



# **DOMESTIC ABUSE RELATED DEATH REVIEW**

**Into the death of Grace**

**In July 2024**

## **EXECUTIVE SUMMARY**

Independent Chair and Author  
Michelle Baird MBA, BA

Report Completed: 30 July 2025

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## 1. THE REVIEW PROCESS

- 1.1. This summary outlines the process undertaken during the Review into the death of Grace, who was a resident in an area in Guildford at the time of her death.
- 1.2. The following pseudonyms have been used to protect the identity 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.
- 1.3. Grace, who had a history of vulnerabilities through poor physical and mental health and alcohol misuse, had been the victim of domestic abuse over a number of years, perpetrated by Daniel and later by Kevin. In July 2024, Grace was found deceased at her home address by her grandmother. An empty one-litre bottle of vodka was found beside her bed.
- 1.4. An Inquest was held in January 2025 at HM Coroner's Court, where the medical cause of death was recorded as alcohol induced ketoacidosis, acute alcohol toxicity and hepatic steatosis (fatty liver).
- 1.5. On 24 September 2024, Surrey Police submitted a referral for a Domestic Abuse Related Death Review (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.
- 1.6. 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.1.5. An extension was subsequently approved to enable the thorough completion of the Review process.
- 1.7. Thirteen of the twenty agencies contacted, confirmed contact with Grace, Daniel, Ashley and Charlie and were asked to secure their files.

## 2. CONTRIBUTORS TO THE REVIEW

2.1. In this case, the following agencies/organisations 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 and Chronology, 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                                          |

2.2. All IMR/report authors confirmed that they were independent of any direct or indirect contact with any of the relevant parties subject to this Review.

2.3. David, Emma, and Lisa also contributed to the Review and provided relevant information, which has been included in the report.

## 3. REVIEW PANEL

3.1 The Domestic Abuse Related Death Review Panel consists of senior officers from statutory and non-statutory agencies, who are able to identify lessons learned and to commit their agencies to setting and implementing action plans to address those lessons. All Panel members were independent and had no direct involvement with, or supervisory responsibility for the services involved in this case.

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                      |

3.2. Following the initial pre-meeting on 17 February 2025, the Panel met formally four times via Microsoft Teams:

- ◆ 12 March 2025
- ◆ 04 June 2025
- ◆ 09 July 2025
- ◆ 30 July 2025.

3.3. 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.

3.4. The Review was concluded on 30 July 2025.

#### **4. CHAIR AND AUTHOR OF THE REVIEW**

4.1. 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.

4.2. 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).

4.3. 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).

- 4.4. 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.

## **5. TERMS OF REFERENCE**

- 5.1. 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.
- 5.2. 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 and;
  - f) Highlight good practice.
- 5.3. Agencies that have 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.<sup>1</sup>
- 5.4. Summarise concisely the relevant chronology of events including:

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<sup>1</sup> The Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Section 7).

- ◆ 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.

5.5. 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.
- ◆ 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 DASH<sup>2</sup> risk assessment tool; safety planning; referral pathway to Multi-Agency Risk Assessment Conference (MARAC)<sup>3</sup>, and to appropriate specialist domestic abuse services.

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<sup>2</sup> 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.

<sup>3</sup> MARAC a multi-agency meeting to share information to safety plan and allocate actions with the aim of increasing the safety of high-risk victims of domestic abuse.

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

## **6. SUMMARY CHRONOLOGY**

- 6.1. The Review has sought to understand Grace and her life from her perspective, drawing largely upon information held within agency records. The Review is also grateful to Emma, David and Lisa for the additional context they have provided. Full details are contained in the Overview Report.
- 6.2. Grace was born and raised in an area in Woking. Her early life was marked by instability, exposure to domestic abuse, and a strained relationship with her

mother. She was asked to leave the family home at the age of 16, leaving her without consistent support at a critical time.

