Domestic Abuse Related Death Review

Executive Summary of the Domestic Abuse Related Death Review of Anis in March 2024

Parminder Sahota Independent Chair and Author

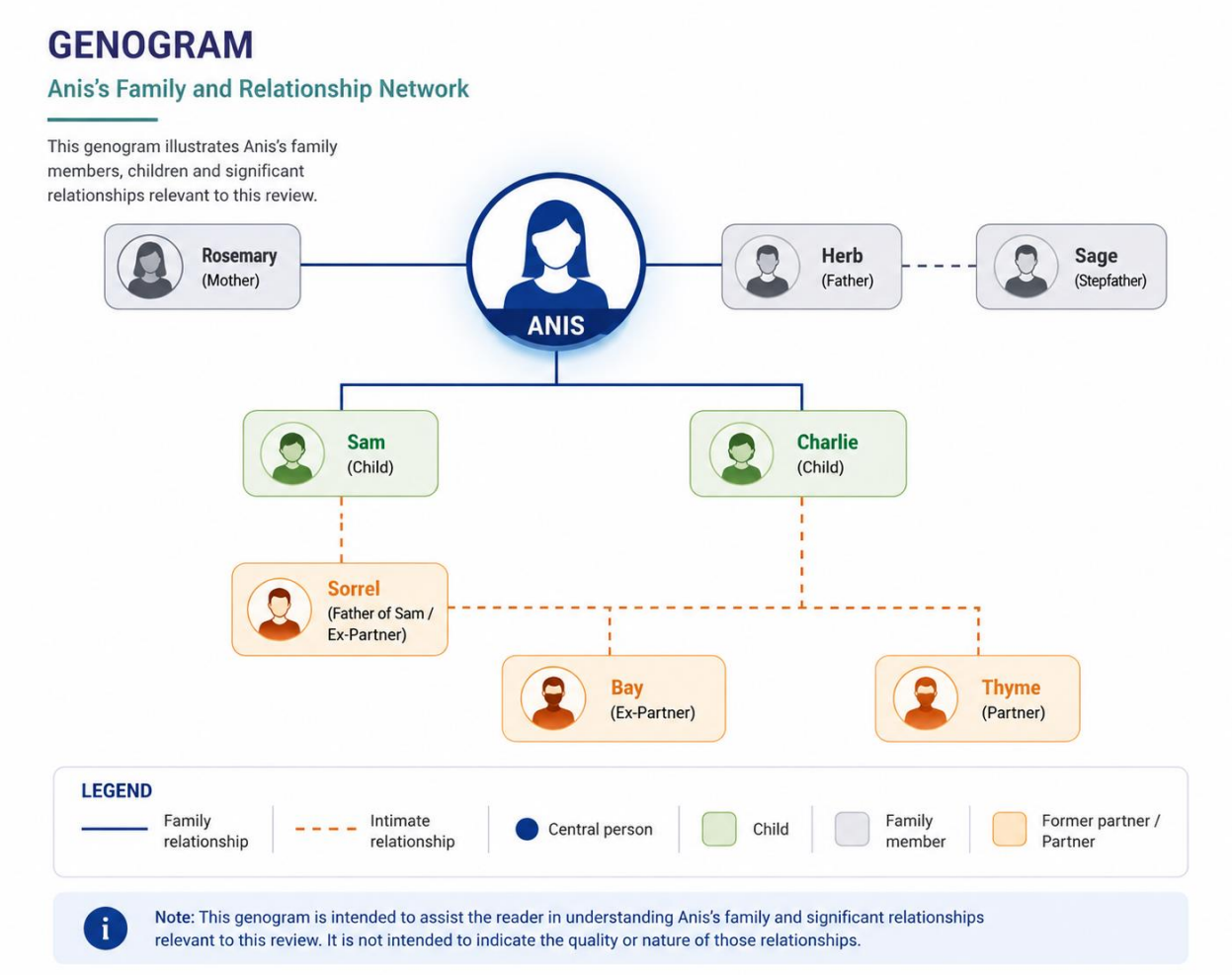
Date Completed: September 2025

Preface

This Domestic Homicide Review (DHR) was commissioned following the tragic death of Anis (a pseudonym) in March 2024. The review examines the circumstances of her death, the responses of involved agencies, and identifies lessons to help prevent future domestic abuse-related deaths.

