needs of an adult with care and support needs, and to recommend and change as a result of the Review process.
- ◆ Whether organisations were subject to organisational change and if so, did it have any impact over the period covered by the DARDR. Had it been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively (including the COVID pandemic).
- ◆ Whether practices by agencies were sensitive to the ethnic, cultural, religious, identity, gender and ages of the respective individuals, and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.
- ◆ Whether family or friends want to participate in the Review. If so, ascertain whether they were aware of any safeguarding concerns or abusive behaviour to Grace prior to her death.
- ◆ Whether in relation to the family members, were there any barriers experienced in reporting the vulnerabilities, care or support needs of Grace or the abuse she was subjected to.
- ◆ The Review must be satisfied that all relevant lessons have been identified within and between agencies and will set out action plans to apply those lessons to service responses, including changes to inform national and local policies and procedures as appropriate.
- ◆ The Review will consider any other information that is found to be relevant, and which may contribute to a better understanding of the nature of domestic abuse and adult safeguarding.

¹⁰ Domestic Abuse Stalking & Harassment (DASH): an evidence-based list of 24 or 27 questions used to assess the level of risk a victim faces – standard, medium or high. High risk indicates referral to MARAC is needed. The threshold for MARAC referral is 14 or above positive answers to the DASH questions.

¹¹ MARAC a multi-agency meeting to share information to safety plan and allocate actions with the aim of increasing the safety of high-risk victims of domestic abuse.

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

5. METHODOLOGY

5.1. An initial scoping meeting established that eleven agencies/organisations had contact with one or more of the subjects of this DARDR. Chronologies and IMRs were produced, enabling each agency to reflect on its involvement, identify areas for improvement and make relevant recommendations to enhance service delivery for individuals in circumstances similar to Grace's.

5.2. The Review panel considered information and evidence gathered from a range of sources, including the IMRs and associated reports, discussions during Panel meetings, conversations with Emma, David and Lisa as well as findings from the post-mortem and toxicology reports.

5.3. A structured methodology was applied to ensure all relevant factors were considered, with particular focus on the timeliness, effectiveness, and coordination of interventions prior to Grace's death. The Review sought to identify any systemic or procedural issues, including failures in communication or coordination between agencies. The findings are intended to inform future practice, policy, and service delivery across the relevant agencies.

6. INVOLVEMENT OF FAMILY AND FRIENDS

6.1. Grace's family and her partner, David were formally notified of the Review's commencement by letter in March 2025 and invited to participate. They were provided with a copy of the draft Terms of Reference and were given the opportunity to provide feedback. In addition, they received the relevant Home Office leaflet and information about Advocacy After Fatal Domestic Abuse (AAFDA).

6.2. During the initial telephone conversations, the Review Chair explained the purpose of the Review and the reasons for its initiation. Grace's mother initially expressed an interest in participating but requested a short delay. However, subsequent attempts to contact her were unsuccessful.

6.3. During a conversation with David, he provided the Chair with contact details for one of Grace's friends. Discussions were also held with David and Emma regarding whether contact should be made with Grace's grandmother. It was ultimately decided not to proceed, given that Grace's grandfather was seriously unwell and undergoing chemotherapy, and her grandmother was already under significant emotional strain.

6.4. David, Emma and Lisa agreed to take part in the Review and were provided with regular updates throughout. Their chosen method of communication was by telephone and email.

6.5. An invitation was extended to David, Emma and Lisa to attend the final Panel meeting on 30 July 2025. David and Emma accepted the invitation, however,

Lisa was ultimately unable to attend. The Chair also invited them to submit any questions they wished to raise with the Panel, ahead of the final meeting.

6.6. The Review Panel deliberated on whether to contact Daniel as part of this Review. A full risk assessment was undertaken based on information available at the time, and the Panel concluded that no contact should be made with Daniel. This was later affirmed as appropriate by David and Emma.

7. CONTRIBUTORS TO THE REVIEW

7.1. Whilst there is a statutory duty on bodies including the police, local authority, probation trusts and health bodies to engage in a DARDR, other organisations can voluntarily participate. In this case, twenty agencies/organisations were contacted by the Review, thirteen of which contributed as follows:

Agency / Organisation	Contribution
Frimley Health NHS Foundation Trust (FHFT)	IMR and Chronology
Named School (1)	Report
Named School (2)	Report
Royal Surrey NHS Foundation Trust (RSFT)	Report
School of Nursing and Public Health, Manchester Metropolitan University	Expertise on substance use in the context of Domestic Abuse
South West Surrey Domestic Abuse Service (SWSDAS)	IMR, Chronology and Expertise on Domestic Abuse
Surrey and Borders Partnership NHS Foundation Trust (SaBP)	IMR and Chronology
Surrey Central Health, Children and Family Health	IMR and Chronology
Surrey County Council Adult Social Care	IMR and Chronology
Surrey County Council Public Health	Expertise on suicide and prevention
Surrey County Council Children's Services	IMR and Chronology
Surrey Heartlands Integrated Care Board (ICB) on behalf of GPs	IMR and Chronology
Surrey Police	IMR and Chronology

7.2. David, Emma, and Lisa also contributed to the Review by providing relevant information, which has been included in the report.

7.3. All IMR authors have confirmed their independence, having no direct or indirect contact with any of the parties involved in this Review.

7.4. The following agencies/organisations were contacted and reported having no contact with either Grace, Daniel or their children:

- ◆ East Surrey Domestic Abuse Service
- ◆ East Surrey Hospital
- ◆ Epsom and St Helier University Hospitals NHS Trust

- ◆ First Community Health Care
- ◆ North Surrey Domestic Abuse Service
- ◆ Probation Services
- ◆ Your Sanctuary

8. REVIEW PANEL

8.1. The Review Panel consists of senior officers from statutory and non-statutory agencies, who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons.

Membership of the Panel:

Agency / Organisation	Job Title
Surrey County Council	Domestic Abuse Related Death Review (DARDR) Coordinator
Guildford Borough Council	Family Support Team Leader
Central Surrey Health	Safeguarding Advisor
Frimley Health NHS Foundation Trust (FHFT)	Adult Safeguarding Named Nurse
School of Nursing and Public Health, Manchester Metropolitan University	Senior Lecturer
South West Surrey Domestic Abuse Service	Chief Executive Officer
Surrey and Borders Partnership NHS Foundation Trust	Safeguarding Adults and Domestic Abuse Lead
Surrey County Council Adults Social Care	Senior Manager Locality
Surrey County Council Children's Social Care	Assistant Director
Surrey County Council Public Health	Public Health Lead
Surrey Heartlands Integrated Care Board (ICB)	Designated Safeguarding Nurse Adults
Surrey Police	Statutory Reviews Lead

8.2. All Panel members were independent and had no direct involvement with, or supervisory responsibility for the services involved in this case.

9. CHAIR AND AUTHOR OF THE REVIEW

9.1. The Independent Chair and Author of this DARDR is a Home Office accredited Chair of Statutory Reviews. She is entirely independent of the Safer Guildford Partnership and all agencies involved, with no prior contact with Grace, Daniel, Ashley or Charlie.

9.2. She holds degrees in Business Management, Labour Law, and Mental Health and Wellbeing and has held directorial roles in organisations. She has extensive

experience delivering training on Domestic Abuse, Coercive Control, Honour-Based Abuse, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement, and holds diplomas in Criminology, Cognitive Behavioural Therapy (CBT) and Emotional Freedom Techniques (EFT).

9.3. Her specialist training includes the five module Homicide Timeline Training developed by Professor Jane Monckton-Smith, a two-day course on Strangulation and Suffocation in England and Wales (June 2022), and several courses through the Institute for Addressing Strangulation (IFAS).

9.4. Having lost her daughter to a domestic abuse related suicide in 2017, she draws on this lived experience, alongside her professional expertise and training to conduct a thorough and sensitive Review, while maintaining full independence from all individuals and agencies involved.

10. PARALLEL REVIEWS

10.1. Grace's inquest was held in January 2025, and information from the post-mortem/toxicology has been used to inform the Review.

10.2. Surrey and Borders Partnership NHS Foundation Trust (SaBP) was conducting a Patient Safety Review concurrently with this DARDR. Their review has now been concluded, and a copy of the report was provided to David on 15 July 2025.

11. EQUALITY AND DIVERSITY

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

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

11.3. Sex - Evidence has shown that domestic abuse is a gendered crime and there is evidence to support the theory that men commit more acts of domestic abuse than women. Statistically, women are more likely to be victims of domestic abuse. In the year ending March 2024, an estimated 1.6 million women and 712,000 men aged 16 years and over experienced domestic abuse, a prevalence rate of approximately 6.6% of women and 3.0% of men¹².

¹²<https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/domesticabusevictimscharacteristicsenglandandwales/yearendingmarch2024#main-points>

11.3.1. Women who experience domestic abuse are three times more likely to have made a suicide attempt in the past year compared to those who have not experienced abuse¹³.

11.4. Mental Health and Disability - Grace experienced complex and enduring health challenges, including a diagnosis of Atypical Anorexia Nervosa¹⁴, anxiety and depression. Although alcohol addiction is not formally recognised as a disability under the Equality Act 2010, Grace experienced long-term issues with alcohol misuse. She attributed many of her health difficulties to the abuse she experienced in her relationship with Daniel. These conditions significantly impacted her ability to maintain consistent attendance at work, particularly during 2022, and contributed to her overall vulnerability.

11.4.1. Grace also disclosed to David that she had experienced adversity throughout her life. She described feeling neglected by her mother and reported being diagnosed with ADHD at a young age, although there was no formal diagnosis on record. These early mental health difficulties were linked to a lack of emotional support in childhood, compounding her vulnerability in adulthood.

11.5. Marriage and Domestic Abuse - Grace described her marriage as being marked by physical and emotional abuse, which she associated with her later struggles with eating disorders and alcohol misuse.

11.6. Race - Grace was of mixed race. There was no evidence that her ethnicity negatively affected the services provided to her by professionals. However, Grace disclosed experiencing longstanding hostility from her former mother-in-law, which she believed was racially motivated. While this was not explicitly addressed by agencies, it may have contributed to her sense of isolation and emotional distress. This highlights the importance of professionals being sensitive to how race and cultural identity can intersect with experiences of domestic abuse, particularly within extended family dynamics.

11.7. As Daniel was not contacted to participate in the Review, the Panel were unable to access his medical history, which limited the ability to fully explore whether any protected characteristics may have been relevant, particularly in relation to mental health or disability. This further restricted the Review's ability to assess whether factors such as mental health or neurodivergence may have contributed to his behaviour toward Grace.

12. DISSEMINATION

12.1. Until this report has been approved for publication by the Home Office Quality Assurance Panel, dissemination of the findings of this DARDR has been restricted to participating professionals, their line managers, Emma, David and Lisa.

12.2. Each of the panel members, the Chair and members of the Safer Guildford

¹³ [Agenda Alliance \(2023\)](#) 'Under-examined and Under-reported: Suicidality and Intimate Partner Violence'.

¹⁴ A diagnosis used primarily in the context of eating disorders.

Partnership have received copies of this report. A copy has also been sent to the Surrey Police and Crime Commissioner, the Surrey Coroner and the Domestic Abuse Commissioner for England and Wales.

12.3. Emma, David and Lisa have been given electronic copies of this report and the Executive Summary to enable them to have the opportunity to read the reports at length and in private.

13. BACKGROUND INFORMATION (THE FACTS)¹⁵

13.1. Grace was born and raised in an area in Woking. She entered into a relationship with Daniel when she was sixteen years of age and were together for eleven years. Two children, Ashley and Charlie were born from the relationship.

13.2. During their relationship, Daniel perpetrated domestic abuse as well as coercive and controlling behaviour toward Grace. As a result, they separated in 2022, and their divorce was finalised in 2023.

13.3. Grace suffered from a range of mental health issues, including anorexia and alcohol addiction. Grace attributed many of these difficulties to the trauma she experienced during her marriage to Daniel, a view that was reflected in disclosures made to professionals, family members and David.

13.4. Grace lived on her own in an area in Guildford and died at her home address. At the time of her death, she was in a loving and supportive relationship with David for 14 months. Although they lived at separate addresses, they spent much of their time together at each other's homes.

Incident Summary

13.5. On an evening in July 2024, at around 7pm, David visited Grace. She had been drinking heavily, appeared unwell, and said she just wanted to rest. Despite his concerns, Grace refused to go to the hospital. David left her to sleep and returned home. Growing increasingly worried about her condition and alcohol intake, David later contacted Grace's grandmother and asked her to check on Grace and try to persuade her to seek medical help. Grace's grandmother told David she would visit Grace first thing the following morning.

13.6. When Grace's grandmother arrived at her home the following morning, she found Grace unresponsive in bed and immediately called the ambulance service, who alerted the police. Sadly, paramedics pronounced Grace deceased at the scene. An empty one-litre bottle of vodka was found beside the bed. No suspicious circumstances were identified, and a report was submitted by the police to the coroner.

13.7. An Inquest was held in January 2025 at HM Coroner's Court, and the

¹⁵ This section sets out the information required in Appendix Three of the Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office December 2016).

medical cause of death was recorded as alcohol induced ketoacidosis, acute alcohol toxicity and hepatic steatosis (fatty liver).

14. CHRONOLOGY

14.1. The events in this section provide background on Grace and Daniel, prior to the timeline outlined in the Terms of Reference. The information has been provided by Emma, David and Lisa and from information drawn from agency chronologies.

Information shared by Emma, David and Lisa:

Emma

14.2. Emma described Grace as a sweet, kind, and gentle soul who wore her heart on her sleeve - an absolute joy, and the most beautiful, adorable person you could ever meet. Grace's early life was shaped by the circumstances of her birth. Her mother became pregnant while in a relationship with a long-term partner of Pakistani origin. However, by the time Grace was born, the relationship had ended due to the expectations placed on her father by his family, who had arranged a marriage for him in line with traditional customs. As a result, Grace's mother raised her as a single parent, with the support of extended family.

14.3. Grace's first encounter with her biological father came when she was just two years old. According to Emma, this was the only time they met. Unbeknown to Emma at the time, the family had requested that he have no further contact with Grace. Consequently, she grew up without knowing her father, a void that remained unfilled throughout her life.

14.4. During Grace's teenage years, her mother married and went on to have two more children. Grace's mother's life changed, her "perfect life" no longer seemed to include Grace. Family photos were often taken, but Grace rarely appeared in them. Grace, a vulnerable teenager, struggled to fit into the new family dynamic and felt like an outsider.

14.5. At the age of sixteen, Grace's mother asked her to leave the family home. She went to live with a family outside her local area, where she stayed for approximately six months. During this time, she was in a relationship with Daniel. Missing him, Grace returned to the area and moved into a shared flat with Daniel and some friends.

14.6. Emma shared that she and Grace shared a particularly close bond, with Grace viewing her as a mother figure. They spent a great deal of time together, and Emma remained a constant source of emotional support for Grace throughout her life.

14.7. In 2017, Grace married Daniel. In the lead-up to the wedding, Emma attempted to reconnect Grace with her biological father, reaching out to inform him of the impending marriage and proposing a meeting. However, the reunion never happened as her father, now married with children, chose not to engage, fearing the repercussions for his family life.

14.8. In the early years of their marriage, Grace and Daniel seemed, from the outside, to be a typical young couple raising two children. However, the pressures of financial instability, exacerbated by repeated redundancies and the impact of COVID began to strain the relationship. As a stay-at-home mother, Grace became increasingly isolated. She confided in Emma that while their relationship had been strong for the first eight years, Daniel had changed into someone she no longer recognised. She told Emma that he had become physically violent, had raped her and had once attempted to run her over.

14.9. Despite these harrowing experiences, Grace showed resilience. In 2021, she began working as a learning support assistant. She regained her confidence, lost weight from her recent pregnancy, and began reconnecting with life outside the home. Emma remembered how Grace “looked absolutely fantastic”, taking pride in her newfound independence and beginning to socialise once more.

14.10. Towards the end of Grace’s life, Emma stated that Grace had, on numerous occasions, cancelled plans to meet up with her and Emma’s mother.

