RUNNYMEDE Community Safety Partnership

surrey safeguarding ADULTS BOARD

DOMESTIC HOMICIDE REVIEW / SAFEGUARDING ADULTS REVIEW

Into the Death of Tracy (Pseudonym)

In March 2022

OVERVIEW REPORT

Independent Review Chair and Report Author
Michelle Baird MBA.BA.
Review Completed: 23 October 2023

CONTENTS

Section		*Page*
	Preface	3
1	Introduction	3
2	Timescales	5
3	Confidentiality	5
4	Terms of Reference	6
5	Methodology	7
6	Involvement of Family	7
7	Contributors to the Review	8
8	Review Panel	9
9	Chair and Author of the Overview Report	9
10	Parallel Reviews	10
11	Equality and Diversity	10
12	Dissemination	11
13	Background Information / Facts	11
14	Chronology	12
15	Overview	14
16	Analysis	26
17	Key Issues & Conclusions	32
18	Lessons Learned	34
19	Recommendations	36
20	Appendix A - Glossary	43
21	Appendix B - Bibliography	44

PREFACE

The Independent Chair and the DHR Panel Members wish to express their deepest sympathy to Tracy's[1] family and all who have been affected by Tracy's untimely death.

The Review Chair thanks the Panel and all who have contributed to the Review for their time, cooperation and professional manner in which they have conducted the Review.

1. INTRODUCTION

1.1. Domestic Homicide Reviews (DHRs) came into force on 13 April 2011, established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

The Act states that a Domestic Homicide Review 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 was related or with whom he was or had been in an intimate personal relationship or

(b) A member of the same household as himself; held with a view to identifying the lessons to be learnt from the death.

1.2. Controlling and Coercive behaviour is defined 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.

a) **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.

b) **Coercive behaviour is:** An act or a pattern of acts of assaults, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.

1.3. Throughout the report the term 'domestic abuse' will be used, as it reflects the range of behaviours within the above definitions and avoids the inclination to view domestic abuse in terms of physical assault only.

[1] Pseudonym used for the deceased.

1.4. The purpose of a Safeguarding Adults Review:

- Section 44 of the Care Act 2014 sets out that Safeguarding Boards must arrange a Safeguarding Adults Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected and there is concern that partner agencies could have worked more effectively to protect the adult.

- Determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death.

- What lessons can be learned and applied to future cases to prevent similar harm occurring.

1.5. Domestic Homicide Reviews (DHRs) and Safeguarding Adults Reviews (SARs) are not disciplinary inquiries, nor are they inquiries into how a person died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

1.6. The key purpose for undertaking this Review is to enable lessons to be learned, where there are reasons to suspect a person's death may be related to lack of safeguarding or domestic abuse. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each homicide, and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

1.7. This Review was held in compliance with legislation and followed Statutory Guidance. The Review has been undertaken in an open and constructive way with those agencies, both voluntary and statutory that had contact with Tracy and Robert[2] entering into the process from their viewpoint. This has ensured that the Review Panel has been able to consider the circumstances of Tracy's death in a meaningful way and address with candour, the issues that it has raised.

1.8. This Domestic Homicide Review / Safeguarding Adults Review examines agency responses and support given to Tracy and Robert, both of White British origin, who were residents in an area in Surrey to the point of Tracy's death in March 2022.

1.9. In addition to agency involvement, the Review also examined the past, to identify any relevant background or possible abuse before Tracy'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.[3]

Summary of the incident

1.10. Tracy's body was found by her younger child behind a shed in her garden after she had been missing for several days. Tracy was last seen three days prior but had not been reported missing to the Police. (See Section 13 for further details).

[2] Pseudonym used for the deceased's husband.
[3] Home Office Guidance for Domestic Homicide Reviews December 2016.

2. TIMESCALES

2.1. On 26 September 2022, following a Review undertaken by Surrey Police's Suicide Prevention Lead, Surrey Police notified the Chair of the Runnymede Community Safety Partnership of Tracy's death which occurred in March 2022.

2.2. The Runnymede Community Safety Partnership Panel noted that the circumstances may require a Safeguarding Adults Review (SAR) to be conducted. The DHR was delayed until an outcome of the SAR referral was provided to allow for a joint Review to be conducted if required. In January 2023, a decision was taken by the Surrey Safeguarding Adults Board that this would not be a joint Review.

2.3. A decision to undertake a Domestic Homicide Review was taken by the Chair of the Runnymede Community Safety Partnership on 26 January 2023 and the Independent Domestic Homicide Review Chair was appointed on 27 March 2023. A pre-meeting of the Review was held on 28 March 2023 to agree process, timescales and Terms of Reference.

2.4. The Home Office and the Coroner were informed by the Runnymede Community Safety Partnership of the decision to commission a Domestic Homicide Review on 31 March 2023. A further update was provided to the Home Office by the Review Chair on 18 April 2023 regarding timescales.

2.5. The Review identified a number of safeguarding issues which were to be the subject of a recommendation and drawn to the attention of the Safeguarding Adults Board, in order that they would be appropriately addressed. The SAB then made a request that the DHR should now become a combined DHR/SAR. On 28 September 2023, the Chair of the Review sought Home Office agreement for the status of the Review to be amended to a joint Review. This was agreed and further time was granted for the Review.

2.6. The Review considered the contact and involvement that agencies had with Tracy and Robert from January 2017 to the date of Tracy's death in March 2022. These dates were selected, as it was at this time that Tracy had reported domestic abuse to the Police subsequent to divorce proceedings commencing.

2.7. The Review was concluded on the 23 October 2023.

2.8. The Review Panel had four formal 'Teams' meetings:

- Pre-Meeting - 28th March 2023 (pre-meeting to agree Terms of Reference and Timescales)
- First Panel Meeting - 7th June 2023
- Second Panel Meeting - 4th September 2023
- Third Panel Meeting - 17th October 2023

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.

3.2. To protect the identity of the deceased and her family, pseudonyms have been used throughout this report. The pseudonym 'Tracy' was chosen for the deceased, 'Robert' for the deceased's husband and "Natasha" for the deceased's friend. The pseudonyms were chosen by the Review Chair as the family declined to participate in the Review. The pseudonym, "Natasha" was chosen by Tracy's friend.

3.3. The findings of this Review are confidential. Information is available only to participating officers/professionals and their line managers.

4. TERMS OF REFERENCE

4.1. This Domestic Homicide / Safeguarding Adults Review, which is committed within the spirit of the Equality Act 2010, to an ethos of fairness, equality, openness and transparency will be conducted in a thorough, accurate and meticulous manner in accordance with the relevant Statutory Guidance for the conduct of this Review.

4.2. Agencies that have had contact with Tracy and/or Robert should:

- Secure all relevant documentation relating to those contacts.
- Produce detailed chronologies of all referrals and contacts.
- Commission an Individual Management Review (IMR) in accordance with respective Statutory Guidance for the Conduct of Domestic Homicide Reviews.[4]

4.3. The Review Panel will consider:

- Each agency's involvement with the following, from January 2017 until the date of Tracy's death in March 2022, as well as all contact prior to that period which may be relevant to domestic abuse, violence, controlling behaviour, self-harm or other mental health issues.

- Tracy who was 58 years of age at date of her death.

- Robert who was 58 years of age at the time of Tracy's death.

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

- Whether there was any history of mental health problems or self-harm, and if so whether they were known to any agency or multi-agency forum.

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

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

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

- 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 Tracy prior to her death.

- 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.

5. METHODOLOGY

5.1. The method for conducting this Domestic Homicide / Safeguarding Adults Review is prescribed by Statutory Guidance. Upon notification of Tracy's death from Surrey Police, a decision to undertake the Review was taken by the Chair and members of the Runnymede Community Safety Partnership, and subsequently the Surrey Safeguarding Adults Board.

5.2. Agencies were instructed to search for any contact they may have had with Tracy and/or Robert. If there was any contact, then a chronology detailing the specific nature of the contact was requested. Those agencies that had relevant contact were asked to provide an Individual Management Review (IMR). This allowed the individual agency to reflect on their contacts and identify areas which could be improved, and to make relevant recommendations to enhance the delivery of services for the benefit of individuals in Tracy and Robert's circumstances in the future.

5.3. The Review Panel considered information and facts gathered from:

- The Individual Management Reviews (IMRs) and other reports of participating Agencies and Multi-Agency forums
- The Pathologist and Coroner's Report
- Discussions during Review Panel meetings
- Discussions with Natasha, Tracy's friend.

6. INVOLVEMENT WITH FRIENDS AND FAMILY

6.1. At the commencement of the Review, the Review Chair contacted Robert (Tracy's husband), Tracy's younger child and Natasha (Tracy's friend) by formal letter and followed up by a telephone call. Robert requested that his old child not be

contacted as the older child is severely autistic. The Review Chair respected Robert's wishes.

6.2. The family were provided with a copy of the draft Terms of Reference and Advocacy After Fatal Domestic Abuse (AAFDA) leaflets explaining DHRs and available support. After consideration, the family informed the Review Chair that they did not wish to participate in the Review and declined the offer of an AAFDA Advocate.

6.3. Two of Tracy's friends were contacted by the Review Chair, one of whom declined to participate in the Review. Natasha agreed to participate in the Review.

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 DHR, other organisations can voluntarily participate; in this case the following eight organisations were contacted by the Review:

- **Adult Social Care Surrey County Council (ASC):** This organisation had contact with Tracy, and an IMR was completed. A senior member of this organisation is a Panel member.

- **Children Social Care Surrey County Council (CSC):** This service had contact with Tracy in 2014 regarding an application made by Tracy to be a foster carer. An IMR was completed which provided background information to Tracy's history. A senior member of organisation is a Panel member.

- **Metropolitan Police Service:** This Police Force had relevant contacts with Tracy and Robert. An IMR was completed, a senior member of this organisation is a Panel member.

- **Office of the Public Guardian:** This organisation had contact with Tracy and were contacted requesting an IMR to be submitted. The Review received no response from them, however, the referrals made by them to Adult Social Care have been included in the Overview Report.

- **Surrey and Borders Partnership NHS Trust (SaBP):** This Trust had contact with Tracy and an IMR was completed. A senior member of this Trust is a Panel member.

- **Surrey Heartlands Integrated Care Board (ICB) for GPs:** This organisation had contact with Tracy and an IMR was completed. A senior member of this organisation is a Panel member.

- **Surrey Police:** This Police Force had contact with Tracy and an IMR was completed. A senior member is a Panel member.

- **Your Sanctuary:** This organisation had contact with Tracy and an IMR was completed. A senior member of this organisation is a Panel member.

7.2. All IMR Authors have confirmed that they are independent of any direct or indirect contact with any of the relevant parties subject to this Review.

8. REVIEW PANEL

8.1. The Review Panel consists of experienced Senior Officers from relevant statutory and non-statutory agencies, none of whom had any prior contact with Tracy or Robert.

