Recommendation	Scope of recommen dation 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 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.	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.	SCC 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.	Completed 31 Dec 2023 Mar/ Apr 2023	Action Completed March/April 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 12/05/2023 23/05/2023 23/05/2023 01/06/2023  Outcomes are being measured 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.

<ul> <li>There is a risk of suicide.</li> <li>3) Application of the Mental Capacity Act 2005, particularly in relation to:</li> <li>Situations in which the parent of a person over 16 years old is refusing the offer of an assessment of that person.</li> <li>Risk assessment practice, including assessment of suicide risk.</li> <li>Professional curiosity.</li> <li>Ensuring effective partnership working with others, including mental health services, police and GPs.</li> </ul>						A risk enablement framework is under development.  No Response Guidance June 2024. Outcome: no case can be closed by a single worker.  Practice Framework March 2023. Outcome: we show residents we care and work in partnership  Review of our Quality Assurance Framework started in September 2024.  Surrey Prevention Strategy 2023. Outcome: agencies are aware of their roles and have a joint commitment to preventing suicide.  Review of our strengths-based practice framework started in September 2024.
Surrey and Borders Partnership NHS Trust (SaBP) - 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 Acttraining 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 Ongoing 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.  Update October 2024 MCA in included in the Safeguarding Adults training at level 2 and 3. The dedicated

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	trainer has also extended her role to presenting the standalone MCA training in the Trust which ensures there is robust crossover of up to date information in both training sessions.  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.  Update October 2024 Learning from this review has been shared at our Ambassadors Against Domestic Abuse Group and cascaded through ongoing monthly meetings with all Divisions. Currently co-producing an updated DA Policy with DA Outreach services which will also contain information and guidance.
Learning from this DHR to be used to support practices in regularly reviewing "high intensity users" to ensure appropriate support is available to the	Local	Learning is embedded within level 3 safeguarding update training and practice leads'	Surrey Heartlands ICB (for GPs)	Learning is included in next round of training events (autumn 2023-spring 2024) and quarterly leads' supervision sessions.	Completed June 2024	June 2024 Training "learning from Surrey DHRs" has helped to improve staff understanding of the needs of high intensity users and

individual and the professionals involved in their care.  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	safeguarding supervision sessions. 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)	Completed June 2024	thereby, enhance the support available to them.  June 2024  Training "learning from Surrey DHRs" has highlighted the need to be aware of the risk of domestic abuse when working with patients at times of relationship breakdown.  Outreach providers have supported training events to continue to raise awareness of services offered and how to refer.
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.	Completed 23 <sup>rd</sup> Oct 2023	Inappropriate language occasionally appears on our records and is challenged on a case-by-case basis but to reinforce the issue the new Domestic Abuse P&P specifically includes guidance on use of language in section 5.1 and this is available to all officers and it is a specific requirement that all DAT officers read it. No evidence from other reviews to suggest that this is a systemic issue. Language matters is a specific element to the current DA training being delivered by Zoe Green (late 23). On 23/10/2023 Jane Lord shared all the learning points from DB at IILB. All three recommendations from this case have been published as a news item on the intranet.

To address performance issue identified	Local	Case referred to	Surrey	Completed	23 <sup>rd</sup> Oct 2023
in relation to failure to correctly record a		senior manager to	Police	23 <sup>rd</sup> Oct	The issue that arose was that
crime transfer from a neighbouring police		provide feedback to		2023	when the crime was transferred to
service. Feedback to Officer concerned		the officer concerned			us it was misinterpreted as
and appropriate action to be taken if		and to take			additional information regarding
deemed necessary.		appropriate action as			an existing investigation rather
·		deemed necessary.			than a separate report. This was
					simply human error rather than a
					failure of policy or
					procedure. The member of staff
					involved has since left the force
					so personal feedback is not
					possible. All matters arising from
					this DHR were presented to the
					bi-monthly Surrey and Sussex
					Investigations and Intelligence
					Learning Board (IILB) on
					23/10/2023 by Jane Lord and a
					decision was made for the
					information to be circulated widely
					across the force for discussion/force wide
					communications. In addition to
					this DI Errol Chetty in OMU has
					confirmed that there is a robust
					process in place for the handling
					of crime transfers with a clear
					policy document and flow chart.
					policy document and now chart.

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To address performance issues identified	Local	Provide guidance for	Surrey	The learning point has been	Completed	23 <sup>rd</sup> Oct 2023
in relation to standard of investigation,		officers in relation to	Police	included on a learning	23 <sup>rd</sup> Oct	This recommendation emerges
reasonable lines of enquiry not being		conducting effective		submission for the next	2023	from DB reporting to us that she
followed.		investigations and the		scheduled joint force IILB		suffered serious domestic abuse
		need to pursue all		scheduled on 28/08/2023.		from her husband when they were
		reasonable lines of				living in Dubai 2009 - 2013 and
		enquiry when		Updated guidance/		the review authors belief that we
		investigating		guidelines released by the		could still have investigated this
		offences.		College of Policing on		under the terms of the Instanbul
				28/08/2023 in relation to		Convention even though it was
				improving and conducting		outside of UK jurisdiction. So far
				effective investigations is to		as we can ascertain the Instanbul
				be implemented in police		Convention was agreed in
				training and to be monitored		principal in 2012 but only ratified
				by the Investigative		by the UK government in 2022
				Improvement Board. This is		and does not apply
				a new directive.		retrospectively so it could not be
						used as a basis to investigate
						offences abroad that were
						reported in 2017 and occurred
						many years earlier. There were
						also some minor concerns about
						one investigation that could have
						been completed more effectively
						and the issue has been circulated
						in the same learning as other
						recommendations from this DHR
						(see above) following discussion
						at IILB. Updated
						guidance/guidelines released by
						the College of Policing on
						28/08/2023 in relation to
						improving and conducting
						effective investigations are to be
						implemented in police training
						and to be monitored by the
						Investigative Improvement Board.
						investigative improvement board.

Your Sanctuary Management team to	Local	Review recording of	Your	New case management	Completed	14 Jul 2023
review the process both as written in		notes and group	Sanctuary	system in place to ensure	14 Jul 2023	This has had a very positive
policy and as understood 'on the ground'		session requests or		effective note recording. All		impact on how our information is
by all staff, in relation to how to ensure		the follow through for		information regarding		stored and shared internally and
any longer term/future actions are		ongoing support.		clients/survivors recorded		externally and has enabled us to
recorded and completed. This is				on the same platform to		follow up on requests for further
particularly relevant when the case is				ensure consistency of		support.
closed as no ongoing support was				information sharing.		
requested.						