14.11. When Grace passed away, Emma asked Grace’s mother for permission to inform her biological father, but her request was denied. It was only at the coroner’s request, in September 2024, that the next of kin be informed, that Emma was finally given the opportunity to reach out. Sadly, this meant Grace’s father did not have the chance to attend the funeral, which had been held in August 2024. He was distraught and devastated by the loss. Although he had not been physically present in her life, he remained connected via social media and loved Grace from afar.

14.12. Emma informed the Review that after not speaking to Daniel for three years, and only partially knowing what Grace had endured in her relationship with him, she had to make an effort to reconnect with him in order to maintain a relationship with Grace’s children - a process she found and still finds extremely difficult. She stated that it is hard to gauge Daniel’s feelings about Grace’s passing, but he appears to be doing a good job raising the children.

David

14.13. David shared with the Review that much of what he knew about Grace’s background came directly from her. Grace had confided in him about her upbringing and the emotional impact it had on her life.

14.14. According to David, Grace described feeling deeply neglected by both her mother and stepfather, and she held no fond memories of them. After leaving the family home, her contact with them was minimal. She never referred to her birth mother as “mum” and instead spoke of being primarily raised by Emma and her grandmother, who provided her with the care and stability which was lacking in her relationship with her parents.

14.15. Grace described her childhood to David as “very disruptive”. Diagnosed with ADHD at a young age, she also began to experience mental health difficulties in early childhood. David stated that Grace believed these struggles were rooted in the

strained and difficult relationship she had with her mother, which left lasting emotional scars.

14.16. At around the age of 23, Grace married Daniel, the father of her two children. David told the Review that Grace's marriage to Daniel was both physically and emotionally abusive, a situation that led to the involvement of various support agencies. Grace had shared with David that the trauma and distress caused by the abuse were major factors in her later battles with anorexia and alcohol misuse. She directly linked her deteriorating health to the harm she experienced in childhood and throughout her relationship with Daniel.

Lisa

14.17. Lisa first met Grace at their workplace in September 2021. Almost immediately, Lisa noticed Grace's anxiety around food during their shared lunches. Having experienced an eating disorder herself, Lisa was able to recognise the signs and soon they began sharing their experiences and coping strategies. Despite this mutual support, it quickly became clear to Lisa that Grace needed more formal intervention.

14.18. Grace confided in Lisa that she ate very little and frequently felt faint, a condition they referred to as "crashing". Lisa observed that Grace showed little motivation to seek professional support and encouraged her to involve her husband, Daniel. However, Grace disclosed that Daniel was unsupportive and was not helping her access the care she needed. Grace often spoke of the eating disorder voice in her head as "Mel", a term she used frequently in conversations and messages with Lisa.

14.19. By November 2021, Grace had begun receiving support from an adult eating disorder clinic. Lisa described the practitioner assigned to Grace as compassionate and consistently available for contact and tailoring flexible meal plans to suit her needs. Lisa reported that Daniel's behaviour appeared to undermine the process. Grace had told Lisa that Daniel would make dismissive comments such as, "Don't worry, I won't make you eat, and we don't have to tell your practitioner".

14.20. In February 2022, Grace started confiding in Lisa about the abuse she was experiencing from Daniel. With Grace's agreement, Lisa confronted Daniel during a visit to their home, recording the escalating tensions.

14.21. Grace disclosed several incidents - on one occasion, Daniel pressured her to attend a family meal despite her eating disorder and anxiety in social settings, minimising her concerns and insisting she attend, saying "everyone is expecting you". Lisa informed Daniel that he seemed not to understand how triggering the situation was for Grace.

14.22. Grace also described an incident where Daniel initiated sex while she was asleep and unable to consent, having taken a sleeping tablet earlier in the evening. Grace reported that she awoke during the act and dug her nails into her hand. Daniel claimed that Grace had been awake at the outset and that he stopped once he realised she was asleep. During Grace's disclosure, Lisa reported that Daniel

repeatedly told her to “shut up” - a phrase he frequently used to silence both her and Grace in conversation.

14.23. When Lisa challenged Daniel about another incident where Grace was allegedly crying and screaming during sex, he dismissed it as “her version” and denied hearing anything.

14.24. Daniel described himself as Grace’s “rock,” claiming to be supportive, but Grace strongly disagreed. She told Lisa that his involvement had instead enabled and reinforced her disordered eating rather than supporting her recovery. Grace once confided that Daniel had said, “I’ll let you throw up if I can have sex with you”. When Lisa confronted Daniel about this, he admitted it with a chilling, “Okay, alright, that might be the one thing that is true”, and then added, “See, I’m honest”.

14.25. Lisa also documented screenshots of messages in which Grace expressed suicidal thoughts connected to her fear of weight gain, highlighting the profound impact of her struggles.

Agency Chronologies

14.26. Grace had multiple contacts with her general practitioner (GP) between 2009 and 2021, which is summarised below:

- ◆ 2009 school difficulties, reactive depression
- ◆ 2010 alcohol intoxication and drug overdose (A&E attendance)
- ◆ 2011 depression
- ◆ 2012 seizure due to medication overdose
- ◆ 2013 depression, mental health referral. Subsequent referral to alcohol services
- ◆ 2013-2022 regular GP contact for depression
- ◆ 2021 referral to eating disorder service

14.26.1. Grace had reported that she was diagnosed with ADHD during childhood, but there was no documented evidence of a formal diagnosis.

14.27. 23 June 2011 - Grace (aged 17) was referred to the Child and Adolescent Mental Health Service (CAMHS) by her GP due to binge drinking and using alcohol to aid sleep. She reported an unhealthy relationship with food, negative body image, past self-harm, a recent incident of cutting her stomach with scissors and suicidal thoughts. Grace was diagnosed with depression and prescribed fluoxetine 20mg daily. Her condition was monitored, and she was discharged from the service on 31 January 2012.

14.28. 13 February 2012 - Grace took an impulsive overdose, citing increased depression and a problematic home life, including being asked to leave the family home by her mother. She was seen by Southern Health Psychiatric Liaison Services (PLS), who advised an urgent review of her medication by her GP. A referral letter was sent to Surrey and Borders Partnership (SaBP) Community Mental Health Recovery Service (CMHRS).

14.29. 04 April 2013 - Grace was referred to CMHRS by her GP due to insomnia, possible hypomania, and low mood, with a query of bipolar disorder given her mother's diagnosis. CMHRS found no evidence of bipolar disorder and her sleep issues were considered long-term. The GP was advised to refer her to a sleep clinic, initiate antidepressant treatment, and consider psychological support if low mood persisted. Grace was also advised to self-refer to a drug and alcohol service due to using alcohol to aid sleep. She was discharged from CMHRS in May 2013. From 2013 onwards, Grace maintained regular contact with her GP.

14.30. 11 November 2021 - Grace was referred to the Adult Eating Disorders Service (AEDS) by her GP due to a restrictive eating pattern, occasional vomiting, and a reported weight loss of one stone in one month.

14.31. 10 December 2021 - Grace was assessed by the AEDS outpatients. She reported a long-standing difficult relationship with food, including vomiting up to three times daily, deranged biochemistry¹⁶, an abnormal ECG and signs of undernutrition. Grace linked the vomiting to starting a new job and anxiety about eating with others. She disclosed controlling behaviour by Daniel, which had increased when she started working and became more independent. Grace noted that Daniel only sought help for her after concerns were raised by her friends.

14.32. 14 December 2021 - Grace was discussed at a Multi-Disciplinary Team meeting (MDT)¹⁷ where a diagnosis of Atypical Anorexia Nervosa¹⁸ was recorded. Excessive alcohol use was noted as a historical issue. A feedback appointment on 17 December confirmed the diagnosis and outlined a treatment plan, including regular physical observations, blood tests, ECG monitoring and enrolment in the Eating Disorder Health Information class (EDHIC). Implementation of the plan was delayed due to Grace testing positive for COVID, with monitoring and class attendance to commence once a negative result was received.

14.33. 24 December 2021 - 28 February 2022: Grace remained engaged with AEDS, attending health monitoring and EDHIC appointments.

14.34. 28 February 2022 - Grace attended an AEDS appointment, during which a domestic abuse, stalking, harassment and honour-based violence risk assessment (DASH), was used to support a conversation about suspected domestic abuse. However, the grading of the assessment was not recorded. The case was discussed at an MDT meeting. It was decided that a safeguarding concern referral to the Multi-Agency Safeguarding Hub (MASH)¹⁹ under Section 42 (s42)²⁰ of the Care Act was

¹⁶ The results of blood or other body fluid tests (like liver function tests or kidney function tests) are outside the expected or normal range.

¹⁷ Teams consisting of individuals drawn from different disciplines who come together to achieve a common goal.

¹⁸ Pattern of obsessive, dangerous weight loss but not underweight.

¹⁹ A centralised unit that brings together professionals from various agencies to facilitate early identification and response to safeguarding concerns about children and young people.

²⁰ A Section 42 enquiry, also known as a safeguarding enquiry, is a process initiated by a local authority in the UK when they have concerns about an adult's well-being, particularly if they are at risk of abuse or neglect. The Care Act 2014 mandates this process to ensure the safety and protection of adults with care and support needs.

not required, as Grace did not present as having care and support needs. She was, however, provided with information about specialist domestic abuse services.

15. OVERVIEW

15.1. This section documents the key contacts that agencies and professionals had with Grace, Daniel, Ashley and Charlie during the timeframe of the Review. It also includes relevant information provided by David, Emma, and Lisa.

15.2. Given the complexity of Grace's circumstances and the involvement of multiple agencies, this section provides a comprehensive and detailed account to support clarity and understanding.

15.3. 07 March 2022 - Grace attended an AEDS appointment. She reported leaving her husband, feeling suicidal, and stated she believed she was "losing her mind". Grace disclosed sexual abuse within the marriage. She was signposted to domestic and sexual abuse services and advised on safety planning, including police contact and child contact arrangements. Concerns were shared with the safeguarding lead. An adult safeguarding referral was made to MASH, and a referral to the Children's Single Point of Access (C-SPA)²¹ was completed.

15.4. 07 March 2022 - Surrey County Council MASH received a referral from SaBP outlining alleged controlling, coercive, psychological, and sexual abuse by Daniel, which had impacted Grace's wellbeing and had led to self-harm. A MASH social worker reviewed the referral the same day and determined that the threshold for a Section 42 enquiry was not met. No further action was taken.

15.5. 09 March 2022 - AEDS received a response from MASH advising that no enquiries were required, as Grace's mental health needs were already being addressed, and she did not meet the threshold for care and support.

15.6. 09 March 2022 - Grace self-referred to the South West Surrey Domestic Abuse Service (SWSDAS), following the end of her relationship with Daniel. She disclosed a history of controlling behaviour, Daniel's suicide threats, her own depression, eating disorder and suicidal ideation. Grace engaged well and was open to support. Safety planning and reporting to the police were discussed.

15.7. 10 March 2022 - Grace contacted SWSDAS, reporting she had received excessive messages from Daniel, which ceased after she asked him to stop. She described feeling isolated and disclosed domestic abuse. Child contact was discussed, and Grace was advised to use a third party. She was currently off work due to mental health reasons but hoped to return by Easter. Safety planning was reviewed, and a risk assessment was completed, graded as "medium risk".

15.8. 14 March 2022 - An SWSDAS outreach worker messaged Grace. She responded the following day, stating she had experienced a difficult few days but was resting. No further contact occurred until June 2022, when Grace re-engaged.

²¹ A central point of contact for referrals and inquiries related to children's safeguarding concerns.

15.9. 15 March 2022 - During an AEDS appointment, Grace stated she was attempting to reduce her alcohol use and reported finding eating stressful. An update was sent to C-SPA on 16 March due to concerns regarding the children's awareness of domestic abuse and Grace's capacity to care for them independently.

15.10. 01 April 2022 - AEDS received a letter from Mindworks regarding Ashley's referral to C-SPA. While no direct abuse was identified, concerns were raised about the potential emotional impact on the children. AEDS was advised to notify Children's Social Care (CSC).

15.11. 04 April 2022 - Grace attended an AEDS appointment. She was due to begin a phased return to work on 19 April. She also reported experiencing blackouts. The care coordinator planned to explore this further with psychology as a possible dissociative symptom.

15.12. 13 April 2022 - Grace's blackouts were discussed by her AEDS care coordinator with a psychologist, who considered them more likely to be episodes of zoning out rather than dissociation. Grace's mood and suicidal ideation were to be monitored, to determine whether a referral to CMHRS was required. She was also encouraged to refer to i-Access for support for alcohol use.

15.13. 19 April 2022 - Children's Social Care received a referral from SaBP following Grace's disclosure to AEDS of six months of psychological and sexual abuse. This marked the first direct referral to CSC. Work was undertaken with a domestic abuse advisor. Grace reported that she had separated from Daniel and that her situation had improved.

15.14. 20 April 2022 - Grace attended an AEDS appointment with her care coordinator and psychiatrist for a medication review. She reported taking medication in the evenings followed by alcohol use. Side effects were discussed, and Grace was advised to contact her GP regarding detoxification.

15.15. 25 April 2022 - Grace cancelled an AEDS appointment. Due to service caseload pressures, no alternative appointment was offered that week. With her risk level rated as AMBER, the frequency of contact was reduced from weekly to every 2-3 weeks, which Grace agreed to.

15.16. 25 April 2022 - Early Help²² contacted Grace to discuss safety planning. She confirmed she had separated from Daniel, changed her locks, and updated her social media passwords. She reported that the children had witnessed verbal incidents but were coping better. Daniel had withdrawn funds from their joint account, prompting her to open a new one. Grace did not wish to pursue a non-molestation order and felt able to manage without further domestic abuse (DA) outreach support.

²² A support approach to identify and address emerging issues for children, young people, and families before problems escalate to the point of needing statutory intervention (such as social care involvement).

15.17. 26 April 2022 - Grace self-referred to i-Access. A letter and text were sent offering a telephone assessment, and a copy was forwarded to her GP. Grace called on the same day, and an appointment was scheduled for 03 May 2022.

15.18. 03 May 2022 - Grace completed a telephone assessment with i-Access. She disclosed a history of domestic abuse and reported daily alcohol consumption (four gin or vodka drinks). She expressed a desire to abstain due to medication and stated that alcohol had no current impact on her daily functioning. A previous CSC referral was noted, with no further action required. The referral to i-Access was accepted, and Grace received an extended brief intervention. A domestic abuse risk assessment recorded that Daniel was no longer considered a threat, and Grace was receiving support.

15.19. 12 May 2022 - Grace attended an AEDS appointment. She noted a lapse in regular appointments and reported the return of daily weighing and binge/purge behaviours.

15.20. 17 May 2022 - At an i-Access appointment, Grace reported daily intake of 2-4 gin and diet lemonade drinks. She linked her alcohol use to a previous abusive relationship and described current drinking as a means of relief, not intoxication, typically after her children were in bed. She was advised to monitor her alcohol units and was provided with safe drinking guidelines.

15.21. 17 May 2022 - An Early Help advisor contacted Grace. She declined Level 3 (Child in Need) services but was signposted to domestic abuse charities, therapeutic support, the Freedom Programme²³, and the Family Information Service²⁴ for self-referral.

15.22. 18 May 2022 - Early Help noted no significant safeguarding concerns. Daniel had moved out, Grace had taken protective actions, and she was engaging with support. Advice was provided, and the case was closed.

15.23. 20 June 2022 - Grace contacted her SWSDAS outreach worker. She reported being on a phased return to work and had been advised by her hospital support worker to seek counselling. She described increased stress, noting that Daniel was not seeing the children and appeared focused on her instead. She suspected drug use on his part and described his behaviour as erratic. The outreach worker offered to arrange a legal consultation for Grace. Grace was also encouraged to update the school and reminded of available support. A referral to SWSDAS counselling was made.

15.24. 27 June 2022 - At an AEDS appointment, Grace reported weighing herself twice daily, binge eating on four out of seven days each week, and experiencing strong urges to restrict her intake and lose weight. She identified her best friend Lisa as a protective factor but admitted concealing her bingeing from her. Strategies to delay binge/purge cycles were discussed.

²³ An 11-week support group for any women fleeing or who have experienced domestic abuse.

²⁴ A local authority-run service that provides free, impartial information, advice, and support to families with children and young people (typically aged 0–25).

15.25. 01 July 2022 - Grace contacted her SWSDAS outreach worker to confirm her attendance at counselling. She was encouraged to complete the six-week programme.