The Panel Members:

Michelle Baird	Independent Domestic Homicide Review Chair
David Warren	Administrator - Know More Limited
Katie Walker	Community Safety Manager - Runnymede Borough Council
Sarah McDermott	Surrey Safeguarding Adults Board Manager
Georgia Tame	Domestic Homicide Review Coordinator Surrey County Council
Andrew Pope	Statutory Reviews Lead - Surrey Police
Helen Milton	Designated Adult Safeguarding Nurse - Surrey Heartlands Integrated Community Board (ICB) for GPs
Suzannah Townsend	Team Manager - Adult Social Care Surrey County Council
Thomas Stevenson	Assistant Director Quality Practice and Performance Children Social Care - Surrey County Council
Charlotte Underwood	Safeguarding Advisor & Consultant Psychiatrist - Surrey and Borders Partnership NHS Trust (SaBP)
Louise Balmer	Adult Community Lead - Your Sanctuary
Lisa Brothwood	Detective Inspector - Metropolitan Police

9. CHAIR & AUTHOR OF THE OVERVIEW REPORT

9.1. The Chair of this Domestic Homicide / Safeguarding Adults Review is a legally qualified Independent Chair of Statutory Reviews. She has no connection with the Runnymede Community Safety Partnership or the Surrey Safeguarding Adults Board, and is independent of all the agencies involved in the Review. She has had no previous dealings with Tracy or Robert.

9.2. Her qualifications include 3 Degrees - Business Management, Labour Law and Mental Health and Wellbeing. She has held positions of Directorship within companies and trained a number of Managers, Supervisors and Employees within charitable and corporate environments on Domestic Abuse, Coercive Control, Self-Harm, Suicide Risk, Strangulation and Suffocation, Mental Health and Bereavement. She has a diploma in Criminology, Cognitive Behavioural Therapy and Effective Freedom Techniques (EFT).

9.3. She has completed the Homicide Timeline Training (five modules) run by

Professor Jane Monckton-Smith of the University of Gloucestershire.

9.4. In June 2022, she attended a two-day training course on the Introduction to the new offence, Strangulation and Suffocation for England and Wales with the Training Institute on Strangulation Prevention.

10. PARALLEL REVIEWS

10.1. Following the Coroner's inquest hearing in June 2022, Tracy's cause of death was multiple drug toxicity and the conclusion was death by suicide.

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. Section 4 of the Equality Act 2020 defined 'protective characteristics' as:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation

11.3. There are recorded mental and physical health problems relating to Tracy. Following the breakdown of her marriage to Robert, a protracted Court case for divorce proceedings ensued and subsequent financial difficulties, all of which had an impact on her mental wellbeing.

11.4. Tracy who was of Catholic faith, had informed agencies that this shaped her view of wishing to remain married to Robert.

11.5. Tracy's sex may be of relevance as statistically women are at greater risk from domestic violence and abuse than men (Walby and Towers, 2017[5]) and more likely to be killed by their partners (ONS, 2022[6]). Although, it is important to note that levels of reporting from male victims are often lower. It is important to highlight the level and extent of domestic violence and abuse against women, but at the same time it is equally important that men are not discriminated against as a result of the

[5] Walby, S. and Towers, J. (May 2017) 'Measuring violence to end violence: mainstreaming gender', Journal of Gender-Based Violence, vol. 1, no. 1, p11-31.
[6] Office for National Statistics (ONS). (2022). Domestic abuse victim characteristics, England and Wales: year ending March 2020.

focus on women as victims.

11.6. There is no information within organisations' records to indicate that any incident mentioned within this report was motivated or aggravated by age, gender reassignment, pregnancy/maternity, race or sexual orientation.

12. DISSEMINATION

12.1. Each of the Panel members, the Chair and members of the Runnymede Community Safety Partnership and the Surrey Safeguarding Adults Board have received copies of this report. A copy has also been sent to the Surrey Police and Crime Commissioner and the Domestic Abuse Commissioner. In accordance with Statutory Guidance, consent was granted by the Home Office for the Coroner to have a copy of this report, on the basis that it would not be shared with interested parties until after this report has been approved for publication by the Home Office Quality Assurance Panel.

13. BACKGROUND INFORMATION (THE FACTS)[7]

13.1. Tracy lived in an area in Surrey with her two children and died at her home address. Tracy and Robert were of White British origin and at the time of Tracy's death, Tracy and Robert were both 58 years of age.

13.2. A referral was made by Surrey Police for a Domestic Homicide Review (DHR) to be considered, as a person over 16 was suspected to have taken her own life in the context of an abusive relationship. The circumstances of Tracy's death appeared to relate to domestic abuse perpetrated by Robert, her ongoing divorce and her relationship with Robert which had completely broken down.

13.3. In March 2022, after being missing for 3 days, Tracy was found dead behind a garden shed at her home by her younger child. According to statements provided to the Police, the family had not reported her missing due to previous bad experiences when dealing with the Police. They did not want the Police involved unless necessary.

13.3.1. An empty diazepam blister pack was found next to Tracy's body along with a coke can and a mobile phone. Tracy's body was lying on top of a blanket.

13.3.2. Tracy's younger child called Tracy's mother who then called the Police. On arrival of the Police and ambulance service, early indications were that Tracy's cause of death was an overdose. Paramedics informed the Police that Tracy's body had been there for some hours and not overnight or longer.

13.4. A post-mortem was conducted, and the toxicology found evidence that Tracy had taken zopiclone, quetiapine and possibly hydroxychloroquine in excess, prior to death. The combination of these drugs may have resulted in acute lethal toxicity.

[7] 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)

13.5. At the time of Tracy's death, the long, acrimonious divorce proceedings had not yet been concluded.

14. CHRONOLOGY

14.1. The events described in this section explain the background history of Tracy, and Robert, prior to the key timelines under Review as stated in the Terms of Reference. They have been collated from the chronologies of agencies and information provided by Natasha, Tracy's friend who had contact with Tracy

14.2. Tracy was the eldest of two children. She was 10 years old when she witnessed her father collapse whilst the family were on holiday, and described the time following her father's death as "*a blur*". Tracy recalled being aware of her mother worrying about how they were going to manage financially without Tracy's father.

14.3. Tracy met Robert when she was 21 years old and married 3 years later, they had two children. Agency records indicate that Tracy felt Robert spent very little time with the children, and this was one of their differences.

14.4. In 2003, the family moved to the United Arab Emirates (UAE) before returning to the United Kingdom in 2010. Tracy reported to professionals in the United Kingdom that she was subjected to domestic abuse by Robert throughout their marriage. This included a significant and violent assault in 2009 whilst living in the UAE, whereby Robert is alleged to have punched and strangled Tracy. She reported to professionals that this resulted in a fractured cheek bone, and a metal plate fitted in her cheek and was hospitalised for two weeks.

14.5. In 2009, whilst living in the UAE, Tracy called Natasha and confided to her about the abuse that Robert had perpetrated against her. Tracy spoke of the assault that occurred in September 2009, which occurred after Tracy had read a '*sex text'* that Robert had sent to "*another woman*".

14.5.1. Natasha informed the Review Chair, that in the years after the assault, Tracy disclosed that Robert had refused to take Tracy to the hospital, withheld her passport and insurance document which resulted in Tracy not being able to attend the hospital on her own. Tracy did not drive and was reliant on Robert's driver to drive her around. Natasha suspected that Robert may had told his driver not to take Tracy to hospital.

14.6. In 2014, Tracy undertook a foster carer's assessment with Children Social Care, and described herself and Robert as "*ambitious, somewhat competitive and willing to take measured risks*" which paid off in terms of the business successes they achieved, which enabled them to have an affluent lifestyle the family enjoyed.

14.6.1. Tracy's assessment as a foster carer was approved in September 2014 until her resignation in August 2016. During this period, she had four short-term placements.

14.7. At the end of 2014, Robert left the marital home. Tracy and Robert continued

to hold joint business ventures despite their separation

14.8. Tracy had a number of physical health problems, including Systemic Lupus Erythematosus (SLE Lupus)[8], Sjögren's Syndrome[9], primary bilary cirrhohosis[10] and coeliac disease[11].

14.9. In September 2015, Adult Social Care (ASC) became involved with Tracy in relation to her role as a carer for her older child. Tracy wanted to ensure the right care arrangements were put in place for her older child, in anticipation that her physical health conditions may be life-limiting. ASC recorded they intended to carry out a carer's assessment under S10 of the Care Act[12], but this was not completed.

14.10. Divorce proceedings commenced in 2016 and were lengthy and acrimonious.

14.11. On 25 September 2016, Robert reported to the Metropolitan Police that Tracy and their younger child had attended his property. Tracy had kicked a door and thrown a stone ornament at Robert causing it to break. A further allegation was made by Robert, whereby Tracy had obtained keys to his property from an estate agent whilst he was on holiday and stolen a computer with server, cut cables belonging to Robert's company and caused water damage to the property.

14.11.1. Tracy was arrested for Theft and Criminal Damage. A search of her property was conducted by Officers, but nothing was found. In interview, Tracy made a counter-allegation of assault and showed Officers she had bruising to her wrist where Robert had grabbed her arm. Tracy disclosed previous domestic abuse perpetrated by Robert, including the serious assault in 2009 whilst the family lived in the UAE that resulted in a fractured cheek.

14.11.2. The younger child was spoken to and confirmed that both parents had pushed each other. Robert was also spoken to and reported that Tracy was "*aggressive*" and he believed she had mental health issues. Robert informed Officers that Tracy had previously been arrested for an assault on him 22 years ago, but no further action was taken. Robert stated he had taken an injunction out on Tracy previously, although this information was not verified.

14.11.3. A Domestic Abuse Stalking and Harassment Risk Assessment (DASH) was completed with Robert and graded standard risk. On 20 October 2016, Tracy was issued with a Harassment Warning. Tracy and Robert informed Officers they would be commencing divorce proceedings and were advised by Officers to use an intermediary.

14.12. On 20 November 2016, Robert called the Metropolitan Police to report that Tracy was removing property from his address. Officers attended and advised

[8] Systemic Lupus Erythematosus (SLE) is an autoimmune condition which can affect many parts of the body, including the skin, joints and internal organs.
[9] Sjögren's Syndrome is a long-term condition that affects parts of the body that produce fluids, like tears and saliva.
[10] An autoimmune disease that attacks the healthy cells and tissues in the liver.
[11] An autoimmune disease that damages the small intestine when gluten is consumed.
[12] Section 10 of the Care Act 2014 requires a local authority to assess whether a carer has needs for support (or is likely to do so in the future), and what those needs are.

this was a civil matter as the house was jointly owned. Officers remained to prevent a breach of the peace. No offences were disclosed.