The panel honours Anis's memory by using her experiences to support improvements in policy, practice, and multi-agency working. We offer our sincere condolences to all those affected.

Pseudonyms have been used to protect privacy. Only the Chair and panel members are named.



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Section One: The Review Process

1.1.1 This summary outlines the process undertaken by the Safer Surrey Heath Community Partnership to review the death of Anis (a pseudonym), a resident of the area.

1.1.2 Anis was 26 years old when she died in March 2024 after taking an overdose of prescribed medication. She left behind two young children, Sam (5) and Charlie (2). Although she left a note and a voice message for her family, neither offered insight into her reasons for ending her life.

1.1.3 This review was commissioned under the Victims and Prisoners Act 2024, which amended the Domestic Violence, Crime, and Victims Act of 2004to establish Domestic Abuse-Related Death Reviews (DARDRs). The review was conducted in accordance with the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (December 2016).

1.1.4 The DARDR process formally commenced in June 2024, when the Safer Surrey Heath Community Safety Partnership determined that Anis's death met the criteria for review. All relevant agencies were contacted to confirm their involvement. Twelve agencies confirmed prior contact with Anis and were asked to secure their records for review.

1.1.5 The panel examined agency involvement between March 2024 and Anis's overdose on sertraline and propranolol, leading to her cardiac arrest and death despite resuscitation efforts, following Anis's October 2022 disclosure of domestic abuse.

1.1.6 Earlier agency involvement was also reviewed due to Anis's history of childhood exploitation and domestic abuse in previous relationships. Her final relationship raised further safeguarding concerns from both professionals and her family.

1.1.7 On 6 November 2024, a Community Safety Officer delivered a letter in person to Anis's parents. The letter included a Home Office leaflet with information about the review, advocacy support (including Advocacy After Fatal Domestic Abuse– AAFDA), and an overview of the DHR process. Both parents expressed willingness to engage and appreciation for the opportunity to contribute.

1.1.8 Despite this initial interest, the family did not re-establish contact. The panel acknowledges the emotional toll such involvement can carry and fully respects the family's decision not to continue. Participation in a review can be profoundly challenging and, for some, re-traumatising. When engagement is possible, it can also offer a space for reflection and healing.

1.1.9 Although Anis's family did not contribute to the review initially, their perspective remains essential. The panel worked with sensitivity and a strong commitment to ensuring Anis's voice was reflected through professional records and practitioner

insight. The findings and recommendations have been shaped by this intent and grounded in the best available evidence.

1.1.10 The Chair and panel committed to writing to Anis's family again following approval of the report, offering another opportunity for input before publication.

1.1.11 Following further contact, the Chair shared the report with Rosemary. She confirmed that she had read the review and provided clarifications. She stated that the medication Anis ingested was propranolol and sertraline, not paracetamol, and that Anis's biological father was not involved in her life until she herself made contact with him in Reigate.

1.1.12 She explained that Anis's period in care followed conflict at home, particularly around restrictions on phone and computer use. Rosemary emphasised that the family did not permit Anis to stay with the man whose house she later went to.

1.1.13 She denied ever assaulting Anis, explaining that any restraint was used only to prevent her from self-harm, including an incident where she stopped Anis from accessing a knife.

1.1.14 Rosemary highlighted that Anis lived with her and her husband during her pregnancy with Charlie, that they often cared for Charlie while Anis worked, and that she was always available to support her.

1.1.15 She confirmed that the family were not aware of domestic abuse in Anis's later relationships, except for abuse from Charlie's father, when the family intervened to ensure her safety.