15.26. 11 July 2022 - Grace attended an AEDS appointment. She was unhappy with her weight and associated feelings and had a strong drive to lose weight, so she increased restriction and bingeing behaviours. She agreed to try limiting weighing to once daily.

15.27. 08 August 2022 - Grace attended AEDS and reported significant food restriction and a lack of motivation for recovery. No self-harm occurred, though she acknowledged urges. She felt verbally aggressive, irritable, and worried this could alienate others.

15.28. 11 August 2022 - Grace started her 6-week domestic abuse counselling through SWSDAS, which she completed on 30 September 2022.

15.29. 20 August 2022 - Grace attended the emergency department (ED) with palpitations, central chest pain and an aching sensation in her arm. She disclosed a recent relapse of her anorexia and that she was receiving support from the community anorexia team care. No safeguarding concerns were identified during this visit.

15.30. 23 August 2022 - i-Access discharged Grace due to non-engagement despite prior attempts to contact her.

15.31. 08 September 2022 - GP telephone consultation regarding panic attacks. Grace disclosed domestic abuse and separation from her husband. She was prescribed propranolol. No referral or contact with domestic abuse services was recorded.

15.32. 22 September 2022 - Grace attended an AEDS appointment. She had started propranolol two weeks prior, which had reduced cardiac symptoms. Domestic abuse counselling complete. Reported eating well and no binges in two months but some restriction creeping back in. Reported feeling out of control if eating alone and weighing daily.

15.33. 22 September 2022 - Grace requested a reduction in her working hours, citing difficulties with childcare and collecting her children from school. Due to low staffing levels at the school where she was employed, the request was declined, however, she was permitted to leave early for the remainder of the term to accommodate her childcare needs.

15.34. 17 October 2022 - Grace attended an AEDS appointment in a highly distressed state, reporting increased impulsivity, out-of-character behaviour and frequent panic attacks. She described feeling as though she was experiencing life from outside her body and expressed thoughts of not wanting to be alive but had no active plans to act on them. She also reported difficulty with basic self-care. Grace consented for AEDS to contact her employer to support a request for time off due to her mental health. A referral was made to CSPA for Early Help as her children had

witnessed her mental health deterioration.

15.35. 01 November 2022 - Grace called the Crisis Line believing she was experiencing psychosis. She reported memory issues, losing days and not remembering anything. She stated that she had thoughts of taking her own life and has made plans but did not disclose the details. She mentioned that her children have been a protective factor, although she had been struggling recently. Grace was advised to visit Safe Haven²⁵, which she did with her grandmother.

15.36. 03 November 2022 - Grace self-referred to i-Access, reporting alcohol withdrawal. She was drinking up to 750ml of gin daily. She stopped drinking after receiving diazepam from her doctor the previous day and reported that her children were staying with her grandmother. Although advised to contact her GP, she was reluctant due to previously not disclosing her alcohol use. A telephone assessment was scheduled for 09 November and a medical summary was requested from her GP, which was received.

15.37. 09 November 2022 - Grace completed a telephone assessment with i-Access, reporting attendance at four Alcoholics Anonymous (AA) meetings that week. A domestic abuse risk assessment identified no current or past risks. A key worker was assigned to Grace on 25 November and scheduled Grace for an appointment on 05 December, which she cancelled due to Charlie being unwell. The appointment was rescheduled for 19 December, but she did not attend; a further appointment was set for 09 January 2023.

15.38. 09 November 2022 - Mind Matters (talking therapy) received a referral from Grace's GP. A telephone assessment was completed on 10 November. Grace identified Christmas and Daniel as triggers. She reported dissociation, low mood, panic attacks and difficulty coping as a single parent - her grandparents arranged to support with childcare. Grace described emotional instability and feeling unsupported by Daniel. An ADHD assessment was put on hold by her GP due to ongoing issues with eating, with a plan to work with the eating disorders team.

15.39. 09 November 2022 - CSC received a referral from AEDS. Level 4 (Child Protection) support was considered by the C-SPA team manager; however, it was determined that the threshold was not met as the children were not deemed to be at immediate risk of harm. Instead, Level 3 (Child in Need) support was deemed appropriate due to the impact of Grace's mental health on the children, with the situation to be kept under review. Consent for Level 3 support was given by Grace, and the case was referred to a family centre in the area.

15.40. 15 November 2022 - A worker from the family centre visited Grace and her children. During the visit, consent was obtained, and both a genogram and outcome star assessment were completed. The genogram mapped Grace's support network, while the outcome star helped identify parenting strengths and areas needing support. Grace rated herself highly in parenting, indicating she felt confident in her role.

²⁵ A mental health support service, designed to offer out-of-hours emotional and crisis support to people who are experiencing or approaching a mental health crisis.

15.41. 16 November 2022 - Mind Matters sent a letter to Grace, with a copy to her GP, explaining that the referral could not be accepted as she was under the care of i-Access and AEDS, and that a re-referral could be made once treatment with those teams was completed.

15.42. 25 November 2022 - The children were seen alone at school by CSC and no concerns were raised. This was the first visit, intended to get to know the children. The main concern they raised was Grace's health. They said they did not see their father very often but did not express any concerns about him.

15.43. 09 December 2022 - An Early Help worker sent a text message to Grace to arrange a follow-up visit, following an earlier message which had gone unanswered. A letter was hand-delivered to Grace offering three appointment times in December advising that, if no response was received, support from the family centre would be closed. No response was received from Grace.

15.44. 09 January 2023 - Grace attended a telephone appointment with i-Access at her request due to childcare. Her initial abstinence lasted three weeks but she relapsed at a friend's birthday celebration. She was currently drinking over 750ml of gin in the evening and drinks until she blacks out. Grace reported that her mental health was stable with no signs of depression - difficulty sleeping led to drinking and using sleeping tablets. Discussed care of children and she stated she had a family support worker and described Daniel and her grandparents as supportive. i-Access spoke with the family support worker, and an email sent with concerns about level of drinking while caring for children. Concerns were shared with AEDS.

15.45. 11 January 2023 - CSC received a referral from the family centre, requesting a step up to Level 4 services. The request was prompted by information received from i-Access, who disclosed that Grace was consuming large amounts of alcohol daily whilst acting as the sole carer for her children. The case was assigned to a social worker to complete a child and family assessment.

15.46. 26 January 2023 - An email was sent from the school's designated safeguarding lead (DSL) to the social worker at CSC, raising concerns about parental conflict. The DSL reported that Charlie appeared upset and very sad at breakfast club, stating: *"Mummy and daddy were arguing this morning. I miss my mummy, and I hugged her this morning when she was crying"*. The DSL was made aware that CSC was undertaking a child and family assessment.

15.47. 30 January 2023 - i-Access telephone appointment with Grace. She was drinking 250ml of gin in the evening and stated that the trigger was boredom. Her panic attacks had reduced significantly. Child safeguarding was discussed and arrangements had been made for the children to be seen at the school by the social worker from CSC.

15.48. 31 January 2023 - An email was sent from the school to the CSC social worker as part of the child and family assessment. No concerns were raised, other than noting that the children were working below expected academic levels. The school noted that tutoring had previously been offered for Ashley, but Grace declined the support.

15.49. 13 February 2023 - Grace was spoken to by her line manager, following a concern raised by a member of staff that she smelled of alcohol. Grace denied the allegation and appeared very upset.

15.50. 15 February 2023 - The social worker conducted a home visit as part of the child and family assessment. Grace, Ashley and Charlie were all spoken to during the visit. Grace discussed her relationship with Daniel, stating that she was “frustrated but not ready to share”.

15.50.1. No safeguarding concerns were identified by the children. They appeared happy in Grace’s care and presented as well looked after. Daniel did not reside in the home, so no observations of his interactions with the children could be made. However, some concern was noted about Ashley appearing reserved and having difficulty opening up.

15.51. 20 February 2023 - Grace attended her final AEDS appointment. She expressed mixed emotions about therapy ending. Grace reported increased alcohol intake over half term (one bottle of wine nightly), which she said she would address with i-Access. Grace was discharged from AEDS.

15.52. 27 February 2023 - i-Access telephone appointment with Grace. She reported that her alcohol intake had increased to 500ml of gin each evening, attributing the trigger to boredom during the half-term break. Daniel was looking after the children that evening to allow her to attend an AA meeting, and a friend was staying with her for three nights.

15.53. 28 February 2023 - The social worker visited the children at school as part of the child and family assessment. The discussion included who visits their home, what they like about their parents, and anything that made them feel worried or sad. The children drew a family tree but excluded Daniel from the drawing.

15.54. 13 March 2023 - The child and family assessment was completed following Grace’s refusal of child in need (CIN) support, prompting a recommendation for a strategy discussion. The assessment sought to understand the impact of Grace’s alcohol use on her children, but this was limited by her minimisation of her drinking and refusal to allow contact with professionals or family members.

15.54.1. Although Grace claimed to have support networks, the lack of consent meant the social worker could not verify whether safety plans were in place via i-Access or her wider support system. This raised concerns that Grace’s alcohol use may not be decreasing as she reported, and that she might be concealing the true extent of her drinking.

15.54.2. The CSC team manager concluded that the family would benefit from further support, particularly involving adult mental health and substance misuse services. This could have been provided through a CIN plan, but parental consent was not given. It was agreed that a strategy meeting should be convened to share information across the professional network and determine whether a child protection enquiry was required.

15.55. 13 March 2023 - Grace called police reporting that her partner, Kevin, had been drinking, using drugs and refusing to leave her home. He left before officers arrived. Grace disclosed she wanted to end the relationship but feared retaliation. She stated that Kevin had a history of sexual offending and reported three incidents of rape, though all were outside the forensic evidence window. Grace declined to support the investigation and did not wish to complete the sexual offence investigation booklet.

15.55.1. A DASH risk assessment was completed and graded as “medium risk”. An outreach referral was made to domestic abuse services. Grace’s two children were at home but asleep during the incident; officers confirmed they were safe and well cared for. A DA kit²⁶ was provided, and an operation encompass notification²⁷ was completed.

15.55.2. A SCARF²⁸ (single combined assessment risk form) was submitted to CSC for the children, and a ‘vulnerable adult’ referral was made to Adult Social Care (ASC) for Grace.

15.55.3. Kevin was arrested at his home, gave a no-comment interview, and was released on conditional bail with conditions not to contact Grace or attend her home. The investigation was closed on 11 April 2023 due to a lack of evidence.

15.56. 13 March 2023 - ASC received a safeguarding referral from the police. This was progressed to a Section 42 enquiry, which was forwarded to the substance misuse social care team for action.

15.57. 13 March 2023 - SWSDAS received a police referral concerning an alleged serious sexual offence by Grace’s partner, Kevin. Police described Grace as vulnerable, and in a controlling, manipulative relationship. An outreach worker contacted Grace the same day; she was in a car with Daniel, as she did not want to be alone. Grace reported that after she asked Kevin to leave, he took drugs, became aggressive and paranoid, and attempted to access her phone.

15.57.1. Refuge options were discussed and Grace planned to prepare an emergency bag, gather documents and money. She believed Kevin would not contact her while on bail and mentioned his prior sexual assault charge. The Hollie Guard app²⁹ was discussed and Grace planned to list Daniel as next of kin. A risk assessment was completed and graded as “medium risk”.

15.58. 13 March 2023 - The CSC social worker carried out an unannounced visit to Grace’s home, but she was not there. A text was sent to her, and she replied that she would be home in 15 minutes and that the children were with

²⁶ A resource pack used during domestic abuse callouts or investigations to support victims and aid safeguarding.

²⁷ A system used by police to inform schools about domestic abuse incidents involving children. It is a safeguarding initiative designed to ensure that schools are made aware, by the next school day, if a child has been exposed to or affected by a domestic abuse incident at home.

²⁸ SCARF - To record, assess, and share safeguarding concerns related to children and vulnerable adults, often following incidents of domestic abuse, neglect, or other welfare issues.

²⁹ A free personal safety app.

Daniel. However, she did not return.

15.59. 16 March 2023 - The ASC social worker contacted Grace, who arranged a follow-up call due to work commitments. In the later call, Grace said she planned to press charges against Kevin and had discussed bail conditions with police. She reported no contact with Kevin since his release.

15.60. 20 March 2023 - A strategy discussion was held regarding concerns that Grace's mental health, eating disorder and excessive alcohol consumption may have been impacting the children. A single-agency Section 47 investigation³⁰ by CSC was agreed, with no actions required from the police.

15.61. 21 March 2023 - The CSC social worker visited Grace and was informed about child protection concerns, including issues around her alcohol consumption. Grace reported she was advised to reduce alcohol gradually but denied incidents of blacking out. Concerns were also raised about her potential risks to children at her workplace. CSC to make a referral to the Local Authority Designated Officer LADO³¹. There was no evidence on file that a referral was made.

15.61.1. The CSC social worker spoke with Daniel by phone as part of the Section 47 enquiry and to share the outcomes of the strategy meeting held on 20 March. Daniel reported no current concerns and said he had recently taken Grace to an AA meeting. He described having regular contact with the children and being actively involved in their care and school activities. He acknowledged Grace's alcohol use but noted she was attending support meetings. He also referred to past blackouts during periods of poor health and believed she had recovered from her eating disorder. Daniel stated he remained available to offer support.

15.62. 21 March 2023 - During a consultation with her GP, Grace disclosed a sexual assault (by Kevin) that had occurred the previous Sunday, in the context of domestic abuse. She had already attended a sexual health clinic and was awaiting swab results, and the police were involved. According to Grace, the clinic examination indicated signs of trauma.

15.63. 23 March 2023 - Grace attended a follow up telephone consultation with her GP to discuss the swab results she received from the clinic, which confirmed genital herpes. An antiviral prescription was issued.

15.64. 24 March 2023 - An ASC social worker spoke with Grace. She had decided not to press charges against Kevin but understood the case could be reopened. Grace reported support from a domestic abuse worker, was managing daily life and work and reducing her alcohol intake. She expressed frustration that i-Access had shared her past issues at a CSC meeting. The social worker agreed to refer her case to the i-Access MDT for review.

³⁰ Investigating concerns that a child is suffering, or is likely to suffer, significant harm.

15.65. 24 March 2023 - i-Access contacted Grace, who reported recent CSC involvement following a domestic abuse incident and felt she had been treated unfairly. She requested that i-Access update CSC on her progress. Grace was informed her key worker would be changed to support her preference for evening appointments. She reported being alcohol-free for three days and, although prescribed diazepam by her GP for withdrawal symptoms, had not taken it. A new key worker was assigned, and an appointment letter issued for 03 April 2023.

15.65.1. A safeguarding risk assessment was completed, noting ongoing CSC involvement due to concerns regarding Grace's children and her employment in a school setting. CSC confirmed that they would be opening a case.

15.66. 27 March 2023 - Outcome of the Section 47 assessment: Grace denied all allegations made against her, stating that she felt she was being judged based on her past. She reported no history of blackouts or loss of consciousness. Grace explained that she had self-referred to i-Access to address her alcohol use and stated that she had since reduced her intake. She also expressed a willingness to undergo breathalyser testing. The threshold for initiating an Initial Child Protection Conference³² was not met, and a safety plan was put in place.

15.67. 14 April 2023 - A child and family assessment visit was carried out by the CSC social worker with Grace and the children. Grace reported being sober for 20 days and agreed to undertake a breathalyser test with i-Access. She had recently been allocated a new key worker at i-Access. Discussions were held around the reasons behind her alcohol use. Grace stated that her GP had prescribed her a short course of medication (three days) to support her sobriety.

15.68. Emma informed the Review, that following Grace and Daniel's divorce in May 2023, frequent disputes arose concerning practical arrangements. These included how the children would get to and from school, given that Grace did not drive, as well as disagreements regarding visiting arrangements and financial support, as Daniel was not contributing towards the children's upkeep. Grace was in receipt of universal credit and relied on financial assistance from her mother's in-laws and other family members to meet her monthly needs.

15.69. David informed the Review Chair that his relationship with Grace commenced in May 2023. He described Grace as a vibrant and loving person who, despite her struggles, had so much to live for. She remained sociable, maintained close relationships with certain family members and friends, and devoted considerable time to her children.