14.12.1. A DASH risk assessment was completed with Tracy and graded standard risk. Within her answers to the assessment, Tracy responded that she had previously been strangled/choked/suffocated by Robert. Tracy advised that she had reported this to an Officer previously in September 2016. Tracy also disclosed that Robert had a problem with alcohol use. A referral to outreach domestic abuse support was offered to Tracy but declined.

15. OVERVIEW

15.1. This section documents the key contacts agencies and professionals had with Tracy and Robert within the agreed timeframe of the Review.

15.2. On 9 May 2017, Tracy attended an appointment with her GP. She informed her GP that divorce proceedings had commenced and that there were various legal and financial issues attached to this. Tracy was issued prescription medication for anxiety and the dosage was increased by her GP on 22 May 2017.

15.3. On 13 November 2017, Robert reported to the Metropolitan Police that Tracy had sent emails to his clients and business partners accusing him of improper business practices. Robert reported that Tracy had stolen confidential information from his home address and was using this information against him during divorce proceedings.

15.3.1. No offences were recorded, and advice was provided to Robert that this was a civil matter, and he should not contact Tracy directly. Tracy was spoken to by Officers and also advised not to contact Robert directly. A DASH risk assessment was completed with Robert and graded standard risk.

15.4. Between 13 November 2017 and 29 January 2018, Tracy sent ten emails and messages to an energy company that Tracy believed Robert worked for. The emails were described as non-threatening with no explicit threats, but "*rambling*" and "*incoherent*" and that Tracy believed there to be hidden money she was entitled to as a result of divorce proceedings. Staff at the company had advised Tracy to stop contact, but this resulted in Tracy sending her child (it is not recorded which child) and an acquaintance to the office. As a result, the energy company had become concerned about Tracy's escalating behaviour and reported the incidents to Police.

15.4.1. The Metropolitan Police contacted Robert who confirmed he and Tracy were in the middle of an acrimonious divorce and that he felt he was being harassed, directly and indirectly, and as a result suffering serious reputational damage due to the contact Tracy was making with business associates and colleagues. He was unaware of the contact to the energy company but stated that this was part of wider harassment he was experiencing.

15.4.2. Robert was asked about Tracy's mental health to which he stated that she suffered from Lupus and took steroids for this, which he believed could be having an impact. Robert stated that he had previously reported harassment, and expressed

his dissatisfaction about the advice provided by the Metropolitan Police that the matter was a civil dispute.

15.4.3. The reporting Officer documented concern that Tracy's behaviour was escalating and that this matter warranted further investigation. Tracy was contacted to arrange a voluntary interview, but was described as "*ranting*" and stated she would rather be arrested before ending the call. The Officer documented that Tracy may have suspected mental health issues and liaised with Surrey Police, who confirmed Tracy was only known to them for civil disputes.

15.5. On 4 December 2017, Tracy disclosed multiple, historic and unreported domestic abuse incidents perpetrated by Robert during their relationship to the Police. This included the serious assault in 2009, following the discovery of a series of 'sex texts' on Robert's phone by Tracy. Tracy reported she was punched by Robert as he attempted to retrieve his mobile phone. Tracy stated she was then held by the throat against a wall, and the assaults resulted in a fractured cheek bone and nerve damage. She reported that she was punched so hard the impression of Robert's ring was left in her cheek.

15.5.1. Tracy went further to report that the fracture resulted in surgery and the fitting of a metal plate in her cheek and remained in hospital for two weeks. On her release from hospital, Tracy stated she was falsely imprisoned in her home for 12 days until the swelling to her face reduced. She reported that further surgery was necessary on her return to the United Kingdom in relation to the nerve damage she sustained during the assault. There were no records to verify this.

15.5.2. Tracy also reported to Officers that in 2014, she had been pushed down the stairs of her home by Robert which resulted in a twisted and bruised ankle, and that in 2015-2016, Robert had slammed a door against Tracy's arm causing severe bruising.

15.5.3. Tracy provided a statement on 5 December 2017 with supporting evidence, including a surgeon's report from 2009 and a series of photographs of the bruising to her arm from the assault in 2015-2016. She informed Officers that the delay in her reporting the assaults was that she had "*always been too afraid to report it as the consequences for me would have been too much"*.

15.5.4. A DASH risk assessment was completed with Tracy and graded medium risk. A referral to outreach domestic abuse support was completed and a warning marker/flag was added to Tracy's Police record identifying her as at medium risk of domestic abuse by Robert.

15.5.5. The subsequent Police investigation lasted five months. Robert was voluntary interviewed under caution on 31 January 2018 and denied all of the allegations of assault. Robert stated the bruising to Tracy's arm was a result of her overuse of prescribed steroids for the treatment of Lupus. However, he did state that Tracy's injuries that she sustained in 2009 were a result of him defending himself when Tracy attacked him with boiling water.

15.5.6. Counter allegations were made by Robert who told Officers that he felt

Tracy was making the accusations due to an ongoing acrimonious divorce. Robert stated he had made similar allegations to the Metropolitan Police, but felt he was not taken seriously as these matters were filed with no further action.

15.5.7. No further action was taken by Surrey Police due to time limits on the reported offences[13], a lack of supporting evidence and limitations on jurisdiction[14]. Officers recorded that although Tracy had provided supporting photos of the bruising to the arm, they were not time dated, a GP's letter regarding bruising to the arm suggested that the likely cause was from an insect bite and neither the GP's letter nor the surgeon's report suggested that the injuries were inflicted by a physical assault.

15.6. On 7 December 2017, a referral from Surrey Police was sent to Your Sanctuary. As well as documenting the physical assaults, the referral identified financial abuse by Robert against Tracy. Your Sanctuary attempted to contact Tracy on 8, 11 and 12 December 2017, but there was no answer.

15.7. On 14 December 2017, Your Sanctuary were successful in contacting Tracy. Tracy informed the Outreach Worker that she had "*a lot going on at the moment*". Tracy advised she would like to be added to the list for the Freedom Programme[15] course that was due to take place in March 2018. Tracy was provided with the number for the Your Sanctuary helpline and advised she could contact them if she needed any further support.

15.8. On 15 March 2018, Tracy reported to Surrey Police the theft of £650 million of family shares by Robert. Tracy later reported a second similar allegation to Action Fraud which involved the hiding and falsification of documents. Tracy informed Officers that she was not confident that this was a matter for Police to investigate. Surrey Police did investigate, but concluded this was a civil dispute as it was considered to form part of the divorce proceedings and the matter was filed with no recorded offences. Officers subsequently submitted a SCARF[16] and Vulnerable Adults at Risk Notification (VAAR) on 21 May 2018 due to Tracy appearing "*gaunt and unkempt"*. The Officer had concerns that Tracy may be struggling to take care of herself.

15.8.1. The SCARF and VAAR were shared with ASC. A DASH risk assessment was completed and graded standard risk. No referral for outreach domestic abuse support was completed as no offences were established.

15.9. On 20 March 2018, the Metropolitan Police issued Tracy with a Harassment Warning Notice following a failure to respond to requests by letter and telephone for Tracy to attend a voluntary interview in relation to the harassment of an energy company.

---

[13] Summary only offences must be commenced within 6 months of the criminal act that is being reported.
[14] Article 44 of the Istanbul Convention extends the jurisdiction of the United Kingdom Courts to be able to prosecute certain violent or sexual offences outside the United Kingdom by a United Kingdom national. The Domestic Abuse Bill 2020 extends the jurisdiction to domestic law.
[15] Freedom Programme is s a course for women who are in, or have experienced, an abusive relationship. The aim of the programme is to help women understand the beliefs held by abusive men, identify and challenge any shared beliefs and help women come to terms with the abuse they have experienced.
[16] A SCARF is a Single Combined Assessment of Risk Form that enables officers and staff to raise concerns and observations in relation to the needs and vulnerability of individuals.

15.10. The lawyer for the energy company was contacted by the Police on 22 March 2018. It was confirmed by the lawyer that that there had been no further contact from Tracy, and therefore did not wish for Tracy to be arrested but agreed that a warning would be appropriate.

15.11. Tracy contacted Adult Social Care on 2 May 2018, requesting an assessment to help inform her of what support was available to her and her older child. She informed ASC that Robert had left her for another woman, there were ongoing divorce proceedings, and she may lose the house as there were possible debts against the property.

15.12. Tracy attended a GP appointment on 15 May 2018, she reported low mood, poor sleep and financial difficulties. Tracy shared her belief that Robert was being "*manipulative*".

15.13. On 22 May 2018, Tracy attended a further GP appointment and reported her sleep had improved after a short course of prescribed medication and was receiving support from her friend and mother. She also disclosed that someone had contacted Police to say she was going to harm her older child, but there was no corresponding agency information to verify this.

15.14. On 10 June 2018, Tracy contacted Surrey Police to report financial and controlling abuse perpetrated by Robert. This included Robert closing the joint bank account to prevent Tracy accessing the money. Officers visited Tracy and established her concerns related to financial matters in the ongoing divorce proceedings. No direct evidence of controlling or financial abuse was apparent, and the matter was filed with no offences recorded.

15.14.1. A SCARF and VAAR were submitted for Tracy, as she disclosed that she was depressed and receiving treatment from a psychiatrist. The SCARF and VAAR were shared with ASC. A DASH risk assessment was completed and graded standard risk.

15.15. Tracy attended a GP appointment on 12 June 2018, she informed her GP that she "*sometimes wants to be dead*". She stated to her GP that her older child and her dog were protective factors. Tracy's GP scheduled a further appointment for two weeks' time.

15.16. On 12 June 2018, a third-party report was received by the Metropolitan Police from a Pension Actuary. The Pension Actuary was working on behalf of Tracy and Robert following a Court order to have their assets split as part of the divorce proceedings. Emails sent by Tracy to the Pension Actuary contained allegations of sexual assault and domestic violence on Tracy by Robert.

15.16.1. The report was transferred to Surrey Police on 13 June 2018. The Metropolitan Police record of the crime report recommended that a welfare check was required to visit Tracy, ascertain any allegations, and safeguard any parties involved.

15.17. On 18 June 2018, Tracy was issued with a Community Resolution[17] by Surrey Police in relation to removing and stealing plants from her neighbour's boundary hedge. Since November 2017, Tracy had been involved in multiple incidents of criminal damage to her neighbour's plants, trees, fence area and cars. In addition, the neighbours were subjected to verbal abuse and on at least one occasion a victim of dangerous behaviour, when it was alleged that Tracy threw a large piece of wood over the fence towards their property. Tracy lost a civil case against her neighbours, with HM Land Registry confirming that the land was owned and registered to the neighbours.

15.17.1. Officers noted that on 18 June 2018, Tracy accepted and fully understood the implications of being issued with a Community Resolution. However, on 4 July 2018, Tracy was captured on CCTV causing further damage to her neighbour's boundary hedge.