Key Findings

1.1.16 The review revealed weaknesses in multi-agency safeguarding, with repeated concerns about neglect and abuse not being addressed promptly, indicating significant unaddressed risks.

1.1.17 The review identified disguised compliance in Anis's engagement with services, which seemed constructive but lacked sustained improvement. This underscores the need for greater professional curiosity and confidence in addressing challenging behaviours in families with complex vulnerabilities.

1.1.18 This review seeks learning, not blame, and does not replace the role of criminal or coronial proceedings. It honours Anis's memory by identifying opportunities for meaningful change across policy, practice, and partnership working.

1.1.19 Pseudonyms are used throughout to protect the privacy of those involved. Only the Chair and panel members are identified by name. The panel offers its sincere condolences to all those affected by Anis's death.

Section Two: Contributors to the Review

2.1.1 The following agencies and their contributions to this review:

Agency	Contribution
Ashford & St Peter's Hospitals NHS Foundation Trust is a district general hospital.	Chronology
Aster Group is a housing association which provides quality, affordable homes to thousands of people across the south of England and London.	Chronology and Independent Management Review (IMR)
Central Surrey Health, Community Health Children's Services (CHCS) supports families from pregnancy to age 19 for those with special needs.	Chronology and IMR
Children's Social Care (CSC) supports children and families in times of need.	Chronology and IMR
Education Services represented Charlie's preschool and primary school. They support children with additional needs in accessing quality education in Surrey.	Chronology and IMR
Frimley Park NHS Foundation Trust (FPH) is a general hospital.	Chronology
GP Practice	Chronology and IMR
Hounslow Children and Family Intake Team**.** Initial contact for Children's Services in Hounslow, assessing referrals and determining support for children and families**.**	Chronology and Closure Record (pre-review period)
South East Coast Ambulance Service NHS Foundation Trust (SECAmb)	Chronology
Surrey and Borders Partnership NHS Foundation Trust (SaBP) provides mental health, learning disability, and substance misuse services.	Chronology and IMR
Surrey Police	Chronology and IMR
Surrey and Sussex Healthcare NHS Trust is a general hospital.	Chronology (pre-review period)

2.1.2 The responses were written by professionals not involved in case management or service delivery.

Section Three: The Review Panel Members

3.1.1 The independent panel members for this review were the following:

Name	Role	Organisation
Andy Pope	Statutory Reviews Lead Public Protection Support Unit	Surrey Police
Bob Darkens	Community Safety Officer	Surrey Heath Borough Council
Claudine Cox	Safeguarding Adults & Domestic Abuse Lead	Surrey and Borders Partnership
Elizabeth Cariss	Named Nurse for Safeguarding Children	Surrey Child and Family Health, formerly Central Surrey Health
Fran Richiusa	Domestic Abuse Related Death Review (DARDR) Coordinator	Surrey County Council Community Protection & Emergencies Directorate
Jayne Boitoult	Community Safety Officer	Surrey Heath Borough Council
Josh Dear	Head of Housing	Aster Housing Group
Linde Webber	Service Manager, Quality Assurance	Surrey Children's Services
Louise Balmer	Adult Community Service Lead and Designated Safeguarding Lead	Your Sanctuary
Nanu Chumber-Stanley	Public Health Suicide Prevention Programme Lead	Surrey County Council Public Health Team
Penny Parrott	Child Safeguarding Advisor	Surrey Child and Family Health, formerly Central Surrey Health
Rebecca Eells	Designated Safeguarding Nurse for Adults	NHS Surrey Heartlands Integrated Care Board
Sharon Turner	Head of Safeguarding Adults	Surrey County Council
Tom Stevenson	Assistant Director for Quality Practice and Performance	Surrey County Council Children's Social Care

Section Four: Chair and Author of the Overview Report

4.1.1 This review was chaired by Parminder Sahota, an independent reviewer with over 11 years of experience in safeguarding and domestic abuse. She has worked for over two decades in the NHS as a Mental Health Nurse, specialising in crisis intervention and supporting those with personality disorders. Parminder has also held senior roles, including Director of Safeguarding and Domestic Abuse Lead for an NHS Trust in London.