15.70. 03 May 2023 - During a meeting with i-Access, Grace reported that she had reduced her alcohol intake to a level she felt in control of and expressed a preference for social drinking with friends, rather than complete abstinence. She was consuming two to three double gins or vodkas per week and attended AA meetings when possible. Grace was offered a place in a controlled drinking group but was unable to attend due to its daytime scheduling. She stated that her CSC social

³² A Child Protection Conference is a formal meeting held when there are serious concerns that a child is at risk of significant harm due to abuse or neglect.

worker tended to assume the worst about her and that she was encouraged to make a formal complaint. i-Access wrote to the social worker on 11 May 2023 to provide an update. Subsequently, Grace was discharged from i-Access.

15.71. 11 May 2023 - CSC received an email from i-Access confirming that Grace had attended an appointment and completed a breathalyser test, which returned a reading of 0. i-Access advised that, as her treatment was now complete, Grace would be discharged from the service.

15.72. 12 May 2023 - The ASC social worker contacted Grace who reported keeping well. She disclosed that she was due to meet her children and no longer required their support.

15.73. 19 May 2023 - CSC informed the police of the outcome of the Section 47 investigation. Although concerns were substantiated, the children were not considered to be at risk of significant harm. The outcome was recorded as “no further action - continue with child and family assessment”. No further action was required from the police.

15.74. 24 May 2023 - A child and family assessment completed by the CSC social worker as part of child protection enquiries, found that neither Ashley nor Charlie raised concerns about their parents or care. Both children appeared happy and comfortable with Grace. School checks also raised no concerns. This suggested that Grace had protected the children from any negative impact of her difficulties. As there was no longer a role for CSC, Grace's case was closed to the service on 25 May 2023.

15.75. 07 June 2023 - A telephone consultation was held with Grace and her GP regarding alcohol withdrawal. It was noted that she had relapsed during the half-term break due to withdrawal symptoms. Lengthy discussions were held around the importance of engaging with i-Access and the GP submitted an urgent referral to i-Access.

15.76. 08 June 2023 - i-Access received the referral from Grace's GP stating that she had started drinking heavily again. An appointment letter was sent to Grace.

15.77. 08 June 2023 - A low level concern was submitted by a senior staff member at Grace's workplace, alleging that she may have consumed alcohol before arriving at work and had brought alcohol for consumption during the week commencing 05 June 2023. HR was consulted, and an investigation was initiated.

15.77.1. The investigation was based on reports from some staff who believed Grace was under the influence of alcohol, and others who stated she had admitted to having alcohol in her possession at work. Grace was suspended on full pay while the investigation was ongoing. In a statement submitted by Grace, she stated that the allegation was damaging to her mental health, and that her social drinking outside of work was her personal business.

15.78. 09 June 2023 - A referral was made to the Local Authority Designated Officer

(LADO). LADO advised that the school should re-establish contact with them depending on the outcome of the investigation.

15.79. 12 June 2023 - During an investigation meeting, Grace disclosed she had a social worker from i-Access who had advised her to obtain a breathalyser, as she had previously been accused of smelling of alcohol and needed to demonstrate her fitness to care for her children. The school reported that the social worker had not contacted them in their capacity as her employer at any point during her employment.

15.80. A formal meeting was due to be held on 22 June 2023, following the investigation in line with disciplinary processes. However, Grace submitted her letter of resignation on 21 June 2023, therefore the meeting did not take place. Grace did not return to work and was paid in lieu of notice until the end of August 2023.

15.81. 19 June 2023 -The ASC substance misuse manager (SAM) approved the closure of the Section 42 enquiry. It was noted that Grace had initially engaged but later disengaged. SAM recorded that the lead enquiry officer's views (LEO) views were that Grace did not have care and support needs that would prevent her from protecting herself, therefore the threshold was not met. Grace had received support from the police, who had provided her with a domestic abuse kit, and she was in contact with an outreach service for domestic abuse.

15.82. 28 June 2023 - Grace did not attend her appointment at i-Access. A 14-day letter was sent to her to attend, failing which, she would be discharged from the service.

15.83. 02 July 2023 - Grace sent an email to the police reporting that Daniel had reversed his car towards her on the 30 June, following a dispute over money during a child access visit.

15.83.1. Officers attended Grace's home and spoke with her at length. She alluded to incidents of physical violence during her marriage to Daniel, saying she had evidence on her phone but did not wish to provide it to the police. Grace described Daniel as extremely jealous, and that he did not want her working with male colleagues or having male friends. She disclosed her fear of Daniel and described how he had controlled and coerced her. This included controlling their joint bank account, isolating her from friends and family, restricting her movements, tracking her location using the 'Find My iPhone' app, monitoring her phone, and eavesdropping on her conversations. Grace stated that when she ended the relationship, Daniel threatened suicide in an attempt to persuade her to stay.

15.83.2. Following their separation, Grace disclosed how Daniel continued to exert control, by hacking into her online accounts, gaslighting her and randomly returning the children when he knew she had plans. Grace linked Daniel's behaviour to her struggles with anorexia and reliance on alcohol as a coping mechanism.

15.83.3. The officer completed a DASH risk assessment, determining the risk as medium, and shared this with ASC and a domestic outreach service. Additionally, a SCARF 'child to notice' form was completed and forwarded to CSC.

15.84. Lisa informed the Review Chair that, in July 2023, Ashley created a spider diagram titled “*Ashley’s Worries*”, expressing concerns in Ashley’s own words. Grace sent a screenshot of this diagram to Lisa, who subsequently shared it with the police in November 2023 due to safeguarding concerns for Grace’s children.

15.84.1. Lisa provided a screenshot of the diagram to the Review Chair, which read as follows:

*“I am scared. Worried about mummy. I am because daddy shouts at mummy”.
“I am hoping mummy is okay. I am scared that I am not safe when daddy shouts”.*

15.85. 03 July 2023 - SWSDAS received a police referral for coercive and controlling behaviour, following an email from Grace to the police about Daniel’s behaviour on 30 June 2023.

15.85.1. The outreach worker contacted Grace the same day. Her divorce from Daniel had been finalised in May, and she remained in the family home. Child contact with Daniel had recently been re-introduced following a period of no contact. Grace reported ongoing post-separation abuse, particularly around finances³³ and child arrangements. At the time she was on gardening leave³⁴ from work and had recently been discharged from i-Access, feeling more in control of her alcohol use.

15.85.2. A DASH was completed and assessed as “medium risk”. Grace continued to allude to physical violence but declined to answer certain questions, suggesting that the level of risk posed by Daniel may be higher. She expressed fear of the consequences of making a formal report to police. Safety planning was reviewed, covering her home, digital safety, travel and the children’s school. Grace was offered a place on the Freedom Programme, which she agreed to consider. She also requested further counselling, which the outreach worker agreed to explore. The request was submitted to management and approved.

15.85.3. A non-molestation order and stalking protection order was discussed, but declined by Grace, who appeared fearful of repercussions. Clare’s Law³⁵ was also considered, but she chose to wait unless further concerns arose around the children. She was reminded she could contact outreach at any time.

15.86. 05 July 2023 - Grace contacted the outreach worker seeking advice on how to approach Daniel about finances, fearing an abusive and controlling reaction. She was advised to email her key points and involve a third party. Her grandfather agreed to attend.

15.87. 06 July 2023 - Police contacted Grace as part of a domestic abuse investigation. She initially expressed willingness to make a statement and attend court but later postponed the arranged appointment. After a period of no contact, she

³³ <https://survivingeconomicabuse.org/what-we-do/research-and-evidence/economic-abuse-a-global-perspective/>

³⁴ Gardening leave is where an employee is suspended on full pay.

³⁵ Also known as the Domestic Violence Disclosure Scheme (DVDS) is a police policy giving people the right to know if their current or ex-partner has any previous history of violence or abuse.

explained on 26 July that she had been busy and revealed she had informed Daniel of police involvement, which had led to a change in his behaviour. Although she declined to seek a non-molestation order, she admitted being afraid of Daniel and was concerned about how giving a statement might affect her mental health.

15.87.1. Following a supervisory review, police decided Daniel should be interviewed under caution. Grace supported this approach and was encouraged to provide a statement beforehand to help inform the interview, to which she agreed.

15.88. 13 July 2023 - Grace contacted the outreach worker, explaining that her family was pressuring her to report past abuse. She was due to speak with police and was advised to be honest about her fears and hesitations. Grace shared that Daniel had recently been kind to her and had urged her not to pursue formal child maintenance, proposing a private arrangement instead. Although Grace felt guilty, she was encouraged to proceed through official channels due to concerns he might not follow through. She was also advised to keep a log of incidents and agreed to use the Bright Sky app³⁶ to monitor any escalation in Daniel's behaviour.

15.89. 02 August 2023 - Grace was discharged from i-Access due to non-engagement and a copy of the letter sent to her GP.

15.90. 22 August 2023 - Grace commenced a six-week course of counselling with a domestic abuse specialist.

15.91. 06 October 2023 - During a telephone consultation with her GP, it was noted that Grace was receiving therapy for domestic abuse and that her therapist had requested a formal diagnosis of PTSD. Grace disclosed experiencing sexual assault and verbal abuse within her relationship. A diagnosis of PTSD was subsequently confirmed. She stated that counselling was helping and was encouraged to continue engaging with the support.

15.92. 13 October 2023 - Police visited Grace at home to collect video evidence she had agreed to share. During the visit, she disclosed a history of coercive control and emotional abuse by Daniel, beginning in 2016 and escalating after she started work in 2021. She described his increasing control over her friendships, phone use, and appearance, and disclosed developing anorexia and alcohol dependency as coping mechanisms. Grace also reported an incident of sexual abuse that led to a PTSD diagnosis, though she declined to discuss the rape in detail. She stated her domestic abuse therapist could corroborate her account.

15.93. 13 October 2023 - CMHRS received a referral from Mind Matters requesting treatment for complex trauma. An attempt was made to contact Grace by phone, but there was no response. The referral was accepted for assessment and consideration of the complex post-traumatic stress disorder (CPTSD) pathway. An appointment letter was sent to Grace on 23 October 2023, for an assessment scheduled for 14 November.

³⁶ The app has a covert option to look like a weather app but by pressing and holding the temperature sign, the user is taken to a secure platform of support, advice and recording keeping. Allows someone to store a journal or videos on a safe cloud.

15.94. 24 October 2023 - The investigating officer and domestic abuse caseworker visited Grace. She stated she supported Daniel's arrest and wanted to be believed but declined to discuss further details. Daniel was reportedly abroad at the time, but Grace expressed fear of him and raised concerns with child maintenance and contact. Occupation orders, child maintenance options and a domestic abuse kit were discussed.

15.95. 26 October 2023 - Grace attended the ED for alcohol withdrawal. She was found by a family member in bed, who was concerned and called 111, which in turn led to an ambulance being dispatched.

15.95.1. During her attendance, Grace disclosed that she was drinking 750ml of vodka daily and had attempted to reduce her alcohol intake without professional support, which resulted in withdrawal symptoms. She disclosed to the staff that she had been drinking excessively for several months.

15.95.2. Grace requested inpatient treatment to support her alcohol withdrawal, but was informed she did not meet the criteria for admission. Instead, she was advised to reduce her alcohol intake by ten units per week, a process that would take at least ten weeks to achieve complete cessation. Grace disclosed that she had two children currently staying with her grandparents. During her attendance, ED staff contacted CSC, and a referral was submitted on the next working day. CSC established a safety plan with the family. ED staff also referred the case to the Trust's alcohol specialist nurses.

15.96. 28 October - 03 November 2023: Grace attended the ED after experiencing vomiting and epigastric pain following the abrupt cessation of alcohol use. She was subsequently admitted to a ward for further treatment.

15.96.1. During her hospital stay, Grace was assessed daily by the alcohol liaison nurse. During an assessment, Grace disclosed a history of domestic abuse and a sexual assault. Referrals were made to i-Access, AEDS, CSC and relevant information was shared with the school nursing team. There was no record of signposting, or a referral made to domestic abuse services.

15.97. 28 October 2023 - Surrey County Council (SCC) MASH received a safeguarding concern from the ambulance service. The referral was reviewed, and it was concluded that it did not meet the Section 42 threshold.

15.98. 28 October 2023 - The CSC social worker made telephone contact with Grace who advised that the children were safe and staying with her grandparents.

15.99. 29 October 2023 - A witness to the incident on 30 June 2023 reported to police that they heard a man, believed to be Daniel, shouting about child contact before driving off. They stated Grace appeared distressed and had said she just wanted to be with Ashley.

15.100. 30 October 2023 - The CSC social worker received a report from the children's school, which noted no concerns about Grace's parenting. It was also reported that Grace had recently started a new job at the school. However, there

were concerns about how she would manage the role in light of current events. The social worker spoke to the children at school, and they appeared physically healthy and well cared for.

15.101. 30 October 2023 - i-Access received a self-referral from Grace. A telephone assessment offer letter and a text were sent to Grace and copied to her GP. Contact was made with Grace on 31 October who explained she was currently in hospital.

15.102. 31 October 2023 - The CSC social worker visited Grace's grandparents. During the visit, the grandparents disclosed that Daniel has had no contact with the children since the divorce. Although he initially provided some support, this ceased, and he went on to abuse Grace via phone.

15.103. 01 November 2023 - Grace contacted i-Access requesting an urgent appointment ahead of her expected discharge from hospital on 03 November, where she was undergoing alcohol detoxification.

15.104. 02 November 2023 - While Grace was still in hospital, the i-Access detox team completed an assessment by phone. She identified her triggers as alleged rape, sexual abuse and domestic violence by Daniel, and remained highly anxious despite her hospital admission. She had been informed she was in liver failure. Grace had previously engaged in private therapy which ended due to case complexity and domestic abuse counselling, both of which ended - the latter triggering increased alcohol use. The detox team planned to follow up after her discharge.

15.105. 03 November 2023 - The CSC social worker spoke with Daniel by phone. He had recently returned from abroad and was aware of the situation. Daniel said Grace informed him that her grandparents were caring for the children and that she had been admitted to hospital due to complications from her eating disorder, including liver failure and pancreatitis. She told him she would arrange for him to have the children for the weekend after her discharge. Daniel noted he usually had weekend contact with the children.

15.106. 03 November 2023 -Telephone call made to Grace by the i-Access detox team. She was returning to work on 06 November, and was still in a probationary period in her role and was concerned she would lose her job. She planned to attend AA meetings and had an appointment booked with CMHRS on 14 November for assessment.

15.106.1. The detox team called the children's social worker, who was in the process of assessing the case, as no child protection plan (CPP) was currently in place. A safeguarding risk assessment update was given, stating the children were staying with Grace's grandparents. Grace was to commence detox online intensive recovery sessions on 06 November 2023.

15.106.2. 03 November 2023 - Police spoke with Lisa, a friend of Grace, who reported they had bonded over shared experiences with eating disorders. Lisa stated that Grace had disclosed emotionally abusive and coercive behaviour by Daniel, including removing food from her and coercively offering to allow her to purge in

exchange for sex. Grace also described frequent shouting by Daniel and would sometimes contact Lisa when feeling unsafe; on those occasions, Lisa would collect her and take her for a drive.

15.106.3. Lisa recalled three occasions when Grace texted to say Daniel had attempted to have sex with her against her will. Although Lisa only met Daniel once and did not witness abuse directly, she had seen text messages in which Daniel accused Grace of gaslighting him. Lisa noted the children appeared well supported by the school, though Ashley had expressed concerns about Daniel's shouting and Grace's wellbeing.

15.107. 14 November 2023 - Grace attended an i-Access recovery group and reported beginning domestic abuse therapy the previous day. However, she felt revisiting past trauma was affecting her recovery and chose to focus on sobriety for now, considering DA therapy again when she felt stronger.

15.108. 14 November 2023 - Grace attended a new patient CMHRS assessment. She reported worsening PTSD symptoms triggered by domestic abuse counselling and an incident in July involving public verbal abuse by Daniel. Grace was using alcohol to cope and had disordered eating. She also had a history of childhood trauma, anorexia, AEDS and CAMHS involvement. Stressors included work suspension and child contact with Daniel. The MDT agreed to offer her a trauma pathway and place her on a waiting list for individual stabilisation skills. A referral was made to a local charity for further support.

15.109. 16 November 2023 - Grace engaged with i-Access via a telephone call, during which she discussed the recent loss of employment and expressed a desire to prioritise her recovery. A referral was made to a citizens advice worker to support her with practical matters. Grace expressed her feelings of overwhelm by the volume of check-in-calls.