15.17.2. Tracy was interviewed under caution by Officers, following her voluntary attendance at a Police station. She admitted damaging the property, however, continued to dispute ownership of the boundary. Tracy was summoned to appear at Magistrates Court in October 2018, for the offence of Criminal Damage.

15.18. On 26 June 2018, Tracy attended an appointment with her GP. She told her GP that Robert had filed for bankruptcy and Tracy accused the Judge and lawyers involved in her divorce proceedings of corruption. Tracy informed her GP that she had been appointed a McKenzie Friend[18] to assist her in the Court process.

15.19. On 26 June 2018, Tracy's GP received a Court Order requiring the GP to provide an opinion on whether Tracy lacked capacity in relation to the divorce proceedings. The GP's opinion, was that Tracy *did* lack capacity to follow and engage with the Court proceedings at that time, as evidenced by Tracy's chaotic thought processes and self-declared inability to concentrate or remember what the extensive paperwork was about.

15.20. The Community Mental Health Recovery Services (CMHRS) received a request from Tracy's GP on 27 June 2018, for a specialist mental health referral. A letter was sent to Tracy with a scheduled appointment with a Community Psychiatric Nurse (CPN) for 18 July 2018.

15.21. On 29 June 2018, ASC received a letter from Tracy's GP stating that Tracy was under a lot of financial and emotional stress due to the acrimonious divorce. This had resulted in Tracy experiencing depression and anxiety. Tracy was also the carer for her older child and the GP requested a carer's assessment be offered to Tracy.

15.22. Tracy contacted CMHRS on 13 July 2018, stating she was unable to make the appointment on 18 July 2018 and requested this was moved to a date in the future, to allow for her newly prescribed medication to start to work. CMHRS

[17] A Community Resolution is a method of dealing with an individual for a lower-level crime, where the individual accepts responsibility for the behaviour and the victim has agreed they don't want formal action taken.
[18] A McKenzie Friend is a person who accompanies an individual to Court to help, support and offer advice.

agreed on 18 July 2018, that Tracy could be discharged back to her GP who could re-refer in six to eight weeks' time.

15.23. On 16 July 2018, the Metropolitan Police received a report that Tracy had sent an email to the Houses of Parliament stating that Robert had physically assaulted her.

15.23.1. The Metropolitan Police made enquiries with ASC on 17 July 2018, who reported being aware of Tracy reporting the abuse in 2017. ASC advised that they had offered Tracy an assessment of needs at the time the report was first received.

15.23.2. The Metropolitan Police transferred the report to Surrey Police. The report was evaluated by Surrey Police and the contents of the email were assessed as "*likely to be false*".

15.24. On 17 July 2018, Tracy attended a GP appointment. She reported visual hallucinations, including rats and people walking across her kitchen. She had recently commenced new anti-depressants. The GP wrote to CMHRS advising them of Tracy's reported visual hallucinations.

15.25. CMHRS wrote to Tracy on 31 July 2018 offering her an appointment on 22 August 2018, this appointment was not attended by Tracy. She was offered a future appointment for 17 September 2018.

15.26. On 24 July 2018, Robert contacted Tracy's GP wanting to know if the GP had written to the Court in relation to Tracy's mental health concerns. No information was shared due to the GP's duty of confidentiality. Robert was reported to have found the GP's response "*unhelpful".* The GP noted that Robert was particularly adamant that there was no money for a financial settlement.

15.27. On 27 July 2018, Surrey Police received a report from Tracy that Robert was alleged to have committed bigamy by remarrying prior to a decree absolute being issued in the divorce proceedings. Surrey Police commenced an investigation that spanned five months, which concluded that Robert had not remarried and there was no evidence of any offences.

15.28. Adult Social Care received a message from Tracy on 31 July 2018, stating she had a lot of personal issues and was recorded to be very upset. She reported that Robert was not helping with her older child, and the responsibility as her child's 'carer' was "*too much*" for her. Tracy had contacted ASC seeking help and advice.

15.28.1. Later that day, Tracy attended a GP appointment and updated her GP on the allegations of bigamy in relation to Robert, that she had contacted ASC for support, and that her visual hallucinations had improved. She reported to be confused regarding her medication.

15.29. ASC contacted Tracy on 1 August 2018. Tracy asked them if they could "*get Robert to look after his children*". ASC offered a carer's assessment for Tracy, but Tracy declined the offer. She informed ASC that she can support her older child but required financial assistance with daily living.

15.30. On 9 August 2018, Tracy had a telephone consultation with her GP as she could not attend the surgery. Tracy reported she had not been able to attend Court and could not understand the paperwork, and therefore was not opening the documents. She felt the Judge did not like her. Tracy reported receiving daily support from her mother.

15.31. Tracy's GP received a letter from Family Court on 14 August 2018 advising that divorce proceedings had been put on hold pending Tracy being appointed a Litigation Friend[19].

15.32. Tracy attended a GP appointment on 30 August 2018. She reported she was feeling better, and her mother continued to offer her support. Tracy reported that she believed Robert was hacking her emails and undertaking fraudulent petitions. Tracy had an Official Solicitor[20] appointed to her due to her lack of capacity, but stated she did not want them to be involved.

15.33. On 5 September 2018, Tracy's GP received a letter from Tracy regarding her lack of capacity for the ongoing Court case. Within the letter, Tracy made numerous and sometimes "*bizarre*" allegations about Robert. The GP noted some concerns around what Tracy considered to be reality and whether she was experiencing symptoms of paranoia.

15.34. The GP had a further telephone appointment with Tracy on 6 September 2018. Tracy reported that she was feeling better in herself, she was attending yoga and going to a weekly group for victims of domestic abuse. It was unknown as to which weekly group she was attending. Tracy informed the GP she had a psychiatric review scheduled for later that month.

15.34.1. Tracy's GP contacted CMHRS on 6 September 2018, to request a further mental health review in an attempt to explore Tracy's mental health concerns, and the possibility she may have a personality disorder[21].

15.35. On 7 September 2018, CMHRS and Tracy's GP discussed Tracy's background history. This included that approximately two months prior, Tracy had been taking huge doses of steroids that she was acquiring from prescribed medication for Lupus and from online sources. Tracy was not managing the doses correctly and would take different doses throughout the day. Tracy's GP had informed Tracy of the dangers of this, had maintained regular appointments to monitor this and felt this behaviour had now stopped.

15.35.1. Tracy's GP informed CMHRS that Tracy would rationalise her steroid use, despite the GP and a rheumatologist informing her she needed to reduce her dosage. This would need to be done gradually and safely. The GP went further to state that Tracy presented as highly distressed by the ongoing divorce proceedings and was presenting with paranoid thoughts. It was noted by the GP that Tracy may

[19] A Litigation Friend is someone who can make decisions on the adult's behalf where the adult lacks mental capacity to manage their own Court case.
[20] An Official Solicitor is appointed by the Court when it is decided it is in the adult's best interests. The Official Solicitor will only decide on issues before the Court. They may also act as a last resort Litigation Friend.
[21] A personality disorder is a mental health condition that affects how an individual thinks, feels, behaves and relates to others.

be hypomanic since her antidepressant dosage was increased.

15.35.2. CMHRS noted that Tracy had previously not attended two offered appointments with CMHRS in July and August 2018. Tracy's GP agreed to advise Tracy of the importance of attending any further scheduled appointments.

15.36. On 17 September 2018, Tracy attended an assessment with CMHRS. She denied current or past use of legal or illegal substances and reported she did not drink alcohol. Tracy disclosed her past experience of domestic abuse by Robert and provided supporting documentation to CMHRS of the serious physical assault in 2009. Tracy reported she had struggled to come to terms with the divorce proceedings and stated that despite the physical abuse she endured, she did not want her marriage to end due to her Catholic faith. Whilst in a relationship with Robert, she had a high quality of life and now had no money to support her family, to the extent that she had struggled to arrange representation in Court.

15.36.1. Tracy acknowledged her difficulties in managing her steroid dosage and the negative impact this had on her mental health. She acknowledged her period of low mood, but attributed this to her legal, social and financial situation. She reported feeling "*much better now*" and had "*found the strength to keep going".*

15.36.2. Tracy reported she had previously believed that she was having visual and auditory hallucinations after hearing rats and seeing shadows, but subsequently realised there were actually rats in the house and provided photographs as evidence, to ensure she was understood at the assessment. Tracy stated that she had no thoughts of self-harm or suicide and that she had never had these thoughts. She went further to say that she would never act on these thoughts due to her religious beliefs. Tracy was noted as presenting well, taking good care of herself and pride in her appearance. She described herself as "*strong, loud and bubbly*" despite the difficulties she had experienced.

15.36.3. CMHRS concluded there was no specific role for them at that time. Tracy was provided with contact details for support services and discharged from CMHRS back to her GP on 19 September 2018.

15.37. On 2 October 2018, as part of the ongoing investigation by Surrey Police into alleged bigamy by Robert, Surrey Police submitted a SCARF and VAAR for Tracy. These were shared with ASC. The SCARF and VAAR were submitted, after Robert raised concerns over Tracy's ability to care for her older child.

15.37.1. Within the SCARF, it stated "*She [Tracy] has recently stated that she will commit suicide rather than leave the family property*". The SCARF noted that Tracy had also recently been declared bankrupt and therefore could not act as her older child's Power of Attorney for financial matters.

15.37.2. ASC MASH noted that Tracy was awaiting a carer's assessment, in light of the divorce. ASC MASH passed the referral to the ASC Locality Team, but the referral was returned to MASH to query whether her older child was open to CMHRS. ASC contacted CMHRS on 8 October 2018 and confirmed that Tracy's older child was no longer open to them.

15.38. ASC contact Tracy's GP on 16 October 2018 raising concerns that Tracy was displaying some "*odd behaviour*" and was not always accurate in the information she was providing.

15.39. On 18 October 2018, Tracy attended a GP appointment. She reported she was feeling better, her sleep had improved, and she was described by the GP as "*measured and looking well*".

15.40. As part of the ongoing neighbour dispute matters, Tracy was arrested on 31 October 2018 for Criminal Damage. This was the day after her appearance at Magistrates Court for related matters.

15.40.1. Whilst in Police custody, it was noted that Tracy was displaying signs of "*eccentricity*" that she would "*rant about things for a long time*" and "*make grand statements about herself*". Officers felt that she may be suffering with her mental health and completed a SCARF and VAAR which were shared with ASC.

15.41. On 1 November 2018, ASC visited Tracy. Tracy was observed with bandages over her lower arms and stated this was due to her steroid use. The Social Worker described Tracy as "*manic and speaking very quickly*". Tracy declined a carer's assessment.

15.41.1. The Social Worker contacted CMHRS to raise the concerns they had from the visit. CMHRS contacted Tracy's GP who requested CMHRS to contact Tracy.