4.1.2 Parminder completed accredited Domestic Homicide Review (DHR) Chair training with AAFDA in 2021 and 2024, in line with Home Office expectations. She has chaired previous DARDRs and Safeguarding Adult Reviews, including within Surrey. Still, she remains independent of the agencies involved in this case and has had no prior contact with Anis's family or friends.

4.1.3 Her trauma-informed and culturally competent approach supports sensitive stakeholder engagement, critical analysis, and the development of evidence-based recommendations to drive meaningful learning and improvement.

4.1.4 The appointment aligns with Statutory Guidance for DHRs, requiring independent chairs with a strong understanding of domestic abuse and safeguarding legislation. Parminder meets these criteria through her professional expertise and extensive review experience.

Section Five: Terms of Reference

5.1.1 The statutory guidance sets out the purpose of DHRs:

a. Learn from domestic abuse deaths to enhance victim safeguarding.
b. Identify inter-agency lessons and actions.
c. Apply findings to improve policies and service responses.
d. Foster early identification of domestic abuse through a coordinated approach.
e. Promote understanding and highlight effective practices.

5.1.2 The review intends to identify the lessons learned from Anis's death and respond to those lessons to prevent deaths connected to domestic abuse and ensure that individuals and families are supported effectively.

5.1.3 The following were agreed upon as the Key Lines of Enquiry (KLOE):

1. Trauma and Mental Health
2. Access to Services and Domestic Abuse
3. Poverty and Domestic Abuse
4. Holding Perpetrators to Account
5. Learning

Section Six: Summary Chronology

6.1.1 Anis's chronology reveals a long-standing pattern of vulnerability, beginning in adolescence. At age 14, she attempted self-harm following grooming and exploitation by a known offender.

6.1.2 Over the years, she experienced multiple high-risk relationships, frequent missing episodes, sexual and physical violence, and significant safeguarding concerns. Despite repeated contact with agencies, a coordinated and trauma-informed safeguarding response was consistently lacking.

6.1.3 By age 17, Anis was exposed to domestic abuse from adult partners, including one incident in which she was knocked unconscious and threatened with a knife. She was repeatedly found in unsafe environments and with adults known to pose a risk.

6.1.4 Risk assessments and referrals were made, but often lacked appropriate follow-up. Transitions between local authorities and missed case transfers contributed to a lack of continuity in care.

6.1.5 As a young adult and mother, Anis continued to face domestic abuse, mental health challenges, and socio-economic hardship. Disclosures made by Anis and professionals highlighted escalating concerns about emotional harm to her children, poor home conditions, and parental mental health. Sam, her eldest child, showed signs of trauma, including self-harming behaviour, social withdrawal, and emotional dysregulation.

6.1.6 From September 2022 to March 2024, the review period showed intensified concerns. Anis disclosed rape, coercive control, and harassment from a former partner. Despite disclosures and engagement with multiple services, she received limited protective intervention. Disguised compliance and inconsistent agency responses reduced the effectiveness of safeguarding efforts.

6.1.7 Significant learning points include the need for proactive, trauma-informed safeguarding; improved inter-agency communication; robust responses to repeated low-level concerns; and early, assertive intervention when children display signs of distress.

6.1.8 Anis's case illustrates how cumulative harm and unmet need across mental health, domestic abuse, child protection, and housing escalate without effective, joined-up responses.

Section Seven: Analysis of Agencies Contact

Aster Group, Housing

7.1.1 Aster Group managed Anis's tenancy from 2019, addressing property issues as they arose. However, the absence of shared information on Anis's vulnerabilities limited their ability to recognise safeguarding risks linked to reports of Anti-Social Behaviour, poor home conditions, or anonymous concerns.