15.110. 20 November 2023 - i-Access made telephone contact with Grace. She reported increased cravings but continued to attend AA meetings and had a sponsor. She also mentioned ongoing issues with Daniel regarding child support and noted that her grandparents can offer limited financial help.

15.111. 22 November 2023 - Telephone consultation with her GP. Grace requested a sick note to enable her to claim benefits as she had lost her job after her admission to hospital in October 2023.

15.112. 05 December 2023 - The i-Access key worker contacted CSC to report concerns about Grace's health and alcohol use. Grace disclosed drinking 350ml of vodka daily to manage vomiting, a harm reduction measure, but appeared intoxicated and in poor health. She stated Daniel had refused to care for the children and indicated she would ask a family member for help if her condition worsened.

15.112.1. The key worker attempted to contact a family member but did not speak to them. He reported that although Grace had been prescribed detox medication, she was not taking it due to continued alcohol use, raising concerns for the children's welfare.

15.112.2. CSC then contacted Daniel, who reported receiving a call from Grace's grandmother expressing concern. Daniel was on his way to collect the children as per the safety plan. The i-Access worker later confirmed Grace said she was not going to harm herself but noted she was intoxicated, incoherent and emotionally distressed. He was reassured that Daniel was taking over care of the children.

15.113. 06 December - 09 December 2023: Grace attended the ED, after vomiting clear fluid with streaks of blood and was subsequently admitted. She had been undergoing an alcohol withdrawal regime in the community but had stopped taking her medication, resulting in relapse. During her admission, she received treatment for acute withdrawal and was seen daily by the alcohol liaison nurse. She disclosed poor mental health, experiences of domestic abuse and reported that her private therapy sessions had been retraumatising. Grace remained engaged with her i-Access key worker. She self-discharged on 09 December. No safeguarding referrals were raised during this attendance.

15.113.1. There was no documentation to verify if the disclosure of domestic abuse was discussed further and/or signposting to local domestic abuse services. It was not clear if a referral to the SaBP psychiatric liaison team was considered. However, based on Grace's clinical presentation, she was unlikely to meet the criteria for assessment during this visit.

15.114. 10 December 2023 - The investigating officer contacted Grace to arrange for her statement to be signed. She advised the officer that she was in hospital and the children were with Daniel.

15.115. 12 December 2023 - The CSC social worker called Grace who informed her that the children were staying with Daniel until she was well enough to care for them again. Grace expressed that she wants the children back but was currently focusing on addressing her health issues.

15.116. 13 December 2023 - The investigating officer contacted Grace's private therapist, whom Grace had said would prepare a report regarding her therapy. The therapist responded that, following a discussion with Grace, she would not be providing a report as she had no direct knowledge of the incidents, only what Grace had disclosed during their sessions.

15.117. 13 December 2023 - Grace attended a face-to-face appointment with i-Access while intoxicated. She reported an increase in her alcohol intake to 750ml of vodka daily. She spoke about her hospital admission on 06 December and stated that she had continued drinking since her discharge on 09 December to stave off nausea. Grace disclosed that she had been inducing vomiting after eating, which she had since stopped, although she still had the urge to do so. She expressed a desire for support but noted that her current weight did not meet the threshold for referral to AEDS.

15.118. 13 December 2023 - CHMRS psychology check in call to Grace. She reported being in hospital recently due to a PTSD flare-up, which led to increased alcohol use. She was experiencing nightmares, panic attacks and avoiding social

plans, and hoping to start psychological therapy early in the new year. A follow-up was booked for January 2024.

15.119. 14 December 2023 - A children and family assessment was completed, and the case was closed to Level 4 services and stepped down to Level 3. The children were to remain in Daniel's care while Grace accesses support services.

15.120. 15 December - 19 December 2023: Grace attended the ED for alcohol withdrawal and was subsequently admitted to a ward. She was seen daily by the alcohol liaison nurse. During these visits, she reported that while progressing with her alcohol withdrawal programme, her PTSD symptoms were worsening. She stated she was due to begin therapy for PTSD in two weeks. At the time of admission, she reported that her children were in the care of their father and would remain with him until i-Access deemed it safe for them to return home. A referral was made to CSC.

15.120.1. During this visit, it was not known that the father of Grace's children was the perpetrator of her abuse. Best practice in liaising with the Trust Safeguarding Children Team would have been beneficial in terms of being able to gather additional information from CSC.

15.121. 20 December 2023 - The investigating officer arranged for Daniel to attend the police station on 29 December to be interviewed.

15.122. 22 December 2023 - i-Access attended a team around the family (TAF) meeting. Grace's children were now in Daniel's care, pending her ability to resume their care. Early Help had begun providing support for Daniel.

15.123. 29 December 2023 - Daniel voluntarily attended a police interview with a solicitor present. He answered all questions and denied allegations of rape, coercive control, stalking, or assault. He claimed these were false allegations made by Grace. He stated that Grace often went away for weekends, leaving him with the children and used her friendship with Lisa and social activities as support for her mental health and anorexia.

15.123.1. Daniel stated that sex was always consensual throughout their relationship and that they never had sex when Grace was intoxicated or asleep. In relation to the incident on 30 June 2023, Daniel said there was a disagreement over child contact, but denied driving aggressively or attempting to harm Grace.

15.123.2. Daniel acknowledged frequent arguments and heavy drinking during the COVID period but denied any physical violence. He stated that both had mutually agreed to use the "Find My Phone" app for safety purposes. He confirmed to the officer that he did not like Grace discussing their relationship with others, as she misrepresented him.

15.124. 31 December 2023 - Grace attended ED due to alcohol withdrawal. She had initially stopped drinking alcohol for 10 days but then resumed by consuming 700ml of spirits. On the day of her attendance, she had only consumed 200ml, which triggered withdrawal symptoms. She reported that this relapse was triggered by

Daniel, stating that she still maintains contact with him because of their children. A safeguarding referral was not completed during this attendance. There was no documentation of domestic abuse routine enquiry or signposting to local domestic abuse services.

15.125. 01 January 2024 - Grace attended the ED due to alcohol withdrawal symptoms, accompanied by David who was listed as her next of kin. She expressed having suicidal thoughts but clarified that she would not act on them. A referral to the SaBP psychiatric liaison team was made to discuss Grace's suicidal thoughts. Following the referral, the psychiatric liaison team contacted Grace's community mental health team to provide an update on her attendance and to discuss safety measures. A safeguarding referral was not completed on this attendance.

15.126. 02 January 2024 - Psychiatric liaison service (PLS) emailed CMHRS to report that Grace attended the ED on 01 January due to alcohol intoxication and fleeting suicidal thoughts. She declined assessment and was therefore not seen by PLS.

15.127. 03 January 2024 - Following the police interview with Daniel on 29 December 2023, the case was reviewed by a supervisor who concluded there was insufficient evidence to submit a file to the Crown Prosecution Service. It was also determined that there were no realistic opportunities to obtain further evidence. The information provided, including the videos submitted by Grace and the neighbour's account of the incident on 30 June 2023, did not support evidence of any criminal offences. Both Grace and Daniel were informed that the case would be filed.

15.128. 03 January 2024 - Grace attended a morning GP appointment and was showing the effects of alcohol consumption. Her children were living with Daniel, with Grace having some contact. She was due to be seen by i-Access on the Friday of that week; in addition, it was noted that she was due to start PTSD therapy, but she "needs to be sober" (Grace's words).

15.129. 03 January - 19 January 2024: During this period, Grace had contact with CMHRS on four occasions. She was in significant psychological and physical distress, with escalating concerns around her mental health, trauma, and substance use. She reported not eating or drinking for several days, experiencing seizures from alcohol withdrawal and continuing to drink alcohol intermittently. Grace disclosed experiencing nightmares linked to past trauma, suicidal ideation with an undisclosed plan and ongoing self-harming behaviours. Grace also expressed her fear of Daniel, reporting previous rape and violence by him. Her contact with CMHRS included a refusal to attend appointments in person, intoxication when seen by staff and a reluctance to engage in support.

15.130. 04 January 2024 - Grace attended the ED, accompanied by David, due to alcohol withdrawal. She appeared intoxicated and was slurring her words. She had not been eating and reported a worsening of her anorexia. Grace was assessed by the alcohol liaison nurse. A safeguarding referral was not completed. Staff liaised with the psychiatric liaison team, who agreed to update her AEDS care coordinator regarding her attendance. There was no evidence to suggest that routine enquiry for

domestic abuse was explored or professional curiosity regarding the safety of her children, and suitability of Daniel, her ex-husband in caring for them.

15.131. 05 January 2024 - Grace attended a face-to-face i-Access appointment while intoxicated, accompanied by David. She reported daily consumption of a bottle of vodka and two recent ED attendances following collapses related to alcohol use and not eating. She expressed a desire to abstain and was advised on managing withdrawal safely, including keeping a drink diary. She declined switching to wine due to concerns about calorie intake.

15.131.1. Grace had a previous diagnosis of pancreatitis, liver damage and heart issues, and reported that she was still not eating. A letter was sent to her GP (appointment scheduled for 10 January), requesting a referral to AEDS. Follow-up appointments were arranged: a medication review with the nurse on 09 January and a key worker session on 12 January. Grace did not attend the nurse appointment on 09 January, which was subsequently rebooked for 18 January.

15.132. 06 January 2024 - Grace attended the ED with alcohol withdrawal and suicidal ideation, reporting multiple collapses that day which she could not recall. She expressed a desire to die and stated she had refused to eat for 10 days, consuming only alcohol. She disclosed PTSD following a sexual assault 18 months earlier. During the visit, she was verbally aggressive towards a nurse and became frustrated while waiting for withdrawal medication, leading to self-discharge against medical advice. Although she initially agreed to see the psychiatric liaison team, she later stated she no longer felt suicidal. She left with David after the risks of self-discharge were explained. No safeguarding referral was completed.

15.133. 10 January 2024 - Grace contacted AEDS reporting that she had consumed only 500 calories over the past two weeks and felt her body was "shutting down". She was advised to attend the ED if unwell. Grace stated that she had attended ED on 06 January but left before receiving medication due to long waiting times. She also reported being unable to access a GP referral due to a lack of available appointments. She was informed that CMHRS could make the referral instead, and a referral form was sent to CMHRS by email.

15.134. 18 January: Grace attended an alternative ED with psychological distress, behavioural changes and symptoms consistent with mental illness. She was admitted to the emergency assessment unit and subsequently transferred to a ward. Grace was discharged on 23 January 2024.

15.134.1. The primary clinical concerns identified during her admission were alcohol withdrawal, a prolonged period without adequate food or fluid intake (six days), associated with a history of an eating disorder, abnormal liver function tests in the context of chronic alcohol use and pancytopenia (low levels of red and white blood cells and platelets), accompanied by low calcium levels. Referrals were made to ASC and CSC due to safeguarding concerns.

15.135. 18 January 2024 - Grace did not attend her medical appointment with the i-Access nurse. The key worker contacted Grace by phone; she appeared intoxicated and was at the ED due to not eating, pending a decision on admission

and detox. David was present. Later, the alcohol liaison nurse confirmed Grace was admitted for malnutrition. The key worker was to explore residential detox, rehabilitation and a professionals' meeting involving AEDS, CMHRS, and CSC, who had all been updated of her admission.

15.136. 19 January 2024: The hospital made referrals to ASC via the multi-agency safeguarding hub (MASH), and to the CSC team, due to safeguarding concerns.

15.137. 23 January 2024, a hepatology doctor (liver specialist) at the hospital requested an ultrasound of Grace's abdomen prior to her discharge. This appointment was scheduled for 31 January 2024.

15.137.1. Grace's GP was requested to repeat phosphate and liver function tests within one week of discharge, consider a referral to the liver services at a named hospital chosen by Grace, and to re-refer her to the eating disorders service. The hospital arranged a review appointment for Grace in three months' time, as well as outpatient investigations: a 24-hour electrocardiogram and a cardiac MRI scheduled for 24 April 2024.

15.138. 25 January 2024 - The hospital received a request from the GP for an abdominal ultrasound, this was cancelled as an appointment had already been booked for 31 January 2024.

15.139. 25 January 2024 - The i-Access detox team contacted Grace, who reported her relapse was triggered by news that Daniel would not be prosecuted for domestic abuse. She was attending AA meetings, an intensive recovery support group and had PTSD stabilisation therapy scheduled for 02 February 2024.

15.139.1. Grace had developed a significant cardiac issue and felt overwhelmed and a burden to everyone, though denied suicidal thoughts, citing her children as a protective factor. She was distressed over limited contact with her children, feeling Daniel was controlling access. Family support was strained, with a relative distancing and grandparents unwell. She was supported by David but remained cautious due to past domestic abuse. A referral was made to ASC for a care assessment, and a professionals' meeting was planned. A notification was sent out for a professionals meeting on 01 February 2024, which was held on 27 February.

15.140. 29 January 2024 - The GP had re-referred Grace to the eating disorders team. In April, the GP wrote again to expedite the appointment given Grace's admissions to hospital, with an appointment being offered for 20 May 2024.

15.141. 31 January 2024 - Grace attended an outpatient appointment at a named hospital for an abdominal ultrasound. The results, which indicated mild hepatic steatosis³⁷, were sent directly to the referring hepatology consultant. These results were not shared with Grace's GP.

15.142. February 2024 - Grace had frequent contact with i-Access throughout February, including multiple telephone check-ins, face-to-face key worker

³⁷ Mild accumulation of fat in the liver, commonly known as fatty liver.

appointments and attendance at recovery and support groups. She initially engaged well, maintained abstinence for a period and preparing to join relapse and SMART³⁸ groups. However, mid-month she experienced a significant relapse, including alcohol use and physical health decline. She continued to struggle with cravings, emotional triggers related to past trauma, and limited family support.

15.142.1. A professionals' meeting was held on 20 February between i-Access and Adult Social Care (ASC), and a referral was made to ASC for Grace to be considered for rehabilitation.

15.142.2. While no formal minutes of the meeting were recorded, notes indicated that a referral was made. However, there was no corresponding entry of this referral within i-Access' records. Adult social care informed the Review that they had no record of receiving the referral, and consequently no rehabilitation was provided to Grace. By the end of the month, Grace was drinking heavily again, and David was advised to seek emergency medical help due to her physical condition.

15.143. 21 February 2024 - GP telephone appointment with Grace to discuss abnormal liver function tests. A referral was made to hepatology for a liver ultrasound. Records indicate that no results were received by the GP in relation to the referral made on 25 January 2024. There was no evidence that the GP followed up with hepatology regarding the outstanding results, and no record that Grace underwent a further ultrasound prior to her death.

15.144. David informed the Review that Grace experienced two seizures in March 2024, during which she bit her tongue. Although Grace was initially reluctant to seek medical attention, David encouraged her to do so due to concerns about a possible infection. He advised her to at least contact her GP. Two days later, Grace called her GP, who recommended that she attend the ED.

15.145. March 2024 - Grace had ongoing and frequent engagement with i-Access in March, including key worker calls, a face-to-face appointment and attempted group attendance. Despite periods of abstinence, she experienced further relapses, seizures, and hospital admissions following self-detox attempts against medical advice. Her alcohol use remained unstable, with documented high-risk behaviour and fluctuating physical health. A professionals' meeting was held to coordinate support, highlighting repeated patterns of heavy drinking, unplanned detox and emergency care. Referrals were made for intensive detox support and relapse prevention. Family contact arrangements were reviewed due to concerns about children's exposure to her condition. A follow-up appointment was scheduled for early April 2024.

15.146. 01 March 2024 - Grace requested a telephone appointment in place of a face-to-face session with CMHRS. She had been in bed all week, supported by David, and admitted to drinking alcohol that day. She reported being incontinent due to extreme fatigue. Grace described a distressing argument with Daniel, who blamed her for the abuse and stated he had "got away with it" after police dropped charges.

³⁸ Helps participants decide whether they have a problem, builds up their motivation to change and offers a set of proven tools and techniques to support recovery.

This led to her not eating for six days. While she denied suicidal intent, she expressed emotional distress, saying she “can’t live with her brain” and wanted the pain to stop. The clinician discussed the impact of alcohol and poor nutrition on therapy, and Grace expressed commitment to attend future sessions sober.