15.41.2. CMHRS subsequently called Tracy who reported she had never self-harmed. She mentioned a friend who took their life by suicide the previous year and said, "*it's sad people feel like this*".

15.41.3. CMHRS signposted Tracy to domestic abuse support, Your Sanctuary and advised Tracy that her GP would see her the following week if she booked an appointment, (this was attended on 4 December 2018). No concerns were raised by CMHRS regarding Tracy's presentation.

15.42. On 6 November 2018, ASC contacted Tracy to arrange a further visit. Tracy stated she had received a lot of phone calls from agencies after the last visit. The Social Worker advised that they had a responsibility to raise safeguarding concerns. Tracy stated she understood why her GP and CMHRS had contacted her and expressed that she felt Robert was somehow influencing the situation. She felt there was no benefit from a further visit by ASC.

15.43. ASC arranged a further meeting with Tracy on 11 November 2018. During the meeting Tracy reported that Robert had hit her, a s42 Care Act adult safeguarding enquiry was carried out.

15.44. Tracy had a telephone appointment with her GP on 24 January 2019 to request a repeat prescription of modafinil, a stimulant medication used to treat sleep disorders. The GP noted that Tracy had never been prescribed this, and requested she attend an appointment to review her medication.

15.45. On 16 February and 21 February 2019, Tracy emailed her GP advising that she was receiving legal aid and disclosed a historic assault by Robert whilst living in the United Arab Emirates. This assault was the same significant assault she had previously disclosed to other agencies in which she suffered fractured facial bones and required surgery. No referral to outreach domestic abuse support was made.

15.46. On 23 February 2019, Surrey Police received a report of a burglary at Tracy's address. Tracy later withdrew the allegation via a series of emails that stated the burglary did not take place. Surrey Police attempted to visit Tracy who presented as vulnerable, but she declined the visit stating she did not want any further contact from Officers as it was impacting on her mental health. A SCARF and VAAR were completed and shared with ASC.

15.47. On 12 March 2019, Tracy asked ASC if they could support her older child in gaining a protective order, to prevent Robert from having contact. ASC advised they would be unable to do this, but signposted Tracy to information regarding protective orders for domestic abuse and provided contact information for Your Sanctuary domestic abuse support. Tracy later informed ASC that she attended a week-long course with Your Sanctuary, but this does not appear to be accurate from Your Sanctuary records.

15.48. On 24 May 2019, the Metropolitan Police received a report that Tracy was receiving threats from Robert. This was transferred to Surrey Police and a request for a welfare check for Tracy was made. There is no corresponding record of this in Surrey Police records, primarily due to a change in the Surrey Police internal IT systems.

15.49. Tracy was found guilty on 24 May 2019 of Criminal Damage in relation to a previous neighbour dispute from 2018. Tracy failed to appear for sentencing and a warrant was issued for her arrest.

15.50. On 3 June 2019, Tracy was arrested for failing to appear in Court in May 2019, fined £100 and ordered to pay the victim £650. In addition, a five year Protection from Harassment Order was issued, preventing Tracy from removing or interfering with any of her neighbour's plants.

15.50.1. Later that day, ASC contacted Tracy to arrange a visit to see her following a decision to reallocate her case due to ongoing safeguarding concerns. Tracy informed ASC she had been arrested. ASC attempted to book a visit, but this was not arranged until 17 June 2019, due to a lack of response from Tracy.

15.51. Tracy contacted ASC on 17June 2019 and apologised for the delayed reply. She informed ASC that she had been instructed by her lawyer that all concerns should now go through her GP, and Tracy subsequently cancelled the arranged visit with ASC for the following day. The GP was contacted by ASC to confirm they had no concerns for Tracy and ASC closed the case.

15.52. On 20 and 22 July 2019, Tracy informed ASC in an email exchange that her younger son was now the older child's Lasting Power of Attorney as Tracy was deemed to lack capacity. ASC noted that Tracy continued to be impacted by the stresses of the ongoing divorce proceedings and attempted to arrange a visit with

Tracy, but Tracy did not respond.

15.53. In October 2019, Tracy had three separate GP appointments in which she confirmed the official solicitor was taking over the divorce proceedings. She reported her mood was low as the stresses of the Court case were increasing, and she recently lost her dog. She also showed her GP paperwork in relation to Robert that showed he had significant financial assets, despite Robert stating this was not the case when he contacted Tracy's GP in July 2018.

15.54. On 26 November 2019, Tracy attended a further GP appointment and informed her GP that a Court of Protection hearing was scheduled for January 2020.

15.55. On 3 March 2020, Surrey Police received a report of theft from Tracy. Tracy was notified that she owed money for work completed on a field her and Robert owned. Tracy reported being unaware of the work completed, and unaware of the debt owed. Tracy stated that a truck arrived, and items were removed from her property for the outstanding balance of approximately £6000.

15.55.1. Surrey Police determined this was a civil dispute over a lawful debt owed by Tracy to third parties, that were interlinked with her divorce proceedings. It was recorded that bailiffs executed a High Court warrant at Tracy's address, and Tracy was advised to contact her legal representatives. Tracy was identified to be vulnerable by Officers and a SCARF and VAAR were completed and shared with ASC.

15.56. On 29 April 2021, Tracy had a telephone consultation with her GP. She reported she had been struggling with her mood and felt like things were "*getting too much*". She reported feeling "*attacked*" in Court. Tracy's GP offered Tracy a face-to-face appointment, but Tracy declined.

15.57. ASC received a referral from the Office of the Public Guardian on 25 May 2021, requesting a home visit be made to check on Tracy's welfare. The referral stated that Tracy "*may be confused*" and was at risk of abuse or neglect.

15.58. On 27 May 2021, ASC deemed that there was no reasonable cause to suspect Tracy was at risk of abuse or neglect, and that whilst she presented with care and support needs, she had demonstrated an ability to protect herself and contacted appropriate agencies with her concerns. It was recorded that a S9 assessment was proportionate.

15.59. ASC contacted Tracy on 9 June 2021, who reported she was "*managing well*" and did not feel she needed support or an assessment.

15.60. Tracy's GP received a letter on 29 September 2021 from an independent professor of psychiatry, concluding that Tracy lacked capacity to engage in the divorce and financial proceedings, but had capacity to appoint her own legal representatives. It was confirmed that the official solicitor never acted on Tracy's behalf, and there had been a number of changes of legal representatives due to legal firms experiencing significant difficulties in working with Tracy.

15.61. ASC received a further referral from the Office of the Public Guardian on 11 January 2022, raising concerns for Tracy in light of her previous experience of domestic abuse by Robert. ASC concluded that Tracy did not have care and support needs, which was inconsistent with previous assessments and closed the case.

15.62. On 27 January and 1 February 2022, Tracy had contact with her GP via a telephone consultation and email exchange. Tracy indicated she was under a lot of stress, was feeling "*muddled*" and requested changes to her medication dosage.

15.63. A friend of Tracy's who wished to remain anonymous left a message for Tracy's GP on 7 February 2022. The friend stated that Tracy had made a suicide attempt on 4 February 2022. The GP contacted Tracy who denied any suicide attempts and stated she had previously had issues with false information being given about her. She informed her GP that she had no thoughts of self-harm or suicide and that it "*takes courage and is not brave enough*".

15.64. Tracy emailed her GP on in March 2022, requesting her medical records from 2021 as she "*is not understanding things right now"*.

15.65. In March 2022, Tracy's GP received a 5 page email from Tracy's previous legal representative. She described Tracy as "*paranoid and delusional"* and that Tracy had made threats of suicide. She asked that Tracy was not informed of her contact with the GP.

15.66. Tracy's GP received three emails from Tracy in March 2022, refuting any concerns for her as false information. She made reference to her former legal representative who had emailed the GP in March 2022 and referred to the individual as "*disgruntled*" and a "*faux creditor claiming ludicrous sums against my estate*". The GP noted that the content of Tracy's emails did appear to indicate paranoia and delusion.

15.67. In March 2022, Tracy had a telephone consultation with her GP. Tracy confirmed she had no intention of self-harm or suicide and was annoyed at the allegation. The GP recorded that Tracy sounded in a good mood, reported she was sleeping well, and her stress was reducing. There was no indication that Tracy needed urgent intervention.

15.68. In March 2022, Tracy's younger child found Tracy dead behind a shed in the back garden of Tracy's home. The younger child informed Officers from Surrey Police that Tracy had previously mentioned thoughts of suicide, although she had stated that "*she would never do this because she was too strong".*

15.69. An investigation by Surrey Police established that there was no evidence of third-party involvement. Following the Coroner's inquest hearing on 27 June 2022, Tracy's cause of death was given as multiple drug toxicity and the conclusion as to the death was by suicide.

16. ANALYSIS

16.1. Agencies completing Individual Management Reports (IMRs) were asked to provide chronological accounts of their contacts with Tracy and Robert prior to the date of Tracy's death.

16.2. Seven organisations have provided IMRs or reports detailing relevant contacts. The Review Panel has considered each carefully from the viewpoint of Tracy and Robert 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. Where they have not done so, the Panel has deliberated if any key lessons have been identified from the chronologies and if so, that they are being properly addressed.

16.3. The Review Panel has checked that the key agencies taking part in this Review have domestic abuse policies (either stand alone or as part of a wider Safeguarding Policy) and is satisfied that those policies are fit for purpose.

16.4. The lessons learnt and recommendations / action plans to address them, are listed later in this report in Section 19.

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

Adult Social Care Surrey County Council (ASC)

16.6. Adult Social Care records showed a period of contact with Tracy that pre-dated Tracy's current record system, and that only limited information was transferred from the earlier system to the current system. Early entries only indicate the incidents happening but does not have any detail about what took place and what the rationale was for any decisions made.

16.7. ASC were made aware by Tracy that she had a life-limiting liver condition from 2016, ASC did not verify with Tracy's GP if this was the case. Tracy contacted ASC on multiple occasions to ensure the right care arrangements were in place for her older child, in anticipation that her life expectancy was a matter of a few years. The IMR Author noted that the information regarding Tracy's health did not appear to have informed any of the later work ASC completed with Tracy.

16.8. It has been acknowledged by the IMR Author, that there were a number of occasions where the need for a carer's assessment for Tracy was identified, but this work was not completed.

16.9. There was a lack of professional curiosity into why Tracy would request support from ASC, but later state there was no further need for that support. This included May 2018, where there were three referrals to ASC in a short period of time. One from Tracy requesting support, another from Surrey Police in relation to Tracy's belief that Robert was attempting to defraud her of millions of pounds and another from Surrey Police who reported concerns that Tracy was struggling to care for herself.

16.10. In July 2018, Tracy contacted ASC for support, and was noted to be particularly upset and wanted help and advice, yet the following day she declined any offer of support from ASC. The IMR Author noted that Tracy may have been experiencing coercion and control, and there was a theme of Tracy requesting support and then quickly retracting. This was not recognised by practitioners at the time.