- 6.3. In her early twenties, Grace married Daniel, and they had two children together. The relationship became increasingly abusive, involving coercive control, financial restriction, surveillance and sexual violence. Grace later linked the trauma she experienced in this relationship to the development of anorexia and alcohol misuse.
- 6.4. Following their separation in March 2022 and eventual divorce in May 2023, Daniel continued to exert control over Grace, particularly through manipulative co-parenting behaviours and digital intrusion. These post-separation dynamics contributed to Grace's ongoing distress.
- 6.5. Between 2022 and 2024, Grace was in regular contact with a range of services. She received support from mental health, substance misuse, domestic abuse, primary care, and emergency health services. Children's and adult social care were also involved due to ongoing concerns about her wellbeing and the safety of her children.
- 6.6. Grace disclosed experiences of domestic and sexual abuse, PTSD, disordered eating, and alcohol dependency. She was diagnosed with liver damage and experienced multiple hospital admissions for withdrawal symptoms, malnutrition, and seizures. Despite this, she struggled to remain consistently engaged with services and was discharged on several occasions due to non-attendance.
- 6.7. Grace also had involvement with the police. In March 2023, she reported her then-partner, Kevin for sexual assault and controlling behaviour. He was arrested and released on bail with conditions. Later that year, in July 2023, she disclosed historic rape and coercive control by Daniel. He was interviewed under caution, but in January 2024, the police closed the investigation due to insufficient evidence to proceed with a prosecution.
- 6.8. Despite multiple disclosures of abuse and frequent crisis presentations, routine enquiry into domestic abuse was not always undertaken, and safeguarding referrals were not consistently made.
- 6.9. In May 2023, Grace began a relationship with David, who described her as vibrant, loving and devoted to her children. Friends and family echoed these views, highlighting her warmth and determination to recover despite the significant trauma she had experienced.
- 6.10. By 2024, Grace's physical and emotional health had deteriorated further. Her children were placed in the care of their father, and her contact with them was supervised. She continued to experience periods of relapse and distress, often linked to unresolved trauma and difficulties in managing safe child contact.

## 7. KEY ISSUES AND CONCLUSIONS

- 7.1. 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.
- 7.2. 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.
- 7.3. 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 partners<sup>4</sup>.
- 7.4. 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.
- 7.5. As a single mother of two young children, Grace was overwhelmed by the demands of parenting, employment (which she later lost), and ongoing financial strain - exacerbated by Daniel's failure to pay child maintenance<sup>5</sup>. 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.
- 7.6. 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.
  - 7.6.1. 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)<sup>6</sup>. Agencies must be aware of these risks and provide appropriate, trauma-informed support.

<sup>4</sup> <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>

<sup>5</sup> [https://survivingeconomicabuse.org/wp-content/uploads/2022/11/SEA\\_Economic-Abuse-A-Global-Perspective\\_Briefing-Note.pdf](https://survivingeconomicabuse.org/wp-content/uploads/2022/11/SEA_Economic-Abuse-A-Global-Perspective_Briefing-Note.pdf)

<sup>6</sup> <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/>

- 7.7. 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.
- 7.8. 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.
- 7.9. 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 advisors<sup>7</sup> (IDVAs). Additionally, there were missed opportunities for safeguarding referrals during some of her hospital attendances.
- 7.10. 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.
- 7.11. 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.
- 7.12. 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.
- 7.13. 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.
- 7.14. 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.

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<sup>7</sup> A trained specialist who provides a service to victims at high risk of harm from intimate partners, ex-partners, or family members.

## 8. LESSONS LEARNED

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

### 8.2. **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.

### 8.3. **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.

### 8.4. **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.

#### 8.5. 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.

#### 8.6. 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).<sup>8</sup>

#### 8.7. Surrey County Council Children's Social Care (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.

#### 8.8. 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

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<sup>8</sup> Potentially traumatic events that occur in childhood (typically before age 18) and can have lasting negative effects on health, development, and wellbeing.

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.

## 9. RECOMMENDATIONS

9.1. The DARD Panel's up to date action plan, at the time of concluding the Review is set out in Appendix A in the Overview report.

### 9.2. **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.

### 9.3. **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.

### 9.4. **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.

### 9.5. **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.

#### **9.6. 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.

#### **9.7. Surrey County Council Children's Social Care (CSC)**

- ◆ Review the offer of 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.
- ◆ Recognising that involvement from children's services is often perceived as a "threat" by vulnerable parents, collaborate with the Motivational Interviewing Leads to integrate this aspect into their work with practitioners, modelling positive interventions that support parental recovery.
- ◆ Circulate management advice stating that all minutes must be uploaded to the Wisdom section of the child's record as soon as they have been approved and signed off.

#### **9.8. 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.

### 9.9. 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.