15.147. 15 March 2024 - Grace attended the ED. She reported resuming alcohol consumption after three weeks of detoxification. David found her severely intoxicated, doubly incontinent and not having eaten for one week. An information sharing form was completed, and the children’s safeguarding team liaised with the children’s allocated social worker. The GP was requested to repeat phosphate and liver function tests in one week, consider a referral to liver services at a named hospital, and refer Grace back to the eating disorders service.

15.147.1. David described Grace’s hospital visit on 15 March 2024 as particularly traumatic. Grace was admitted with dangerously low electrolyte levels. She was placed on a bed in a corridor for most of the day, and although a drip was administered, she was discharged before receiving the full course of treatment.

15.147.2. David objected, stating that Grace could barely walk and was not fit to be sent home. The doctor advised that she continue therapy with i-Access, despite i-Access being the service that had referred her to hospital. Grace was devastated by this experience and subsequently refused to attend further hospital appointments.

15.147.3. Two days later, Grace suffered two seizures. According to David, Grace’s GP confirmed that these were the result of critically low electrolyte levels - an issue that could likely have been prevented had she completed her hospital treatment.

15.148. 20 March 2024 - Grace attended the ED with an infected tongue bite, sustained during two seizures that occurred two days earlier. Her partner, David, witnessed the seizures and placed her in the recovery position. Grace reported that David did not want her to seek medical attention. Her GP advised her to attend the ED following a phone consultation. During her visit, a nurse privately assessed Grace’s safety due to concerns about David discouraging her from seeking help. Grace reassured the nurse that she felt safe with David. Blood tests revealed an electrolyte imbalance, believed to be the cause of the seizures. She was advised to return if symptoms recurred.

15.149. 27 March 2024 - A referral was made to Surrey County Council (SCC) by a named hospital requesting a follow-up by the central duty team. The referral related to alcohol dependence and withdrawal seizures, with Grace’s latest admission involving a tongue injury. She was engaging with i-Access. Grace had relapsed with her eating disorder and was on the AEDS waiting list. The hospital assessed that Grace had treatment needs for alcohol use, eating disorder and complex post-traumatic stress disorder (CPTSD), but no identified social needs. Her children were with their father, which had triggered her relapse. Referrals were made to SCC mental health and substance misuse social care teams for joint assessment.

15.150. 28 March 2024 - The referral from SCC mental health locality to the SCC substance misuse team was acknowledged, and plans were made for a joint

assessment. The ASC social worker contacted Grace for an initial discussion, she was out and agreed to speak later.

15.150.1. In a later call, Grace explained she had been hospitalised due to low electrolytes and seizures caused by alcohol withdrawal. She described a trauma-related relapse and stated she was receiving support. Grace said she struggled to leave home due to anxiety, was unable to meet her activities of daily living (ADLs) when unwell and agreed to a Section 9 care assessment³⁹.

15.151. 28 March 2024 - Grace attended a CMHRS psychology appointment. She reported feeling much better and stated that the initial trigger related to Daniel was being managed with support from i-Access and her family. However, both Grace and Daniel had declined advice from family services to use a professional third party for child handovers, despite Grace acknowledging the risks and recognising Daniel as a potential trigger. She expressed satisfaction with how they were currently managing the situation. A crisis plan was initiated, and her i-Access key worker was updated.

15.152. 02 April 2024 - At the i-Access MDT, concerns were raised about the children visiting Grace while she may be intoxicated. CSC advised supervised contact, though Early Help planned to close the case. Grace was engaging with CMHRS and remained on the AED service waiting list and was offered intensive recovery support once abstinent.

15.153. 04 April 2024 - i-Access received an email from CSC advising that they have closed their involvement with the family.

15.154. 16 April 2024 - A social worker from ASC had a telephone conversation with Grace. She described feeling “up and down” but was engaging with i-Access. Grace had supervised contact with her children, who were living with their father. An appointment for a joint Section 9 assessment was arranged for 14 May at Grace’s home.

15.155. 19 April 2024 - Grace attended the first of eight stabilisation sessions with CMHRS accompanied by David. She reported increased flashbacks, hallucinations, and nightmares, though she did not link these to therapy. She found staying with David helpful due to trauma associations with her home. Grace expressed frustration with i-Access, feeling judged as a parent after CSC was involved. She declined an offer from her psychologist to attend an i-Access appointment with her but was encouraged to speak with her key worker if finding it difficult to work with him. Three models of understanding the brain’s reaction to threat were introduced, which Grace found helpful.

15.156. 24 April 2024 - Grace did not attend her scheduled cardiology appointment at a named hospital. No follow-up was made with Grace, although a letter was sent to her GP advising of her non-attendance.

15.157. 26 April 2024 - Grace attended her second stabilisation session with CMHRS. She reported feeling unwell due to alcohol withdrawal and had cancelled a

³⁹ Assessment for adult care and support needs.

recent i-Access appointment, although she continued to monitor her alcohol intake. She had been unable to see her children because of her health. Grace agreed for her psychologist to attend her next i-Access appointment. She also disclosed that Daniel had threatened to deny her access to the children if she spoke to professionals about his past abuse.

15.158. David informed the Review Chair that Grace's therapy was paused in May 2024, as these sessions were exacerbating her distress and increasing her alcohol intake. While David agreed that the decision was appropriate, he believed that these sessions had already taken a significant toll on Grace's mental health.

15.159. 03 May 2024 - Grace did not attend her third stabilisation session with CMHRS due to detox symptoms and vomiting. A rescheduled appointment on 07 May was also missed due to train strikes, despite the psychologist's attempts to find alternatives. The psychologist confirmed they would attend Grace's i-Access appointment on 09 May, but she did not attend that either. Following the third missed appointment, her case was scheduled for discussion at the multi-disciplinary team (MDT). After a further call on 23 May, it was agreed that Grace needed to focus on her physical recovery first, and she was discharged from the service.

15.160. 08 May 2024 - Grace's GP spoke with both Grace and her case worker at i-Access. Her engagement with i-Access had been inconsistent, making it difficult for the service to support her effectively. A new referral to CSC was made by i-Access, as it had come to light that Grace was having unsupervised contact with her children, despite this not being permitted.

15.161. 14 May 2024 - The ASC worker completed a Section 9 assessment at Grace's home. She shared her history of trauma and a coercive marriage. Her children were her priority, and she aimed to create a safe environment for them to return home. Grace was well-presented and her home was immaculate. She intended to return to work and was supported by David. Grace was engaging with i-Access for alcohol use and the CMHRS for trauma and her eating disorder.

15.161.1. The assessment concluded that Grace's needs were treatment-based and did not meet the threshold for care and support needs. The case closure was submitted for approval, and Grace was closed to the service on 30 May 2024.

15.162. 24 May 2024 - Grace attended a face-to-face appointment with her i-Access key worker. She disclosed that she had received a phone call from Daniel, during which he told her not to speak to CSC about him and warned that, if she did, he would prevent her from seeing the children. Grace also shared that Charlie was reluctant to leave her home at the end of visits.

15.163. 10 June 2024 - A telephone call was made to Grace by the domestic abuse advisor within the C-CPA. Grace stated that she did not feel additional support was necessary but consented to signposting. Concerns remained regarding Grace's alcohol use; however, she was currently receiving support and maintained supervised contact with the children. As suitable advice had been provided and relevant support was in place, the case was closed, with no further role for CSC at this stage.

15.164. David had reported several concerns to the Review Chair regarding the care Grace received from i-Access.

- ◆ Grace disengaged from i-Access and often refused to communicate with them, particularly after feeling let down by the support she received.
- ◆ She was assigned a male key worker when she self-referred in October 2023, and despite repeated requests for a female key worker, due to trauma linked to her abusive marriage, this request was never fulfilled.
- ◆ A significant breach of confidentiality occurred when information from Grace's drink diary, intended to be private, was shared with CSC, who subsequently shared it with her ex-husband, Daniel. This led to serious threats against Grace and caused a breakdown in trust. Although i-Access later issued an apology, no clear explanation was provided.
- ◆ Grace was repeatedly asked to recount traumatic events during appointments with different professionals. Being required to revisit these experiences multiple times was deeply distressing for her and contributed to her reluctance to engage with further medical or therapeutic support.

Month of Grace's death - July 2024

15.165. AEDS discussed a referral with Grace's i-Access key worker. Concerns were noted about her vomiting, drinking on an empty stomach, poor nutrition, and limited engagement with alcohol treatment. i-Access noted that she was not fully able to engage with treatment at this time and would be referred to a different group to better address her current difficulties. It was noted that her children were with their father and contact should be supervised. CMHRS had discharged her as alcohol use and eating issues were barriers to psychological therapy. AEDS subsequently discharged Grace.

15.166. David informed the Review that in the days leading up to Grace's death, she had not been eating and was drinking around half a bottle of vodka daily. David stated that a disagreement with Daniel, her ex-husband, regarding child access had triggered this relapse.

16. ANALYSIS

16.1. The Review panel has checked that the key agencies taking part in this Review have Safeguarding and Domestic Abuse Policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

16.2. Eight agencies/organisations have provided Individual Management Reports (IMRs), detailing relevant contacts with Grace, Daniel, Ashley and Charlie. In addition, three reports were received relating to Grace.

16.3. The Review panel has considered each carefully to ascertain if interventions, based on the information available to them, were appropriate and whether agencies acted in accordance with their set procedures and guidelines. Good practice has been acknowledged where appropriate.

16.4. The lessons learned and recommendations/action plans to address them are listed in Sections 18 and 19 of this report.

16.5. The following is the Review Panel's analysis of the agencies/organisations interventions:

Frimley Health NHS Foundation Trust (FHFT)

16.6. Between August 2022 and March 2024, Grace had numerous emergency department attendances. While there were examples of good practice, there were also notable missed opportunities in safeguarding and multi-agency coordination.

16.7. At an attendance for alcohol withdrawal in August 2022, Grace disclosed she worked in a school. Best practice would have included professional curiosity, liaison with the safeguarding children team, and consideration of a referral to the Local Authority Designated Officer (LADO). Further enquiry could have explored whether her employer was aware of her circumstances or providing support. Some multi-agency working occurred, but further improvement was needed.

16.8. In October 2023, a doctor took a "think family" approach during an ED attendance, identifying that Grace had two children living with her and recognising the impact of her alcohol misuse. This led to immediate contact with Surrey's out-of-hours children's services team and a safeguarding referral the next working day, enabling a community safety plan.

16.9. Throughout this time, Grace received consistent support from the alcohol liaison nurse service. She was referred to i-Access and the community dietetic team for ongoing support prior to her discharge in November 2023.

16.10. Despite these instances of good practice, safeguarding concerns were sometimes overlooked due to the focus on Grace's clinical needs, particularly withdrawal symptoms. There was insufficient recognition of self-neglect as a safeguarding concern, and referrals regarding her children were not consistently submitted.

16.11. Throughout her ED attendances, Grace was open about her experiences of alcohol misuse, PTSD, anorexia, and historic abuse, including domestic and sexual abuse by her ex-partner Kevin. While these disclosures were documented, they were not routinely explored, and domestic abuse was only directly addressed at her final ED attendance in March 2024, in relation to her current partner, David. More consistent routine enquiry could have facilitated earlier disclosure and support.

16.12. Despite the availability of the hospital Independent Domestic Violence Advocate (IDVA) service, Grace was never referred. This may have been attributed to inconsistent IDVA presence due to staffing shortages and limited staff awareness or confidence in the referral process. Although an internal domestic abuse bulletin had been circulated, not all staff may have had regular access to it.

16.13. As Grace's mental health declined, she had several contacts with, and one referral to the Surrey and Borders Partnership (SaBP) psychiatric liaison team. On

some occasions, Grace chose not to engage with the support offered. She attended the emergency department on two occasions expressing suicidal ideation, but self-discharged both times. In each instance, the psychiatric liaison team notified her community mental health team.

16.14. Given Grace's involvement with multiple agencies (FHFT, i-Access, community mental health services and GP), there were missed opportunities to hold a multi-disciplinary team (MDT) meeting to coordinate care and safety planning. The FHFT adult safeguarding team was not alerted to her repeat presentations, and no referral to Adult Social Care was considered, which could have identified her care and support needs, including those relating to self-neglect.

16.15. At her final ED attendance on 20 March 2024, Grace presented with a tongue injury following a seizure. Staff noted that her partner, David, had not sought medical help. Due to concerns that he may have discouraged her from seeking care, a nurse spoke with Grace privately. Grace reported feeling safe. The nurse demonstrated good practice through professional curiosity and routine enquiry.

Recommendations have been made by the IMR author.

Named School (1)

16.16. Grace was employed as a learning support assistant from 19 April 2021 to 31 August 2023. Prior to starting, an occupational health assessment confirmed a history of stable insomnia and anxiety, with no impact on her capacity to work. She was deemed fit for employment.

16.17. The school was aware of a strained or possibly estranged relationship with Grace's parents, as she listed another family member as her emergency contact. Grace had frequent health-related absences throughout her employment, supported by medical certificates. There were no known indicators of domestic abuse until June 2023, when a colleague, during an internal conduct investigation, reported that Grace had disclosed police involvement following abuse by her partner, Kevin, who also used drugs.

16.18. Throughout Grace's employment, the school provided significant support for Grace's wellbeing, including flexible working hours, counselling support, eating disorder strategies, workload adjustments and a phased return after absence.

16.19. During the investigation in June 2023, Grace was treated with sensitivity, and support was provided to her throughout. She was suspended on full pay pending the outcome and informed of her right to representation. The school made a referral to the Local Authority Designated Officer (LADO) and signposted Grace to Education Support and her domestic outreach worker. During her suspension, the school continued to maintain regular wellbeing visits as part of their supportive approach.

No recommendations have been made.

Named School (2)

16.20. Grace began working at the school in September 2023 as a home school link worker. She initially settled in well and presented positively, but later disclosed ongoing personal difficulties, including issues within her marriage, child contact arrangements with her ex-husband, and a strained relationship with her parents. An increase in sickness-related absences led to meetings with her line manager and senior staff to explore support options.

16.21. In October 2023, Grace was admitted to hospital. Her line manager remained in contact with the hospital, and concerns were raised by family members caring for her children about her longstanding issues and general wellbeing. Although Grace initially attributed her hospitalisation to food poisoning, a Children's Social Care worker later confirmed it was due to alcohol withdrawal. Grace had previously disclosed alcohol misuse but stated she had completed rehabilitation via i-Access, was abstinent and in recovery.

16.22. While Grace was in hospital, a referral was made to children's social care regarding concerns for her children, consistent with previous child protection concerns from their former school. Due to Grace's safeguarding role, internal meetings were held to assess her capacity to continue in post.

16.23. Grace returned to work on 13 November 2023 but was suspended pending investigation due to inconsistencies between her account and information from external agencies, raising concerns about her fitness for the role. The school followed safeguarding and employment procedures and provided support, including help with her children's school attendance, in-school support for the children, and a home safety visit. The school also maintained ongoing contact during her suspension to support her wellbeing and response to the allegations.

16.24. In December 2023, children's social care continued assessments and visited the children in school. Following the termination of Grace's contract due to non-completion of probation, she withdrew her children from the school. A transition meeting took place involving the new head teacher, a social worker, a charity worker, and the children's father, who had assumed primary care.

16.25. Grace continued to receive remuneration beyond her official end date to support her financially.

No recommendations have been made.

Royal Surrey NHS Foundation Trust (RSFT)

16.26. Grace's admission in January 2024 was managed promptly and appropriately, with professionals recognising the seriousness of her presentation and ensuring she received urgent inpatient care. The hospital admission allowed her complex needs to be addressed holistically, with attention given not only to alcohol withdrawal but also to her eating disorder, nutritional deficiencies, and abnormal blood results. Dietetic support was offered, and cardiology follow-up was arranged for 24 April 2024, demonstrating a thorough and multi-disciplinary approach to her

care. Alongside the clinical focus, safeguarding needs were also identified, with referrals made to Adult Social Care via MASH and to Children's Services to ensure her vulnerability and the welfare of her children were considered.

16.27. The alcohol liaison nurse demonstrated good practice by contacting i-Access directly to support continuity of care. Grace's GP was requested to follow-up blood monitoring, re-referrals to specialist services, and advised on ongoing management following her hospital admission. This information sharing across primary, secondary, and specialist services demonstrated good coordination of care and oversight of Grace's health risks.