16.11. In October 2018, ASC received a safeguarding referral from Surrey Police raising concerns that Tracy was unable to care for her older child appropriately. The IMR Author noted that in the last four months, ASC had received information that Tracy was bankrupt, experiencing depression and anxiety, had reported a history of domestic abuse by Robert and was going through an acrimonious divorce. Tracy had informed ASC that things were "*too much for her*", the Court of Protection had found her lacking mental capacity to act as a Lasting Power of Attorney and ASC had received a SCARF suggesting Tracy may be at risk of suicide.

16.12. The IMR Author acknowledged, that work was often embarked upon on the basis that there were significant issues that needed to be addressed, but ASC concluded *"that there were no significant issues to be addressed*". ASC did not demonstrate professional curiosity into why there was this apparent change the first time this happened and did not identify this as becoming a pattern.

16.13. In April 2019, ASC provided Tracy with contact details for Your Sanctuary, but did not support her in contacting the service or enquire with Your Sanctuary as to whether Tracy had contacted them. Tracy later informed ASC that she attended a week-long course with Your Sanctuary, but this appeard to be incorrect. It is possible that Tracy's response resulted in ASC believing she had suitable support in place for her experience of domestic abuse.

16.14. In July 2019, Tracy informed ASC that her younger child was now the older child's Lasting Power of Attorney, as Tracy was deemed to lack capacity. This was an indicator that Tracy had care and support needs in her own right and should have been considered for a S42 enquiry[22].

16.15. The IMR Author acknowledged that ASC did not work with other agencies as well as could have been expected. This included little contact with Tracy's GP and CMHRS. Tracy was eligible for S9 Care Act[23] assessments, these assessments were not completed.

16.16. ASC did not always recognise that Tracy had care and support needs. Where care and support needs were identified, the response was inconsistent.

Children Social Care Surrey County Council

16.17. Children Social Care had no contact with Tracy or Robert during the Review

[22] The enquiry establishes whether any action needs to be taken to prevent or stop abuse or neglect and if so, what and by whom.
[23] The assessment must focus on the person's needs and how they impact on their wellbeing and the outcomes they want to achieve.

timeframe. They did however have contact with Tracy in 2014 relating to an application made to be a foster carer.

16.18. What appears clear is that in the intervening period, Tracy's psychological health deteriorated to the point that she ended her life in 2022.

Metropolitan Police Service

16.19. The IMR Author acknowledged that the responses provided during contacts between the Metropolitan Police and the parties involved were largely appropriate. However, significant changes in public protection policy have evolved since incidents that occurred which date back to 2016.

16.20. First Instance Harassment Warnings became obsolete in the Metropolitan Police Service from the 31 January 2020. HMICFRS (His Majesty's Inspectorate of Constabulary and Fire and Rescue Services) recommended that all Police forces cease the use of harassment warning letters following national inspection, on the basis that there was no evidence they were effective, and it was considered they had been used inappropriately in cases that had progressed to Homicides. This decision was supported by the NPCC (National Police Chiefs Council) Lead for stalking and harassment, the College of Policing (CoP) and the Metropolitan Police Service Chief Officers. Officers are advised and directed to consider a range of other tactical options, such as (but not exhaustive) Domestic Violence Prevention Notices and Domestic Violence Prevention Orders, Non-Molestation Orders, Stalking Prevention Orders and/or Restraining Orders. This is documented in more detail in the latest Metropolitan Police Service Domestic Abuse Policy (last updated in June 2023).

16.21. The IMR Author acknowledged that the nature of the harassment reported was obviously complex and although it was largely assessed to be disagreements over civil issues, a First Instance Harassment Warning was issued to Tracy. This would not occur today, and it is more likely that Tracy would have been arrested or interviewed voluntarily under caution at a Police station (or no further action taken if appropriate).

16.22. Greater professional curiosity should have been exercised on some occasions when Tracy disclosed previous physical violence to Officers in September and November 2016. It appears that assumptions were made by Officers that these matters had been investigated when this should have been confirmed. At the time of the incidents, all allegations should have been recorded on a crime report as per Home Office Counting Rules.

16.23. If a counter-allegation had been recorded, this may have prompted a DASH risk assessment to have been completed with Tracy. This may have provided a more holistic understanding of risk to both parties and an opportunity for a referral to outreach domestic abuse support. Subsequently, Tracy was treated as the primary perpetrator and not as a victim too.

16.24. The College of Policing Authorised Professional Practice refers to 'First Response Guidance to Domestic Incidents' and states:

"Counter-allegations require Police Officers to evaluate each party's complaint separately and conduct immediate further investigation at the scene (or as soon as is practicable) to determine if there is a primary perpetrator. If both parties claim to be the victim, officers should risk assess both. There may also be circumstances where the party being arrested requires a risk assessment, as in the case of a victim retaliating against an abuser. Officers should bear in mind the possibility that the relationship is a mutually abusive one."

16.25. Good practice was demonstrated when offences were reported to the Metropolitan Police but required transfer to Surrey Police. These were conducted swiftly and with effective liaison between the two forces. (with the exception of one).

16.26. The IMR Author noted an Independent Office for Police Conduct (IOPC) recommendation was made previously for the Metropolitan Police Service on the subject of counter-allegations, and therefore does not propose a further recommendation.

Surrey and Borders Partnership NHS Trust (SaBP)

16.27. There was evidence of good communication and information sharing between SaBP and Tracy's GP, including a timely response to GP referrals.

16.28. Tracy was offered appointments that were convenient for her and was given a period of time to ensure that her medications were at an effective stage prior to an assessment. This demonstrated good professional judgement and a person-centred approach.

16.29. Tracy attended an assessment with CMHRS in September 2018. During this assessment she disclosed being the victim of domestic abuse by Robert. There was no professional curiosity or confirmation that her disclosures of domestic abuse had been previously disclosed to other agencies or queried, as to whether Tracy may want support from an outreach domestic abuse support service. Tracy disclosed during the assessment that Robert was "*malicious*" and that the divorce proceedings were very distressing for her. Post-separation abuse was not identified and the assessor records that the risk posed to Tracy by others was 'low'.

16.30. Tracy informed CMHRS that she was a carer for her older child, but there was no liaison with ASC to confirm whether Tracy had received a carer's assessment.

16.31. The IMR Author noted that despite good information sharing between SaBP and Tracy's GP prior to the assessment in September 2018, the assessment was not subsequently shared with Tracy's GP.

16.32. It was acknowledged by the IMR Author that some of the entries in Tracy's SystmOne records were variable, with information recorded in the wrong section.

16.33. SCARF reports were appropriately reviewed by SaBP MASH and forwarded to the CMHRS. However, it is unclear on some occasions what actions were taken. The IMR Author identified there was no evidence that the risk assessments, care

plans or crisis and contingency plans were reviewed or updated following the receipt of SCARF reports.

16.34. At no point during Tracy's contact with CMHRS was there any record of her capacity being assessed or discussed, although the IMR Author noted it is also important to recognise the assumption of capacity as the default.

Surrey Heartlands Integrated Care Board (ICB) for GP's

16.35. There were over 50 direct contacts between Tracy and her GP practice during the Review period, and the majority of these were directly related to the ongoing divorce proceedings and the financial settlement associated with this. At the start of the Review period, divorce proceedings were already underway and were still not concluded at the time of Tracy's death in March 2022.

16.36. The Review acknowledged that Tracy had a good relationship with her GP and was able to speak openly about the difficulties she was facing, despite not always trusting professionals. Whilst Tracy had a positive relationship with her GP, the support she needed went far beyond what would be considered reasonable for one professional to provide. Patients with complex needs can often become reliant on one trusted professional.

16.37. GP records noted that Tracy was experiencing financial abuse, but there was no signposting or referral to outreach domestic abuse support made by Tracy's GP. It may be that Tracy could have benefitted from this support.

16.38. In June 2018, a Court Order was issued requiring Tracy's GP to give an opinion on whether Tracy lacked capacity in relation to the divorce proceedings. The IMR Author has found this to be relatively unusual for this decision to be made by a GP rather than a specialist, particularly with regards to a protracted legal case. The IMR Author spoke with the GP who described feeling out of their depth with the Court request. The GP did seek medico legal support from their medical defence organisation, and was advised that the GP had no alternative but to comply as this was issued as a Court Order.

16.39. During the COVID pandemic in 2020/2021, Tracy's routine contacts with the GP practice were via telephone rather than face to face, but this did not seem to have changed the nature of the contacts. In 2021, the IMR Author noted that Tracy only had one GP consultation (although she did have routine medication reviews with the practice pharmacist in August and November), which is a significant reduction on previous contact frequency.

Surrey Police

16.40. Tracy disclosed historic allegations of domestic abuse by Robert in 2017. Surrey Police appropriately completed a DASH risk assessment and a referral to outreach domestic abuse support.

16.40.1. At the time of the report, summary only offences were required to be reported within six months of the offences occurring as this formed part of the basis

for no further action to be taken. Although Officers did recognise the potential for using the incident as evidence of 'bad character' should the case have reached the prosecution stage. In January 2022, it was announced by the Government that under the Police, Crime, Sentencing and Courts Bill 2022, victims of domestic abuse will be allowed more time to report incidents of assault against them. Time limitations have been changed to six months from the date the incident is reported to police with an overall time limit of two years from the date of the incident.

16.40.2. Whilst this would not have changed the outcome of this incident, it is an important change to legislation and ensures victims of domestic abuse have enough time to seek justice.

16.40.3. The IMR Author identified that there was a missed opportunity in December 2017 for Officers to speak with Tracy who had taken the photographs of her bruised arm in relation to the assault allegation that occurred in 2015-2016.

16.41. The IMR Author identified that Surrey Police did not adopt a proactive approach in relation to the arrest of Robert, which didn't take place until eight weeks after a statement had been provided by Tracy on 5 December 2017 and then conducted by way of voluntary attendance. Records suggest that a contributory factor in respect of the delay was an inability to trace Robert's current address. There is also an indication that Robert may have been out of the country around this time. It was not considered that Robert's late apprehension impacted on Tracy's safety, as neither party are understood to have any contact for at least a year prior to the matter being reported to Police.

16.42. On 10 June 2018, Surrey Police responded to a report from Tracy that she was experiencing controlling and financial abuse perpetrated by Robert. Whilst the IMR Author agrees with the outcome of the investigation, it is noted that it was extremely problematic to differentiate between what might constitute financial abuse and the division of the family assets as part of the ongoing divorce proceedings.

16.42.1. The case remained recorded as a domestic incident, but the Officer did not consider an outreach domestic abuse referral for Tracy, which the IMR Author acknowledges was an omission.