7.1.2 This review encourages closer partnership working between housing providers and safeguarding agencies. Strengthening information sharing, training staff in recognising signs of abuse, and clarifying referral pathways are all areas where learning can support improved safeguarding of tenants.

Central Surrey Health, Community Health Children's Services (CHCS)

7.1.3 CHCS maintained consistent involvement through maternity and health visiting services. Anis engaged with appointments and was receptive to support. However, the review noted that her history of trauma and vulnerability was not consistently reflected in care plans or risk assessments.

7.1.4 Despite known risk factors, Anis was not assigned to Universal Plus services during her second pregnancy. Opportunities to explore escalating concerns and connect with Children's Social Care were missed.

7.1.5 The review recommends strengthening documentation, ensuring follow-up processes are applied, and embedding a trauma-informed approach across all tiers of health visiting through interagency collaboration. This is recommended because Anis's trauma, though recorded, was not reviewed through a trauma-informed lens, and existing follow-up processes were not implemented.

Children's Social Care (CSC)

7.1.6 CSC was involved with Anis between 2013 and 2016, and 2022 and 2023. During her teenage years, after experiencing grooming and abuse, referrals were made. While these actions reflected appropriate initial safeguarding steps, long-term trauma-informed and contextual safeguarding was not evident.

7.1.7 Multi-agency planning and sustained interventions were limited, reflecting a learning point for future coordinated responses.

7.1.8 In her later engagement as a parent, Early Help services were initiated and provided some support. However, indicators such as domestic abuse, poor home conditions, and mental health concerns were not consistently escalated or explored in a coordinated way.

7.1.9 Tools like the Graded Care Profile were not used, and domestic abuse referrals lacked documented follow-up. Learning from this review suggests the importance of using assessment frameworks and timely multi-agency action when risk thresholds are met.

Education (Preschool and Primary School)

7.1.10 Sam's preschool and primary school engaged positively with Anis and demonstrated early recognition of safeguarding concerns, especially after her disclosure in 2022. Nonetheless, documentation and follow-up actions varied, with missed opportunities for information sharing and inter-agency coordination.

7.1.11 The transition between educational settings was not formally structured, reducing continuity of safeguarding oversight. Strengthening communication protocols and ensuring consistent documentation of concerns could support earlier and more effective intervention.

GP Practice

7.1.12 Anis's contact with her GP practice was limited, which is not uncommon for individuals facing trauma and instability. Her deteriorating mental health in early 2023 prompted medication changes and referrals, but her disengagement from services did not trigger further follow-up.

7.1.13 Her disclosure of domestic abuse in February 2023 offered a key opportunity for safeguarding coordination. The case highlights the need for clearer protocols regarding follow-up when safeguarding risks are disclosed, especially for individuals who may struggle to engage with services. Trauma-informed primary care and improved integration with mental health and safeguarding pathways are critical.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

7.1.14 SaBP supported Anis through mental health services across different stages of her life. Eye Movement Desensitisation and Reprocessing (EMDR) was provided during adolescence, although engagement became more difficult over time.

7.1.15 In 2023, Anis presented with complex needs, including Post-Traumatic Stress Disorder, anxiety, and emotional instability. While procedures were followed, outreach efforts could have been strengthened.

7.1.16 This highlights the importance of sustained, proactive engagement for individuals affected by trauma, and more integrated working with safeguarding and perinatal teams to ensure risks are reviewed collectively.

Surrey Police

7.1.17 Surrey Police recorded multiple contacts with Anis regarding exploitation, domestic abuse, and safety concerns. These were appropriately recorded; however, the review identified areas for improvement in learning about how information was shared and followed up across agencies.

7.1.18 In some instances, decisions relied heavily on Anis's ability to engage, which can be challenging for those with trauma histories.