16.28. On 31 January 2024, Grace attended an outpatient appointment for an abdominal ultrasound. As the referring clinician, the hepatology doctor would normally be responsible for receiving the results and communicating these to the GP. However, because the scan took place after Grace's discharge, the results were not included in the discharge summary. The report was subsequently uploaded to the Surrey Care Record, making it accessible to the GP once Grace disclosed that she had undergone the scan.

16.29. It was noted by the report writer that, on review of Grace's abdominal ultrasound, no abnormalities were detected with her liver at that time, other than a mild fatty liver. *"The British Liver Trust noted that mild fatty liver is reversible and at this stage, there was no serious damage or scarring. Fatty liver can be completely reversed if the underlying cause is removed; however, if fat continues to build up, it may progress to the next stage of liver disease"*.

16.30. When Grace relapsed in March 2024, emergency staff not only treated her acute presentation but also ensured safeguarding concerns were addressed, liaising directly with the children's allocated social worker.

16.30.1. Grace received a full assessment by the Alcohol Liaison Team and Emergency Department (ED) staff, with discussion involving the ED Consultant on Call. Records confirm that hospital admission was not required for alcohol withdrawal, and a community-based plan with i-Access was in place to manage withdrawal safely, reintroduce food and fluids, and support her recovery. Grace remained in the ED for around 11 hours, was discharged appropriately, and follow-up arrangements were communicated to her GP, including referrals to the Liver Services Team and Community Eating Disorders Team.

No recommendations have been made.

South West Surrey Domestic Abuse Service (SWSDAS)

16.31. Grace self-referred to SWSDAS in March 2022, following the end of an abusive relationship with her husband, Daniel. Over the next 18 months, she engaged periodically and received emotional support, counselling, safety planning, and practical advice.

16.32. During this time, she experienced two abusive relationships, first with Daniel and later with Kevin, whose behaviour was coercive and sexually abusive. Her

experiences reflected a complex, prolonged pattern of abuse, compounded by mental health difficulties, substance misuse, and safeguarding concerns involving both herself and her children.

16.33. From the outset, Grace disclosed coercive control, Daniel's suicidal ideation, her own mental health and eating disorder, prompting early safeguarding action, including safety planning and discussion of police involvement and supervised child contact.

16.34. SWSDAS demonstrated strong multi-agency working, including effective information sharing with police and wider services. Coordinated support included school outreach, legal advice, and multi-agency discussions.

16.35. Support was trauma-informed and person-centred. A trusting relationship was built through regular, flexible check-ins that maintained engagement. Safety plans were regularly reviewed, and she was encouraged to consider non-molestation orders and a Clare's Law application.

16.36. Digital safety tools such as the Hollie Guard and Bright Sky app were promoted. Grace's reluctance to involve the police or pursue child maintenance was respected, and she was supported to make informed decisions and manage child contact through third parties.

16.37. It was recognised Grace likely experienced more abuse than disclosed. Her fears about Daniel's arrest limited engagement with DASH risk assessments, resulting in a consistent "medium risk" rating between March 2022 and July 2023. This may have underestimated her situation, potentially missing the threshold for a MARAC referral and a more coordinated safeguarding response.

Recommendations have been made by the IMR author.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

16.38. Grace had a long history of engagement with SaBP services from 2011 to 2024, including involvement with Child and Adolescent Mental Health Service (CAMHS), Adults Eating Disorder Service (AEDS), i-Access, Mind Matters, Community Mental Health Recovery Service (CMHRS), Single Point of Access (SPA) and Safe Haven.

16.39. In December 2021, Grace disclosed to AEDS that Daniel became increasingly controlling after she gained independence through work and only sought help for her eating disorder under pressure from her friends. These disclosures were not explored as potential indicators of domestic abuse.

16.40. On 07 March 2022, Grace informed AEDS she had asked Daniel to leave the family home and described long-standing hostility from his mother, which she believed was racially motivated. She also disclosed sexual abuse by Daniel during their marriage. While domestic abuse advice was given and referrals made to MASH and C-SPA, there was no evidence her ethnicity was considered or that AEDS

engaged directly with domestic abuse services. A more proactive response may have been beneficial.

16.41. On 15 March 2022, AEDS raised concerns about Grace's capacity to care for her children and noted the children were aware of the abuse. However, a mistaken referral was made to Mind Works instead of Surrey County Council's C-SPA. Mind Works declined the referral and advised contact with social care, but no evidence confirms this occurred. The confusion was attributed to similar terminology between services and was an issue seen in other cases, leading to updated staff guidance.

16.42. In April 2022, Grace self-referred to i-Access. While the domestic abuse risk assessment acknowledged previous abuse by Daniel, the risk of post-separation abuse, especially given their shared parenting, was not identified.

16.43. 06 June 2022 - Grace reported to AEDS that she had self-harmed following a distressing exchange with Daniel. She was advised to speak to her domestic abuse worker, but no further exploration of the incident took place.

16.44. In January 2023, Grace disclosed to AEDS she had entered a new relationship (with Kevin). Despite her history of abuse, no risks associated with the new partner were explored.

16.45. 13 March 2023, Grace informed i-Access about a police-involved incident involving her new partner. Although a domestic abuse risk assessment was completed, the issue was not pursued further. CSC and police were reportedly aware.

16.46. 20 March 2023, i-Access attended a strategy meeting with CSC, but there were no further details or notes from this meeting available on record. There was, however, evidence of ongoing contact between i-Access and the children's social worker later in the month.

16.47. 16 November 2023 - i-Access referred Grace to their citizen's advice worker due to Daniel not paying child maintenance. This was not recognised as an indicator of economic abuse in the context of post-separation abuse.

16.48. 13 December 2023 - Grace described a flare-up of PTSD symptoms and increased alcohol use to CMHRS, which resulted in a hospital admission. She referred to alcohol as her "safety net." There was no evidence that this disclosure was explored in relation to the risks to her safety or its impact on her mental health and wellbeing, particularly in the context of her experiences as a domestic abuse survivor.

16.49. 27 March 2024 - i-Access attended a professionals meeting, where it was noted that contact with Daniel was a trigger for Grace and that child contact was taking place at a contact centre.

16.50. 28 March 2024 - Grace told CMHRS that although she was aware of the advice to involve a professional third party in handovers, she was satisfied with the current arrangement. Describing contact with Daniel as a trigger for Grace placed

the emphasis on her response, rather than on Daniel's abusive behaviour. While this was likely not i-Access's intent, it highlights the importance of language and the need to ensure accountability remains with the perpetrator. Grace's comment that she was satisfied with the handover arrangements may have been influenced by threats from Daniel, which later came to light, and could reflect an attempt to avoid further professional involvement.

16.51. 26 April 2024 - Grace disclosed to CMHRS that Daniel had called, warning that if she continued speaking to professionals about "what he did," he would stop her from seeing the children. On 24 May, Grace told i-Access that Daniel had again called, this time instructing her not to speak to social services about him or he would prevent her from having access to the children. There was no evidence these disclosures were recognised as indicative of post-separation abuse.

16.52. Despite these gaps, there was strong multi-agency communication, with appropriate information sharing and adherence to confidentiality protocols, particularly ensuring Daniel was not informed of Grace's disclosures. i-Access remained engaged with Grace despite her difficulties in maintaining contact and supported her towards abstinence. Effective coordination was evident between i-Access, CMHRS, and AEDS, particularly around her discharge, which was managed in line with correct procedures.

Recommendations have been made by the IMR author.

Surrey Child and Family Health HCRG

16.53. Grace received health visiting services from Central Surrey Health (CSH) between December 2014 and October 2018, linked to the births of her children, Ashley and Charlie. Initially offered a universal plus service due to concerns about her mental health, Grace was later stepped down to universal services. Domestic abuse was explored during routine assessments. Grace denied any experience of domestic abuse during both Ashley and Charlie's early health visits, though the enquiry post-Charlie's birth was initially limited by Daniel's presence.

16.54. The final contact with CSH Children's Services was a transfer-in visit in October 2018 after the family moved to an area in Woking. No safeguarding concerns were identified, and the family continued to receive universal services.

16.55. During the DARDR timeframe, there was no direct engagement with Grace or her children by CSH. However, CSH participated in a multi-agency strategy meeting on 20 March 2023, convened due to concerns around Grace's alcohol misuse and its impact on parenting. This led to a single-agency Section 47 enquiry and a Child and Family Assessment, which concluded in June 2023. CSH's 0–19 Service was updated but did not engage further, consistent with practice for families not receiving targeted support.

16.56. From October 2023 to March 2024, CSH was notified of several ED attendances related to Grace's alcohol use. These were recorded in her health records but not shared with the children's school nurse, in line with standard

protocol. During these attendances, the children were reportedly in the care of their father or Grace's grandparents.

16.57. Areas identified for improvement:

- Minimal information or engagement regarding Daniel, the children's father, reflecting a broader systemic issue of under-involvement of male carers, as highlighted in the 2021 "Myth of Invisible Men"⁴⁰ report.
- Fathers not routinely included in clinical systems unless receiving targeted services, due to information governance constraints.
- Reduced school nursing capacity and a lack of school or adult safeguarding team liaison limited support and missed opportunities for early intervention.
- Limited professional curiosity around the impact of Grace's deteriorating mental health, alcohol misuse, and parental separation on the children.

16.58. CSH has since implemented safeguarding prompts in children's supervision templates, 'Think Family' training for adult and children's practitioners, and a 'Think Family' 7-minute briefing with supporting guidance and training, which includes fathers and male carers in assessments.

Recommendations have been made by the IMR author.

Surrey County Council Adult Social Care (ASC)

16.59. Grace was not known to ASC prior to the safeguarding referral in March 2022, despite a history of trauma, fluctuating mental health and an eating disorder. On reviewing the referral from AEDS, MASH assessed that Grace's primary needs related to treatment for these issues. Attempts to gather collateral information were hindered by MASH staff not having access to SaBP's system, Systm1.

16.60. As the decision was made not to initiate a Section 42 enquiry on the grounds that Grace was deemed able to protect herself, there was no indication that a referral was made to Surrey County Council Mental Health Central Duty team (CDT) for a Section 9 assessment. Such an assessment, or a Section 11.2(b) if she was willing to engage, could have provided a more accurate understanding of whether Grace had care and support needs, or whether such needs were apparent.

16.60.1. MASH's decision making was not unreasonable given the information available, but their analysis and hypothesising appeared limited. Grace was managing multiple difficulties linked to trauma, domestic abuse and caring responsibilities for two young children - all likely to affect her ability to function and manage her daily living. A referral to CDT should have been made.

16.61. On 14 May 2024, a joint Section 9 assessment by the mental health locality team and the substance misuse social care team was completed. However, it failed to consider Grace's four-year history of involvement with health, social care, and

⁴⁰https://assets.publishing.service.gov.uk/media/6141e34f8fa8f503bc665895/The_myth_of_invisible_men_safeguarding_children_under_1_from_non-accidental_injury_caused_by_male_carers.pdf

domestic abuse services. At the time of assessment, Grace was articulate, and her home environment was described as immaculate. She showed motivation to address her mental health, substance misuse and regular eating disorder relapse.

16.62. The response from community-based services was generally adequate, though there was scope for improvement. The social worker involved in the safeguarding enquiry, later reflected that with hindsight, they could have initiated a multi-agency risk management approach, completed a Section 9 assessment at the earliest opportunity and have been more proactive in seeking face-to-face contact with Grace. It was also acknowledged that Grace's relationship choices could have warranted consideration from a mental capacity perspective, although no concerns were identified during conversations with her.

16.63. Staff were familiar with domestic abuse and safeguarding processes, yet there was no evidence that a MARAC referral was considered or that prior MARAC involvement was explored. This highlights the need for community teams to regularly review their domestic abuse responses and understand referral pathways to specialist services.

16.64. The Section 42 enquiry pursued in the community was of a good standard, demonstrating personalised safeguarding practice focused on meeting Grace's stated outcomes. The Section 9 assessment was strength-based, clearly recording Grace's priorities and wishes. There was evidence of effective collaborative working between mental health and substance misuse social care teams. Throughout, social care staff were respectful of Grace's right to self-determination while remaining persistent in following up safeguarding concerns.

Recommendations have been made by the IMR author.

Surrey County Council Children's Social Care (CSC)

16.65. The family were known to the service from 2022, following a referral from Surrey and Borders Partnership (SaBP). Grace and her family were initially offered Level 3 (Child in Need) support, with appropriate information sharing between CSC, health and education. The case was discussed at the daily domestic abuse meeting, demonstrating effective early inter-agency collaboration between police SPA, children's SPA, and the C-SPA domestic abuse advisor.

16.66. As support progressed, a team around the family meeting and ongoing family network meetings were convened to coordinate multi-agency support, including health, i-Access, and domestic abuse services. Alcohol dependency emerged as the primary concern affecting Grace's parenting, with her eating disorder and mental health also addressed within assessments. Relevant support services were in place, and direct work was undertaken with the children both at home and school.

16.67. The case was later escalated to Level 4 (Child Protection) support as concerns increased. While police involvement was noted, the extent and nature of information sharing after CSC became involved was unclear.

16.68. There was a notable lack of professional curiosity at both levels 3 and 4 regarding domestic abuse by Daniel that Grace disclosed.

16.69. Additionally, the absence of recorded minutes from the team around the family and family network meetings represented a significant failing, hindering continuity and the ability to evaluate the effectiveness of support provided.

Recommendations have been made by the IMR author.

Surrey Heartlands Integrated Care Board (ICB) - On behalf of GPs

16.70. Grace had been registered with her GP practice since 2018 and was known to have a longstanding history of mental health issues and alcohol misuse, dating back to her teenage years and predating the timeframe of the Review. Correspondence from SaBP referenced significant childhood trauma and a period of homelessness during adolescence.

16.71. March 2022 - September 2022: Grace's contact with the practice during this period was largely related to her engagement with the AEDS for Atypical Anorexia Nervosa. She attended regularly for blood tests and ECGs, as requested by the AEDS team, and was issued work certificates as needed. AEDS initially signed her off work, followed by a phased return prior to the school summer holidays in 2022. She returned to work fully in September 2022 but soon began to experience panic attacks and a worsening of her longstanding depression.

16.72. September 2022 - The first mention of domestic abuse was on 08 September. At that time, Grace was separated from Daniel, the perpetrator of the abuse. The GP noted that she was receiving counselling for post-traumatic stress disorder in relation to the abuse. There was no mention, either at this point or in subsequent contacts, of any referral to, or engagement with domestic abuse outreach services. Earlier discussions about the role of such services may have enabled Grace to access more specialist and holistic support. Over the next 6 months, Grace was seen by SaBP services for eating disorders, substance misuse and talking therapies.

16.73. October 2023 - May 2024: During this period, Grace had fourteen GP appointments involving seven different clinicians. Notably, between November 2023 and April 2024, seven of these appointments were with the same GP, reflecting the practice's efforts to establish and maintain continuity of care. Grace was also receiving input from several specialist services, including the eating disorders team, i-Access and mental health services.

16.74. Good communication was noted between the GP practice and Grace's key worker at i-Access. The telephone consultation on 08 May 2024 showed concerns raised were openly discussed and acted on appropriately. i-Access and the GP practice worked together to support Grace's engagement, as by then her alcohol consumption was causing significant damage to her physical health.

16.75. Early 2024: Grace's physical and mental health significantly deteriorated. Her liver function was severely impacted by ongoing alcohol use, and she was referred

for a specialist liver assessment at a named hospital. She experienced seizures, prompting a referral to neurology. Grace was also admitted to hospital on several occasions due to refeeding syndrome - a potentially fatal metabolic complication that can occur following reintroduction of nutrition after a period of starvation. Individuals experiencing mental ill health are particularly susceptible to refeeding syndrome, often in the context of self-neglect, eating disorders or substance misuse.

16.76. Following receipt of Grace's hospital discharge summary dated 01 January 2024, an appointment was scheduled with her regular GP for 03 January. On 27 February, she was seen by a GP who had not previously been involved in her care; this GP arranged a follow-up appointment with her regular clinician for the following day. Over this period, her regular GP arranged multiple follow-up appointments.