16.43. On 12 June 2018, the Metropolitan Police transferred a crime report to Surrey Police following a third-party report that Tracy had been sexually assaulted and domestically abused by Robert. Surrey Police only had a record of the safeguarding referral and not the crime report. This matter has been raised to the relevant senior leader to investigate whether Surrey Police action was compliant with crime recording policy and procedure.

16.44. In March 2019, Surrey Police received a report of theft of property from Tracy's home. Surrey Police later established that the items were lawfully removed with Tracy's permission into storage. This appears to have been to prevent Robert from taking the items. Surrey Police deemed this to be a civil dispute and no further action was taken. The report records that a SCARF was completed, but the IMR Author was unable to find a record of the document.

16.45. In March 2020, the Domestic Abuse Bill 2020 was published and extended the jurisdiction under Article 44 of the Istanbul Convention[24] to cover domestic law. As such the IMR Author has sought legal advice in regard to Tracy's reports of historic domestic abuse whilst she resided in the United Arab Emirates.

16.46. The IMR Author also identified unhelpful and inappropriate language in an early supervisory review that set the wrong tone for the investigation. This matter has been passed on to the relevant Surrey Police senior leader for their consideration. This example of unhelpful and inappropriate language on Police reports will also be included in a submission to the bimonthly Surrey & Sussex Investigations and Intelligence Learning Board (IILB) for discussion and subsequent force wide communication.

16.47. The IMR Author has considered whether an absence of timely SCARF and VAAR submissions in relation to Tracy and the dispute with her neighbour (there was only one submission in relation to thirteen incidents), constituted a systemic oversight by Officers.

16.47.1. The incidents recorded over a five-month period, comprised Tracy displaying clear signs of irrational and illogical behaviour. However, the IMR Author does not believe that Tracy always overtly presented as vulnerable and in need of care and support. As such there would have been no perceived requirement by responding Officers for other agency involvement.

Your Sanctuary

16.48. Tracy had limited contact with Your Sanctuary in 2017 following a referral from Surrey Police.

16.49. Good practice was identified in repeated attempts to reach out to a new client following a referral. This had a positive result, and an Outreach Worker was able to speak with Tracy and offer support.

16.50. Tracy expressed a desire to undertake the Freedom Programme, but it is not clear if she ever undertook the course. The IMR Author identified a lack of follow up with Tracy, and a missed opportunity to contact Tracy again nearer the time the course was due to commence to offer support and assist in Tracy's attendance on the course.

17. KEY ISSUES & CONCLUSIONS

17.1. The Review Panel has formed the following key issues and conclusions after considering all of the evidence presented in the reports from those agencies that had contacts with Tracy and Robert.

17.2. The Review Panel commends the agencies that had contact with Tracy and Robert for the thoroughness and transparency of their reports. Whilst all the lessons

[24] Article 44 of the Istanbul Convention extends the jurisdiction of the United Kingdom Courts to be able to prosecute certain violent or sexual offences outside the United Kingdom by a United Kingdom national.

identified will be addressed by the action plans set during this Review, many would not have had a significant bearing on the circumstances surrounding Tracy's death. The Review Panel has however, recognised the following as being key issues, albeit some with the benefit of hindsight:

17.3. Following her separation from Robert, Tracy disclosed to all agencies that she had suffered domestic abuse perpetrated by Robert. This included a significant assault when Tracy and Robert were living in the United Arab Emirates and further domestic abuse on their return to the United Kingdom.

17.4. The domestic abuse disclosed by Tracy was not recognised by agencies in all its forms. Tracy experienced post-separation abuse. Post-separation abuse can be defined as the ongoing, wilful pattern of intimidation of a former intimate partner including legal abuse, economic abuse, threats and endangerment to children, isolation and discrediting and harassment and stalking (Spearman, Hardesty and Campbell, 2022)[25].

17.5. For Tracy, the post-separation abuse she experienced was perpetuated by financial inequality and power and control dynamics through ongoing divorce proceedings. Tracy stated that were times when she was discredited by Robert (and possibly legal representatives) regarding her mental health. This was further impeded by Tracy being unable to fund a course of action that may have supported her or resulted in signposting to agency provision. This was evident in the suggestion of a privately funded psychologist report regarding her capacity to understand the Court proceedings.

17.6. Although some agencies recognised the resulting impact the divorce proceedings were having on Tracy, no agency identified that Tracy was experiencing post-separation abuse in a wider context. There were missed opportunities for referrals to be made for specialist outreach domestic abuse support services.

17.7. Past experiences of domestic abuse are likely to form an ongoing presence of fear of the perpetrator. For Tracy the post-separation abuse was set against a background of additional stresses such as her caring responsibilities for her older child, her extensive physical health conditions, an ongoing neighbour dispute and mental health concerns.

17.8. Tracy's care and support needs were not always recognised and responded to. There were missed opportunities to undertake S9 assessments for Tracy and consideration as to what additional support could be offered to her to keep her safe from abuse.

17.9. Domestic abuse has additional impacts on people with care and support needs. Perpetrators can use a victim's dependency to assert and maintain control. In particular Tracy's physical health conditions and concerns that she needed to ensure the correct support was in place for her older child should her health deteriorate. She also remained financially attached to Robert with shared company assets and the family home in which Tracy and her children continued to reside.

[25] Spearman KJ, Hardesty JL, Campbell J (2022). 'Post-separation abuse: A concept analysis'. Journal of Advanced Nursing, p1225-1246.

Financial dependence was a fear Tracy articulated, having witnessed her mother experiencing this following the loss of Tracy's father. This may have intensified her worries and sense of uncertainty.

17.10. There were a number of missed opportunities to provide Tracy with additional support as a carer for her older child via a carer's assessment. There was a pattern in which Tracy would request support and then advise agencies this was no longer required.

17.11. The stresses that Tracy was experiencing were often attributed to the ongoing divorce proceedings, but few agencies recognised that Tracy may have been experiencing caregiver's stress. Signs of caregiver's stress can include anxiety, becoming easily agitated or angry, feeling low, misusing substances including prescribed medication, missing medical appointments, having frequent health related issues, poor sleep and weight loss or gain.

17.12. Almost all these factors were experienced by Tracy within the Review timeframe, and at times may have been attributed to mental health concerns due to the narrative that Tracy lacked capacity.

18. LESSONS LEARNED

18.1. The following summarises the lessons agencies have drawn from this Review. The recommendations made to address these lessons are set out in the action plan template in Section 19 of this report.

Adult Social Care Surrey County Council (ASC)

18.2. ASC identified that during their work with Tracy, her individual care and support needs were not always identified. This was particularly apparent for Tracy who was experiencing issues with her mental health and emotional wellbeing, and had experienced (and was still experiencing) domestic abuse, and there was a known risk of suicide. Tracy's care and support needs were impacting on her personal relationships, caring responsibilities, and her divorce proceedings.

18.3. There was a lack of professional curiosity into the information provided by Tracy. Subsequent partnership working, particularly with Tracy's GP and CMHRS was ineffective and a holistic approach with the family was not undertaken.

18.4. The learning from this Review will be shared with the Quality Improvement Group to explore how this can be improved in the future.

Metropolitan Police Service

18.5. The IMR Author submits that whilst there were some issues identified, these were early on in the Review timeframe. Since that time period, significant changes have been made to the Metropolitan Police Service's public protection policies and therefore, any identified learning is no longer relevant to current practice.

Surrey and Borders Partnership NHS Trust (SaBP)

18.6. SCARF reports were appropriately reviewed, however it was not always clear what actions were taken. There is ongoing work within the Trust around recordkeeping with a specific focus on risk assessments, care plans and crisis and contingency plans.

18.7. There is a need for increased recognition of post-separation abuse. There is ongoing work within the Trust around domestic abuse, in particular staff training, raising awareness and promoting safeguarding procedures.

18.8. Despite awareness that Tracy was deemed to lack capacity in relation to Court proceedings, there was no consideration given to whether a mental capacity assessment should be undertaken. A briefing for all staff on safeguarding procedures and the Mental Capacity Act will be shared.

18.9. The learning from this Review will be shared through training, internal learning platforms and governance arrangements.

Surrey Heartlands Integrated Care Board (ICB) for GPs

18.10. Whilst Tracy had a positive relationship with her GP, the support she needed went far beyond what would be considered reasonable for one professional to provide. Patients with complex needs can often become reliant on one trusted professional.

18.11. Greater consideration needs to be given to how practices identify their most complex and dependent patients, in order to support both patient and professional. A number of the acute hospital trusts have “high intensity user” teams and practices should be supported in developing similar internal arrangements. It is worth noting that many practices have some processes in place, and this enables sharing of good practice across primary care networks and GP federations.

18.12. GPs will often support patients at times of relationship breakdowns, including separation and divorce. Consideration should be given to the coexistence of domestic abuse alongside acrimonious separations; both as a reason for the relationship breakdown and as coercive/controlling behaviour through the Courts. Staff need to be empowered in asking, enquiring about post-separation abuse and offering referrals to specialist support services if domestic abuse is found to be a factor.

Surrey Police

18.13. Tracy made a number of disclosures of offences to Surrey Police. The standard of some of the investigations was insufficient with Officers not always following all reasonable lines of enquiry and a delay in the arrest of Robert.

18.14. There were two incidences identified of unhelpful and inappropriate comments made in supervisory reviews during investigations.

18.15. Issues were identified in relation to failure in correctly recording a crime transfer from a neighbouring Police Force.

Your Sanctuary

18.16. Tracy expressed a desire to undertake the Freedom Programme course due to take place in March 2018. There was no follow up from Your Sanctuary to see if Tracy wished to engage with the course and whether Your Sanctuary could arrange this for her. Your Sanctuary need to consider how they can ensure that longer term, future actions are recorded and completed. This is particularly relevant when the case is closed, and no ongoing support is requested.

19. RECOMMENDATIONS

Adult Social Care (ASC)

19.1. ASC will use the learning from this Review to inform the ongoing work of the Safeguarding Improvement Group, which is overseeing this programme of work. In particular, the effectiveness of ASC work to recognise that a person has care and support needs, particularly where:

1) Those needs arise from issues to do with the person's mental or emotional wellbeing.

2) The needs are impacting on outcomes such as developing and maintaining family or other personal relationships; accessing and engaging in work, training, education or volunteering; making use of necessary facilities or services in the local community including public transport and recreational facilities or services; and carrying out any caring responsibilities the adult has for a child.

   - The person who has experienced domestic abuse.
   - There is a risk of suicide.

3) Application of the Mental Capacity Act 2005, particularly in relation to:

   - Situations in which the parent of a person over 16 years old is refusing the offer of an assessment of that person.
   - Risk assessment practice, including assessment of suicide risk.
   - Professional curiosity.
   - Ensuring effective partnership working with others, including mental health services, police and GPs.

Surrey and Borders Partnership NHS Trust (SaBP)

19.2. A briefing for all staff on safeguarding procedures and the Mental Capacity Act to be shared through internal governance arrangements.