7.1.19 The review emphasises the need for trauma-informed policing and consistent multi-agency risk assessment. Enhancing the use of safeguarding tools (e.g. Domestic Abuse, Stalking, and Honour-Based Violence, Single Combined Assessment of Risk Form) and ensuring timely referrals to support services could improve outcomes in similar cases.

Section Eight: Key Issues Arising from the Review/Lessons Learned

Coercion and Control

8.1.1 This review highlights key themes that offer valuable learning for agencies and professionals supporting individuals with complex needs. It reinforces the need for early intervention, recognising cumulative risk, and integrated multi-agency collaboration.

Domestic Abuse and Coercive Control

8.1.2 Concerns regarding controlling or coercive behaviour, verbal abuse, and the physical disciplining of children were reported by Anis and third parties. Recognising the indicators of coercive control, even in the absence of formal disclosure, is crucial.

Neglect and Parenting Capacity

8.1.3 Professionals and community members noted poor living conditions and concerns about the children's appearance, missed appointments, and inconsistent medication and nourishment. Addressing neglect requires exploring the underlying causes and linking families to appropriate support.

Mental Health and Wellbeing

8.1.4 Anis disclosed a history of trauma, self-harm, and suicidal thoughts. There were instances where her emotional distress was visible but not fully explored. A trauma-informed approach, combined with consistent follow-up, is essential.

Multi-Agency Communication and Response

8.1.5 There were inconsistent responses to repeated concerns and limited information sharing across agencies. Tools such as the Empowering Communities Integrated Network System offer a platform for improving collaboration. Ensuring all relevant partners actively participate in shared safeguarding systems would strengthen oversight and responsiveness.

Community and Professional Concerns

8.1.6 Neighbours and professionals raised concerns that were not always escalated or triangulated across services. While malicious referrals are a possibility, they must be balanced with risk assessments that prioritise child welfare.

Substance Use and Environmental Risks

8.1.7 Isolated reports of substance use and antisocial behaviour in the local area impacted Anis's wellbeing and that of her children. Such concerns should be assessed in context and considered as part of broader safeguarding planning.

Child Safeguarding and Emotional Well-being

8.1.8 Concerns were raised regarding Sam's emotional well-being, behavioural presentation, and potential developmental needs. Timely assessment and support for children's emotional and developmental health are vital components of safeguarding.

Housing and Living Conditions

8.1.9 Housing-related risks, including reports of rats, poor sanitation, and environmental hazards, were not consistently connected to safeguarding. Housing professionals play a vital role in recognising early warning signs and contributing to coordinated responses.

8.1.10 Across all themes, the review encourages reflection, improved professional curiosity, and enhanced information sharing. A whole family, trauma-informed approach, alongside clear, coordinated safeguarding planning, will better support individuals like Anis and reduce the risk of harm.

Section Nine: Conclusion

9.1.1 The purpose of this review is to understand the circumstances surrounding the death of Anis and to present her life through a safeguarding lens.

9.1.2 The review found that while Anis had multiple points of contact with services, the cumulative risks she faced, including domestic abuse, neglect, and mental health struggles, were not consistently recognised or addressed in a coordinated way. No agency referred Anis to specialist domestic abuse support.

9.1.3 A key learning is the need to consider cumulative harm. Concerns that appear low-level in isolation can, when viewed together, signal significant risk. Stronger use of professional curiosity and persistence is needed when working with individuals experiencing complex trauma or disguised compliance.

9.1.4 The review also highlights the importance of robust information sharing and inter-agency communication. Disclosures and warning signs should be consistently followed up on, even when engagement is limited.

9.1.5 Improving responses to domestic abuse, mental health, and environmental risks, through training, clearer escalation pathways, and shared responsibility, can help safeguard those at risk of serious harm.

9.1.6 Ultimately, this review calls for a more trauma-informed, whole-family approach to safeguarding that includes proactive outreach, integrated care, and shared accountability across all agencies.