16.77. July 2024: Grace's final recorded contact with her GP was in July 2024 for a rash. The final letter from the eating disorders service was also received in July, confirming that Grace had been discharged back to the care of her GP.

16.78. The IMR author acknowledged that no evidence could be found that Grace was seen as an adult with care and support needs, or that a referral to adult social care was considered by any of the GPs who she consulted with.

16.79. The Surrey Safeguarding Adults Board policy and procedures⁴¹ help to define who may be considered an adult with care and support needs, and this includes "*someone who misuses substances or alcohol to the extent that it affects their ability to manage day-to-day living*". It also helps to set out the impact of the need on that individual's daily life. In Grace's case, a number of impacts could be seen, including managing and maintaining nutrition, developing and maintaining family or other personal relationships, accessing and engaging in work, and carrying out any caring responsibilities the adult has for a child.

16.80. Safeguarding adult referrals may have been made by other agencies, but no corresponding documentation was found in the GP record to support this.

Recommendations have been made by the IMR author.

Surrey Police

16.81. Police involvement with Grace was limited to her two reports of domestic abuse, both of which were appropriately responded to and investigated. The investigations were conducted by specially trained officers and reviewed by supervisors at relevant stages. However, they were difficult to progress due to limited details about the offences and a lack of corroborative evidence.

16.82. The specialist officers investigating the disclosures against Daniel, demonstrated persistence in attempting to gather sufficient information and engaged with Grace to progress the investigation. They also offered her specialist support and safeguarding advice.

⁴¹ [SSAB Policy and Procedures - Surrey Safeguarding Adults Board](#)

16.83. Despite the absence of supporting evidence, Daniel was interviewed as a suspect and provided his account of the relationship with Grace. This was the only direct contact police had with him.

16.84. Following the interview, the case was reviewed by a supervisor, who determined there was insufficient evidence to submit to the Crown Prosecution Service, and no realistic prospect of obtaining further evidence.

16.85. There appeared to be limited communication with partner agencies concerning the children's welfare. Police made SCARF referrals in relation to the incidents involving Grace and Daniel, but it does not appear they were updated on subsequent disclosures of rape against Daniel, particularly relevant when the decision was made for the children to reside with him. It is unclear whether this information was shared with partner agencies.

16.86. Overall, the actions of the officers involved were deemed satisfactory. No learning was identified for Surrey Police.

No recommendations have been made by the IMR author.

17. KEY ISSUES AND CONCLUSIONS

17.1. The Review panel identified the following key issues and conclusions after considering all the evidence presented in the reports from those agencies that had contact with Grace, Daniel, Ashley and Charlie.

17.2. Grace's early life was marked by childhood trauma and neglect, followed by physical and sexual abuse from two different partners in adulthood. After separating from Daniel, she remained trapped in a cycle of abuse, compounded by mental health difficulties and an eating disorder. Her perceived vulnerability may have made her more susceptible to coercive control in subsequent relationships.

17.3. Although separated, Daniel continued to exert coercive control over Grace, including unlawfully accessing her online accounts. Research shows that domestic abuse often continues or escalates after separation, with women commonly facing ongoing threats and intimidation from former partners⁴².

17.4. Co-parenting presented additional challenges. Grace expressed significant anxiety about her children being with Daniel but felt compelled to maintain contact for their sake. She continued to experience threats and controlling behaviour from Daniel, which perpetuated emotional distress and trauma. Her relationship with Kevin also triggered her alcohol use.

17.5. As a single mother of two young children, Grace was overwhelmed by the demands of parenting, employment (which she later lost), and ongoing financial

⁴² <https://www.gov.uk/government/publications/controlling-or-coercive-behaviour-statutory-guidance-framework/controlling-or-coercive-behaviour-statutory-guidance-framework-accessible#section-6-post-separation-abuse-related-harms-offences-and-other-forms-of-domestic-abuse>

strain - exacerbated by Daniel's failure to pay child maintenance⁴³. She also felt overwhelmed by constant interactions with various agencies, requiring her to attend numerous meetings and phone calls, which added to her emotional exhaustion. There was a persistent fear that her children might be permanently removed from her care.

17.6. The emotional impact of losing care of her children to Daniel in 2023 does not appear to have been fully recognised by agencies. Her distress and substance use escalated following their removal. Greater awareness and more robust responses are needed to support parents following such removals.

17.6.1. Evidence shows that child removal has an immediate and enduring impact on mothers, particularly those with complex needs. In some cases, it is associated with premature and preventable deaths (Pause, 2023)⁴⁴. Agencies must be aware of these risks and provide appropriate, trauma-informed support.

17.7. Grace was motivated to improve her situation, including reducing her alcohol use and addressing her eating disorder. However, she was trying to do so in an environment full of triggers. While counselling was helpful at times, it also negatively impacted her wellbeing, as she felt triggered after sessions and would use alcohol to cope with her psychological distress.

17.8. Grace was engaged with the drug and alcohol service, i-Access, for years, but there was a lack of awareness of domestic abuse, coercive control, and post-separation abuse as contributing factors in her drinking. Despite her attributing alcohol use to ongoing abuse from Daniel and recent abuse from Kevin, no contact was made between i-Access and specialist domestic abuse services.

17.9. Grace had multiple hospital admissions due to alcohol-related issues, during which she disclosed domestic abuse and trauma triggers as causal factors for her drinking. There was a lack of professional curiosity, and no referrals made to independent domestic violence advisors⁴⁵ (IDVAs). Additionally, there were missed opportunities for safeguarding referrals during some of her hospital attendances.

17.10. David informed the Review that he had repeatedly requested residential rehabilitation for Grace but was informed she did not meet the threshold. He felt her situation was not treated with the urgency or seriousness it required. Grace had also requested inpatient detox but was declined.

17.11. There was little evidence across agency records of suicide risk being identified or appropriately assessed and supported. There is a need for alignment between domestic abuse and suicide prevention policies to support practitioners in recognising their intrinsic link.

⁴³ https://survivingeconomicabuse.org/wp-content/uploads/2022/11/SEA_Economic-Abuse-A-Global-Perspective_Briefing-Note.pdf

⁴⁴ <https://www.pause.org.uk/news/pause-contributes-to-new-research-on-paper-youre-normal-narratives-of-unseen-health-needs-among-women-who-have-had-children-removed-from-their-care/>

⁴⁵ A trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members.

17.12. Agencies primarily responded to Grace's presenting needs rather than the wider context of abuse and trauma. This reactive approach meant opportunities to identify and address domestic abuse were consistently missed. Professional curiosity was limited, and routine enquiries about domestic abuse were not consistently made.

17.13. Ashley's "Spider Gram", titled *Ashley's Worries*, clearly illustrated her fear. Under the Domestic Abuse Act 2021, children are recognised as victims in their own right. Professionals must understand the direct, traumatic impact of domestic abuse on children - not merely as witnesses, but as individuals whose lives are shaped by the perpetrator's behaviours.

17.14. Grace sadly died from alcohol-related complications, despite years of engagement with support services. Her alcohol use was inextricably linked to her experiences of domestic abuse, both historic and post-separation.

18. LESSONS LEARNED

18.1. The following summarises the lessons agencies have drawn from this Review.

18.2. Frimley Health NHS Foundation Trust (FHFT)

- ◆ Strengthen and improve safeguarding adult and children training. Incorporating the use of professional curiosity and the link between domestic abuse, mental health and substance misuse within training.
- ◆ Ensuring staff recognise and consider frequent attendances holistically and not in isolation of each presentation. This includes recognition of alcohol misuse as a form of self-neglect, arranging an MDT/Professionals meeting.
- ◆ Strengthen the gap in current practice around routine enquiry into domestic abuse. Increase Trust staff confidence, knowledge and skills to conduct routine enquiry and support victims appropriately and effectively. Supporting staff to carry out routine enquires, risk assessments and ensure they are effectively safety netting. Supporting staff to feel confident when patients disclose domestic abuse.
- ◆ Strengthening the communication between safeguarding children and adult teams, psychiatric liaison and alcohol services.

18.3. South West Surrey Domestic Abuse Service (SWSDAS)

- ◆ Although the service is client led, every attempt should be made to make a final call to the client prior to them being closed to the service.
- ◆ Where there is concern that clients may be minimising their disclosure, advice should be provided of the potential impact this may have on their access to wider safeguarding support.

18.4. Surrey and Borders Partnership NHS Foundation Trust (SaBP)

- ◆ There were missed opportunities to recognise and respond to post-separation abuse, as well as to explore other forms of abuse disclosed. While such

discussions may have been distressing for Grace, they could have been pursued in collaboration with specialist domestic abuse services.

- ◆ The impact of previous and ongoing domestic abuse, as well as other trauma experienced by Grace does not appear to have been fully recognised.
- ◆ The language used at times could be perceived as 'victim blaming', or as minimising the impact of domestic abuse and trauma.
- ◆ Communication had taken place with David, a family member and Lisa. There was no evidence that they were viewed as carers or offered referrals for an assessment in their own right.
- ◆ Embed gender-responsive practices within services, ensuring that women have access to female key workers where preferred.
- ◆ Domestic abuse specialists to be included in substance use care plans to ensure safer coordinated support.

A recommendation related to the first lesson learned has been incorporated into the multi-agency recommendations in the Action Plan.

18.5. Surrey Child and Family Health HCRG

- ◆ Due to the reduced capacity within the school nursing service, there was no opportunity for school nurses to exercise professional curiosity about the impact on the children of their parents' separation, and their mother's deteriorating mental health and her alcohol misuse.
- ◆ There was no evidence of professional curiosity or trauma-informed practice in response to Grace's known history of depression and anxiety.
- ◆ Daniel and David were not sufficiently considered or engaged in assessments. Information about Daniel, the children's father was minimal, reflecting a continued challenge engaging men as part of holistic family assessments.

18.6. Surrey County Council Adult Social Care (ASC)

- ◆ An s9 assessment should have been offered to Grace at a much earlier point of engagement. Grace first came into contact with MASH in March/April 2022 but was not assessed until May 2024.
- ◆ A professional's meeting would have been beneficial early in the process of engagement. Ideally, this should have occurred during the s42 assessment in May 2024.
- ◆ All social care professions should have a clear understanding of the MARAC process, including how to make referrals and to report concerns.
- ◆ All social care professionals would benefit from training around trauma-informed approaches (TIA), to understand the impact of Adverse Childhood Experiences (ACE's).⁴⁶

⁴⁶ Potentially traumatic events that occur in childhood (typically before age 18) and can have lasting negative effects on health, development, and wellbeing.

18.7. Surrey County Council Children's Services (CSC)

- ◆ Child protection processes can cause fear for parents, which can in turn exacerbate existing issues particularly around dependency. A more holistic approach that accounts for this fear might have improved engagement and outcomes.
- ◆ Interventions remained at the Child in Need level, which was considered appropriate, but improved multi-agency information sharing may have supported more tailored and effective responses.
- ◆ Records of Family Network Meetings (FNM) and Team Around the Family (TAF) meetings should be accessible to ensure informed decision-making.

18.8. Surrey Heartlands Integrated Care Board (ICB) - On behalf of GPs

- ◆ Specialist domestic abuse outreach was not discussed, and this represents a gap in the support offered to Grace. In addition, the practice significant event learning identified a need for a greater awareness of domestic abuse amongst non-clinical and support staff.
- ◆ There was no indication that Grace was considered as an adult with care and support needs, which may have guided staff in making a referral to ASC. As with domestic outreach, this was another support mechanism that may have been helpful for Grace and those helping to care for her as her health deteriorated.

19. RECOMMENDATIONS

19.1. The DARDR Panel's up to date action plan, at the time of concluding the review is set out in Appendix A of this report.

19.2. Frimley Health NHS Foundation Trust (FHFT)

- ◆ Strengthen and improve safeguarding adult and children's training.
- ◆ Incorporate the role of hospital IDVA into the training sessions.
- ◆ EPIC template/flow sheet implementation.
- ◆ Strengthening communication and supervision with alcohol liaison teams.

19.3. South West Surrey Domestic Abuse Service (SWSDAS)

- ◆ When closing cases every attempt should be made to make a final call to the client reminding them of the support plan and safety planning completed, and if possible, signposting them on for further support from other organisations. Exit assessment to be completed accordingly.
- ◆ Protocol to advise clients who are at "standard/medium" risk, but we believe to be minimising high risk abuse, that a full disclosure may give them access to comprehensive multi-agency safeguarding through the MARAC process.

19.4. Surrey and Borders Partnership NHS Foundation Trust (SaBP)

- ◆ Integrate trauma-informed principles into all substance use support plans, ensuring staff receive regular training in trauma-informed care and domestic

abuse awareness. Training should specifically address recognising and responding to both past and ongoing abuse, and the intersection between trauma, domestic abuse, and substance use.

- ◆ Increase awareness of non-victim blaming language to support clinicians to understand the importance of this and how it can influence their thinking and decisions, as well as those of the adults who make use of our services.
- ◆ Ensure that carers are recognised and provided with appropriate advice and support.
- ◆ Embed gender-responsive practices within services, ensuring that women have access to female key workers where preferred.
- ◆ Ensure domestic abuse specialists are integrated into substance use care plans immediately upon disclosure of domestic abuse.

19.5. Surrey Child and Family Health HCRG

- ◆ HCRG practitioners to explore domestic abuse at every contact with known victims, including individuals identified as perpetrators.
- ◆ 0-19 team practitioners to routinely enquire about domestic abuse whenever it is safe to do so.
- ◆ Practitioners to take a more proactive approach to understanding the role of partners within the family, ensuring that fathers are routinely considered in assessments and actively engaged when involved.

19.6. Surrey County Council Adult Social Care (ASC)

- ◆ Ensure that Section 9 assessments are offered at the point when the three-point test is applied to a safeguarding concern, where there appears to be care and support needs. This may include setting clear timeframes for completion.
- ◆ Schedule professionals' meetings earlier, ideally during the s42 enquiry to adopt a multi-agency approach. Complex cases should include consultation with relevant specialists e.g. substance misuse and mental health practitioners.
- ◆ Conduct regular best practice sessions in teams for all social care professionals on the MARAC process, including how to make referrals and reporting concerns. Consider inviting the police to support these sessions to demonstrate good practice.
- ◆ Liaise with Surrey County Council Academy to explore available training on trauma informed approaches (TIA) for all social care practitioners.

19.7. Surrey County Council - Children's Social Care (CSC)

- ◆ Review how to support to victims of domestic abuse when consent is not given to further involvement from CSC.
- ◆ Review how CFLL gains information about involved agencies and what information can be gained/shared where full consent is not provided.
- ◆ Circulate management advice that all minutes need to be uploaded into the Wisdom section of the child's record as soon as they have been approved and signed off.

19.8. Surrey Heartlands Integrated Care Board (ICB) - On behalf of GPs

- ◆ All patients who disclose domestic abuse (current, recent or historic) to be offered information on local domestic abuse outreach services. This may involve signposting (providing information and contact details for self-referral) or making a referral on the individual's behalf, guided by the person's wishes.
- ◆ All staff to be reminded that significant mental health and/or substance misuse issues may meet the Care Act definition of adults with care and support needs. The impact of these issues on the individual's daily function should be considered to inform discussions about referrals into ASC - whether for a care and support needs assessment and/or an adult safeguarding referral.

19.9. Multi-Agency Recommendations

- ◆ Increase staff awareness of post-therapy triggers and ensure check-in support is in place.
- ◆ Recognise post-separation abuse, including coercive control, as a significant and ongoing risk factor for substance use, mental ill-health and physical health.
- ◆ Incorporate routine assessment for coercive control within substance use patterns to ensure early identification and appropriate intervention.
- ◆ Where a service user demonstrates motivation for recovery, offer access to in-patient, trauma-informed rehabilitation that addresses both substance use and trauma concurrently.
- ◆ Professionals across all agencies should be trained to recognise the strong link between domestic abuse and suicide risk.
- ◆ Recognise the significant emotional impact that loss of child custody can have on a parent, particularly where there are pre-existing vulnerabilities such as substance misuse, mental ill-health, or a history of trauma.
- ◆ Agencies to adopt a more coordinated approach to multi-agency engagement, including joint visits and shared communication protocols.
- ◆ Professionals should be supported to recognise how race, cultural identity, and extended family dynamics can influence experiences of domestic abuse, particularly for individuals of mixed heritage.