19.3. Learning themes from this Review to be shared through training, internal learning platforms and governance arrangements.

19.4. A briefing for all staff to recognise post-separation abuse to be shared across the Trust, within safeguarding internal training and Quality Assurance Group meetings.

Surrey Heartlands Integrated Community Board (ICB) for GPs

19.5. Learning from this DHR to be used to support practices in regularly reviewing "high intensity users" to ensure appropriate support is available to the individual and the professionals involved in their care.

19.6. Learning from this DHR is used to support staff working with patients at times of relationship breakdown and considering if domestic abuse is a factor. Specialist Outreach signposting/referral to be supported when identified as appropriate.

Surrey Police

19.7. To address performance issues identified in relation to inappropriate supervisory comments recorded within investigations. Feedback to be given to Officers concerned and learning to be shared.

19.8. To address performance issue identified in relation to failure to correctly record a crime transfer from a neighbouring Police service. Feedback to Officer concerned and appropriate action to be taken if deemed necessary.

19.9. To address performance issues identified in relation to standard of investigation - reasonable lines of enquiry not being followed.

Your Sanctuary

19.10. Your Sanctuary Management team to review the process both as written in policy and as understood 'on the ground' by all staff, in relation to how to ensure any longer term/future actions are recorded and completed. This is particularly relevant when the case is closed as no ongoing support was requested.

19.11. The DHR Panel's recommendations and up to date action plan at the time of concluding the Review on 23 October 2023 are detailed in the template below. After publication of this report, the Runnymede Community Safety Partnership and Surrey Safeguarding Adults Board will discuss with partner agencies how other existing cross agency strategies can build on these recommendations.

Recommendation	Scope of recommendation i.e. local or national	Action to take	Lead Agency	Key milestones achieved in enacting recommendation	Target date	Completion date and outcome
The learning for Adult Social Care from this DHR touches on issues ASC have seen in other reviews. This indicates that these are not issues that ASC will quickly resolve and anticipate a programme of work will be needed. ASC will use the learning from this review to inform the ongoing work of the Safeguarding Improvement Group, which is overseeing this programme of work. In particular, the effectiveness of ASC work to recognise that a person has care and support needs, particularly where: 1) Those needs arise from issues to do with the person's mental or emotional wellbeing. 2) The needs are impacting on outcomes such as developing and maintaining family or other personal relationships; accessing	Local	To present a report to our Safeguarding Improvement Group (SIG) on the learning from this review, so that the SIG can incorporate this learning within its programme of improvement work.	Adult Social Care	The presentation will have been given to our Safeguarding Improvement Group. A series of workshops have been rolled out to the locality managers highlighting the role of assessment in promoting wellbeing and preventing abuse, along with guidance on actions to be taken where there are assessment refusals.	31 Dec 2023 Mar/ Apr 2023	**Action Outstanding** To be timetabled at the SIG in November. **Mar/Apr 2023** Part 1 sessions led by the DASS on: 08/03/2023 15/03/2023 20/03/2023 30/03/2023 Part 2 sessions led by the Principal Social Worker and Head of Safeguarding on: 10/05/2023 12/05/2023 18/05/2023 23/05/2023 01/06/2023 Outcomes are being measured

and engaging in work, training, education or volunteering; making use of necessary facilities or services in the local community including public transport and recreational facilities or services; and carrying out any caring responsibilities the adult has for a child. • The person who has experienced domestic abuse. • There is a risk of suicide. 3) Application of the Mental Capacity Act 2005, particularly in relation to: • Situations in which the parent of a person over 16 years old is refusing the offer of an assessment of that person. • Risk assessment practice, including assessment of suicide risk. • Professional curiosity. • Ensuring effective partnership working with others, including mental health services, police and GPs.						through regular audits and supervision to ensure learning is embedded and is being utilised. The PSW will oversee this work. The themes can be followed up at the following forums: reflective practice sessions, lunch and learn sessions, the Community of practice and the Operational Managers Group meetings. A risk enablement framework is under development.

A briefing for all staff on safeguarding procedures and the Mental Capacity Act to be shared through internal governance arrangements.	Local	Safeguarding training to include the Mental Capacity Act with use of key studies and compliance of the Mental Capacity Act-training will be monitored in the Trust.	SaBP	The Safeguarding team and the Legal team to provide guidance and discussion on complex case discussions. To share national and local updates through the internal governance.	31 Dec 2023	**Action Outstanding** The intended outcome is that staff having gained a better understanding of the MHA and safeguarding procedures will be more confident in dealing with complex cases.
Learning themes from this Review to be shared through training, internal learning platforms and governance arrangements.	Local	Briefing on learning themes to be provided to all Trust staff.	SaBP	Learning from all SARs and DHRs are shared through training, team meetings and internal governance.	31 Dec 2023	**Action Outstanding** Outcome is that staff will through training improve their knowledge and efficiency in such cases.
A briefing for all staff to recognise post-separation abuse to be shared across the Trust, within safeguarding internal training and Quality Assurance Group meetings.	Local	In the Safeguarding training and Ambassadors against domestic abuse meetings to include the signs of post separation abuse.	SaBP	To share information from legal documents such as the Domestic Abuse Statutory Guidance and monitor how it is imbedded in daily practice.	Ongoing	**Ongoing** The intended outcome is that staff will through training and support improve their understanding and efficiency in dealing with post-separation abuse.
Learning from this DHR to be used to support practices in regularly reviewing “high	Local	Learning is embedded within level 3 safeguarding update training and practice	Surrey Heartlands ICB (for GPs)	Learning is included in next round of training events (autumn 2023-	Late spring 2024.	**Ongoing** The outcome is to improve staff

intensity users" to ensure appropriate support is available to the individual and the professionals involved in their care.		leads' safeguarding supervision sessions.		spring 2024) and quarterly leads' supervision sessions.		understanding of the needs of high intensity users and thereby, enhance the support available to them.
Learning from this DHR is used to support staff working with patients at times of relationship breakdown and considering if domestic abuse is a factor. Specialist Outreach signposting/referral to be supported when identified as appropriate.	Local	Learning is embedded within level 3 safeguarding update training.	Surrey Heartlands ICB (for GPs)	Learning is included in next round of training events (autumn 2023-spring 2024)	Late spring 2024.	**Ongoing** With the intention of making staff more aware of the dangers of relationship breakdown and possible domestic abuse.
To address performance issues identified in relation to inappropriate supervisory comments recorded within investigations. Feedback to be given to Officers concerned and learning to be shared.	Local	Case referred to Senior Manager. Individual feedback not possible due to officers' having left the service. Submission to the bimonthly Surrey and Sussex Investigations and Intelligence Learning Board (IILB) for discussion/force wide communications.	Surrey Police	Learning to be discussed at next scheduled IILB on 23/10/2023.	31 Dec 2023	**Action Outstanding** Sharing the learning through discussion in this manner, should remind Officers of the dangers of ill-considered comments.
To address performance issue identified in relation to failure to correctly record a crime transfer from a neighbouring police service. Feedback to Officer concerned and appropriate	Local	Case referred to senior manager to provide feedback to the officer concerned and to take appropriate action as deemed necessary.	Surrey Police		31 Dec 2023	**Action Outstanding** The outcome is that this Officer will recognise the importance of correctly recording

action to be taken if deemed necessary.						information in the future.
To address performance issues identified in relation to standard of investigation, reasonable lines of enquiry not being followed.	Local	Provide guidance for officers in relation to conducting effective investigations and the need to pursue all reasonable lines of enquiry when investigating offences.	Surrey Police	The learning point has been included on a learning submission for the next scheduled joint force IILB scheduled on 28/08/2023. Updated guidance/ guidelines released by the College of Policing on 28/08/2023 in relation to improving and conducting effective investigations is to be implemented in police training and to be monitored by the Investigative Improvement Board. This is a new directive.		**Ongoing** The intended outcome is for Officers to improve their investigative skills.
Your Sanctuary Management team to review the process both as written in policy and as understood 'on the ground' by all staff, in relation to how to ensure any longer term/future actions are recorded and completed. This is particularly relevant when the case is closed as no ongoing support was requested.	Local	Review recording of notes and group session requests or the follow through for ongoing support.	Your Sanctuary	New case management system in place to ensure effective note recording. All information regarding clients/survivors recorded on the same platform to ensure consistency of information sharing.	14 Jul 2023	**14 Jul 2023** This has had a very positive impact on how our information is stored and shared internally and externally and has enabled us to follow up on requests for further support.

Appendix A: Glossary

AAFDA	Advocacy After Fatal Domestic Abuse
ASC	Adult Social Care
CCTV	Closed Circuit Television
CMHRS	Community Mental Health Recovery Service
COP	College of Policing
COVID	Coronavirus Disease
CPN	Community Psychiatric Nurse
DASH	Domestic Abuse Stalking and Harassment
DHR	Domestic Homicide Review
EFT	Effective Freedom Techniques
GP	General Practitioner
HMICFRS	His Majesty's Inspectorate of Constabulary and Fire and Rescue Services
ICB	Integrated Care Board
IILB	Investigations & Intelligence Learning Board
IMR	Internal Management Review
IOPC	Independent Office for Police Conduct
MASH	Multi Agency Safeguarding Hub
NHS	National Health Service
NPCC	National Police Chiefs Council
ONS	Office of National Statistics
S9	Section 9
S42	Section 42
SaBP	Surrey and Borders Partnership
SAR	Safeguarding Adults Review
SCARF	Single Combined Assessment of Risk Form
SLE	Systemic Lupus Erythematosus
UAE	United Arab Emirates
VAAR	Vulnerable Adults at Risk

Appendix B: Bibliography

- Walby, S. and Towers, J. (May 2017) 'Measuring violence to end violence: mainstreaming gender', Journal of Gender-Based Violence, vol. 1, no. 1, p11-31.
- Abused Women or abused Men? An examination of the context and outcomes of dating violence: Follingstad, Wright, Lloyd, and Sebastian 1991.
- A Model for Female - Perpetrated Domestic Violence: Delia Anastasia Bernardi & Francois Steyn.
- A Review of Research on Women's use of Violence with Male Intimate Partners: SC Swan, LG Gambone, JE Caldwell 2005.
- An evidence-based response to Intimate Partner Violence: WHO guidelines.
- CAADA Responding to Domestic Abuse: Guidance for General Practice.
- Code of Practice for Victims of Crime (October 2015).
- Crime Survey for England and Wales for year ending March 2017.
- Coercive and Controlling Behaviour: Professor Jane-Monckton Smith.
- Domestic Abuse Act 2021.
- Domestic Homicide Review Toolkit.
- Domestic Abuse: Finding from the Crime Survey for England and Wales year ending March 2017.
- Who Does What to Whom? Gender and Domestic Violence Perpetrators in English Police records: Marianne Hester.