Section Ten: Recommendations

Individual Management Review Recommendations

Community Health Children's Services

1. Practitioners will continue to ask about relationships and domestic abuse at every contact where it is safe to do so. Prompts are on the Targeted Antenatal, New Birth Visit, and Maternal 6-8 Week Review Templates. Make the routine enquiry embedded in the training we deliver and discuss it with practitioners in supervision.
2. All practitioners within the 0-19 years' service attend trauma-informed care training and regularly refresh their knowledge.

Children's Social Care

A. Team managers to dip sample and check in supervision that the impact of diversity and ethnicity on parental resilience and vulnerability is addressed in child and family and early help assessments.
B. Family support workers, social workers, and their managers need to be familiar with resources related to domestic abuse and be able to support victims of domestic abuse to complete effective safety plans. A network of Domestic Abuse Champions to be identified in the Early Help and Assessment Service, who can link with the Domestic Abuse Outreach Workers.
C. Team managers must oversee who attends Team Around the Family Meetings and ensure good representation from all partners.
D. Practitioners and their managers will supervise Team Around the Family meetings and track self-referrals to specialist agencies.
E. To improve the partnership between adult mental health and children's social care. A working party will be established to develop agreed-upon practice guidance, ensuring that treatment plans for mental health are shared and incorporated into risk assessments and safety plans.

F. Training on trauma-informed practice will be disseminated to all Early Help and Assessment Services practitioners.
G. Safeguarding training needs analysis to ensure all managers and practitioners have updated their safeguarding training and understand when to dispense with consent.
H. Assessments are to include face-to-face meetings with fathers and observations of their relationships with their children.
I. Supervision within the Early Help service will be audited to ensure practice standards are met.

Education

To address the issues highlighted above relating to record keeping in Early Years settings and the transfer of information between settings, the following recommendations and actions were identified in discussion with the Surrey County Council Manager for Early Years Quality, Education and Inclusion:

I. The SCC Early Years Team should re-share their safeguarding guidance, which includes information on record-keeping and the transfer of information between settings, at a future Early Years Network meeting (held termly) and periodically thereafter.
II. The SCC Early Years Team should re-circulate their safeguarding guidance to all Early Years settings via a future E-Bulletin (issued weekly) and do so periodically thereafter.
III. Plans are underway to establish Designated Safeguarding Lead (DSL) Forums for Early Years settings. When these Forums are in place, the SCC Early Years team should deliver a session on safeguarding, record-keeping and information transfer that is repeated periodically thereafter.
IV. Since September 2023, it has been mandatory for all Early Years settings to undertake a biannual safeguarding audit, which includes a visit from an SCC Early Years team member to undertake a safeguarding conversation. The conversation consists of consideration of the setting's systems for recording and sharing safeguarding information. This audit process is likely to continue to strengthen practice in this area.

From September 2025. Early Years Foundation Stage safeguarding reforms will be implemented (Early Years Foundation Stage Safeguarding Reforms - Consultation Response). This will include new statutory responsibilities regarding attendance monitoring for early years settings. The SCC Early Years team will provide training for settings during the summer term of 2025.

GP

The only GP recommendation for this review relates to the missed opportunities to review Anis's mental health in the spring and winter of 2023. It should be noted that such reviews are not required at a prescribed interval. However, both instances represented ideal opportunities to offer a review and proactively pursue follow-up in the case of missed appointments in November and December 2023.

This learning is to be shared directly with the specific GP practice. Learning from this case will also be shared with other GP practices across Surrey through the regular forums of safeguarding leads and learning events.

Surrey and Borders Partnership NHS Foundation Trust

a. Publicise information about support available for adults and families experiencing financial hardship.

DARDR Recommendations

Recommendation One:

Drive consistent, trauma-informed application of existing domestic abuse and coercive control tools and guidance across the partnership.

Responsible Agency: Surrey Against Domestic Abuse Partnership

Action (Local)

1.a Issue a partnership directive requiring all agencies to ensure frontline staff have access to and confidently use existing tools, referral pathways, and coercive control guidance, supported by a baseline audit, targeted training, and survivor-informed feedback.

Recommendation Two:

Ensure Aster Group implements consistent, trauma-informed referral pathways for domestic abuse concerns by aligning with the Surrey Safeguarding Escalation Policy and supporting staff with targeted training.

Responsible Agency: Aster Group

Actions (Local)

2.a Ensure all internal agency procedures align with the Surrey SCP Escalation and that staff are trained to recognise when and how to escalate concerns, including low-level or third-party reports that may indicate emerging risk.

2.b To embed trauma-informed principles in housing procedures and equip officers to recognise and respond to trauma and domestic abuse effectively.

Recommendation Three:

3.1 Domestic abuse incidents must be consistently risk assessed, considered for MARAC referral where appropriate, and supported with timely safety information for victims/survivors.

3.2 Trauma-informed and ACE-aware practice should be reinforced within existing safeguarding and frontline work locally, while also being advocated for at a national/system level.

Responsible Agencies: Adult Social Care, Aster Group, Community Health Children's Services, Children's Social Care, GP Practice, and Surrey Police

Actions (Local)

3.1a Share and embed best practices across local services to support day-to-day application.

3.1b Strengthen use of trauma-informed and ACE-aware approaches through safeguarding training, staff supervision, and multi-agency work.

Responsible Agencies: ICB and Adults and Children's Social Care

Actions (National/System-Level Advocacy)

ICBs

3.2a Advocate for consistent trauma-informed training across the workforce and for the development of ACE-awareness prompts/tools.

3.2.b Use national routes, including NHS England forums (regional/national safeguarding, IT, and primary care) and membership bodies (NHS Confederation, NHS Providers).

Social Care

3.2c Advocate for consistent trauma-informed training across the children's and adults' workforce.

3.2.d Escalate through national forums, including ADCS/ADASS, LGA, Skills for Care, and Social Work England, which feed into DfE and DHSC.

Recommendation Four:

Ensure consistent application of the existing neglect framework and 'Think Family' principles across all Child and Family and Early Help assessments, with clear multi-agency input and oversight.

Responsible Agency: Children's Social Care

Action (Local)

4.a Use a combination of enhanced supervision, system prompts, family and partner feedback, and multi-agency case learning sessions to reinforce consistent, high-quality assessment of neglect and parental risk factors across all teams.

Recommendation Five:

Ensure safeguarding alerts on electronic patient records are routinely reviewed and actively considered by all Community Health Children's Services staff, so that risk factors inform every stage of assessment, care planning, and decision-making.

Responsible Agency: Community Health Children's Services

Action (Local)

5.a Ensure all staff consistently review and acknowledge safeguarding alerts flagged on the patient's electronic record at every contact or review, integrating this step into routine clinical and administrative processes to support informed and safe decision-making.

Recommendation Six:

Strengthen the consistent application of trauma-informed practice across all frontline services by embedding ACE awareness into day-to-day decision-making, early intervention, and multi-agency collaboration.

Responsible Agencies: Children's Social Care, Education and GP Practice

6.a Ensure staff consistently apply trauma-informed approaches by embedding ACE-awareness prompts into assessments, care planning, and multi-agency decision-making processes.

Recommendation Seven:

Strengthen community-based safeguarding by partnering with local charities and organisations to raise awareness, increase public confidence in reporting, and extend early intervention pathways beyond statutory services.

Responsible Agency: Surrey Heath Community Safety Partnership

Action (Local)

6.1 Collaborate with local charities and community groups to co-design and deliver targeted public campaigns and establish accessible, community-based reporting pathways for safeguarding concerns.

Safer Surrey Heath Community Partnership is responsible for monitoring the implementation of the action plan. The actions are intended to facilitate safer and more effective responses to domestic abuse victims and survivors. This must be emphasised to ensure that agencies are accountable for completing their actions.