Domestic Abuse Related Death Review

Overview Report into the death of Anis in March 2024

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Independent Chair and Author
Date Completed: September 2025

"Behind each review is a voice that must be heard. Our responsibility is to listen, to learn, and to act." – PS Safeguarding LTD

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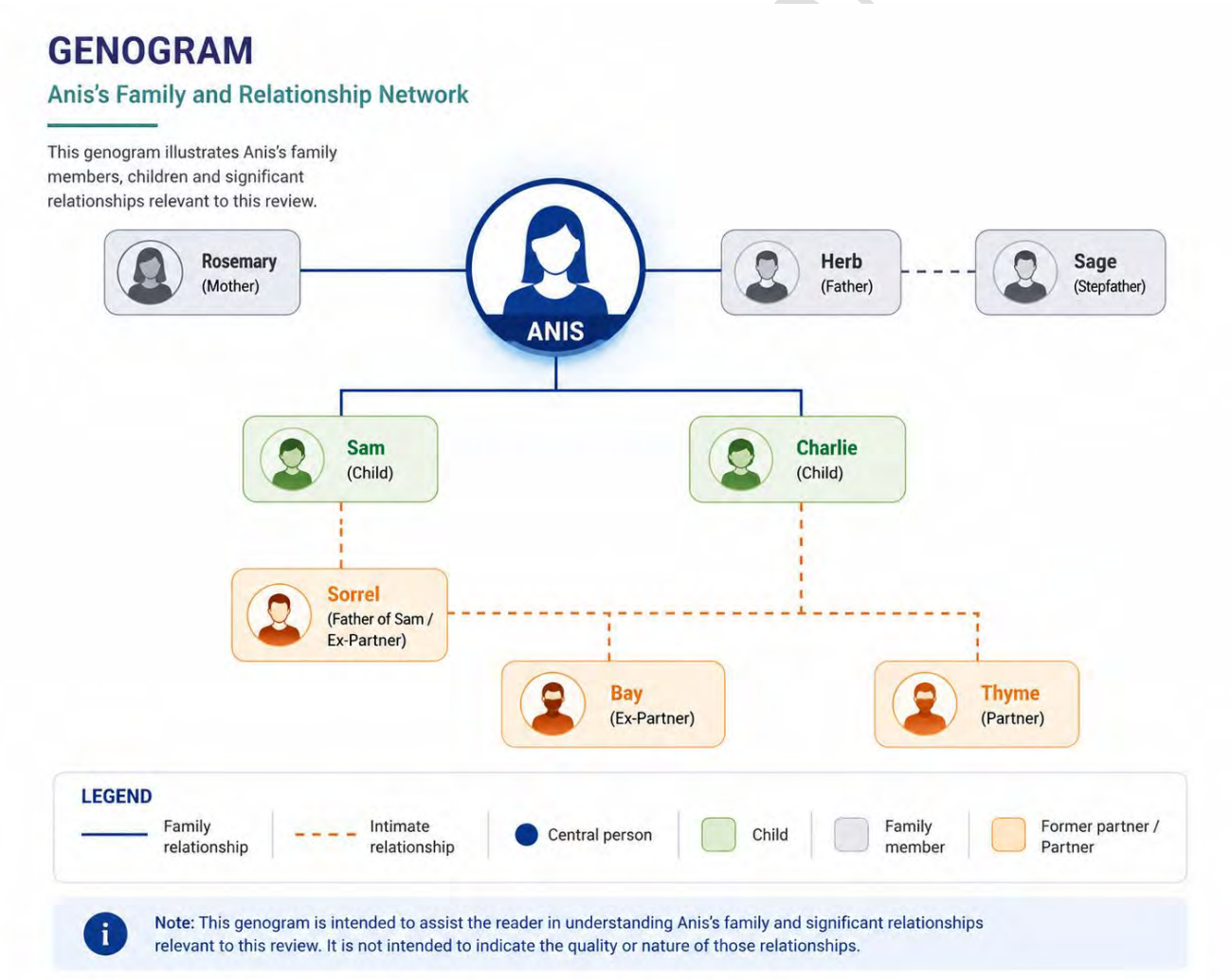
Preface

This Domestic Homicide Review (DHR) was commissioned following the tragic death of Anis (a pseudonym) in March 2024. The purpose of the review is to understand the circumstances leading to Anis's death, evaluate the effectiveness of agency responses, and identify lessons that can help improve the prevention of domestic abuse-related deaths in the future.

This review seeks to honour Anis's memory by ensuring her experiences contribute to meaningful changes in practice, policy, and inter-agency collaboration. The panel offers its heartfelt condolences to all those affected by her death. Despite sincere efforts, the review panel was unable to establish meaningful engagement with Anis's family.

The chair acknowledges the trauma that such circumstances may cause, and the panel has selected pseudonyms to be used throughout this report. Only the chair and panel members are identified by name.



The primary goal of a DHR is to facilitate learning from the deaths of individuals aged 16 and over who have been, or appear to have been, victims of violence, abuse, or neglect by a partner, family member, member of the same household, or another person with whom they had a close personal relationship. Professionals must understand what happened, identify missed opportunities, and recommend systemic improvements to prevent similar tragedies in the future.

Anis's life was marked by significant adversity, including adverse childhood experiences, exploitation, trauma, and domestic abuse in adult relationships. Despite these challenges, Anis demonstrated resilience, sought help at various points, and was described as a devoted mother to her two young children. Her sudden death is a profound loss, and this review is dedicated to learning from her experiences to safeguard others in similar circumstances better.

The Independent Chair would like to thank the panel members and all contributing agencies for their time, honesty, and cooperation.

1.1 Introduction

1.1.1 The report was written after Anis's death at the age of twenty-six in March 2024. Surrey Police referred Anis to the Surrey Heath Community Safety Partnership (SSHCP) in June 2024.

1.1.2 In 2011, Section 9(3) of the Domestic Violence, Crime, and Victims Act of 2004 introduced Domestic Homicide Reviews (DHR).

1.1.3 The Victims and Prisoners Act 2024 modifies the Domestic Violence, Crime and Victims Act 2004, highlighting the importance of establishing and conducting reviews related to deaths caused by domestic abuse, renamed to Domestic Abuse-Related Death Reviews DARDR.

1.1.4 The SSHCP determined that Anis's death was eligible for review. Since it was not a homicide, they designated it as a DARDR. However, the review was conducted in accordance with the Multi-Agency Statutory Guidance for Domestic Homicide Reviews (December 2016).

1.1.5 In March 2024, Surrey Police were called to Anis's home by her mother, Rosemary, who had also contacted the ambulance service. Anis had taken an overdose of prescribed medication.

1.1.6 The ambulance crew initiated treatment, and Anis experienced cardiac arrest and died. Anis left a note saying goodbye to her family and children (Sam, aged five and Charlie, aged two), and her mother received a delayed farewell voice message. It is important to note that neither of these communications provided any insight into her death.

1.1.7 During the police investigation, it was established that Anis had a relationship with Thyme. Her family described him as "creepy" and suggested he was with her in the days before her death, and Anis's child implied he had stolen items from her.

1.1.8 The panel agreed that the review should focus on **September 2022 to March 2024** to determine whether any relevant background or history of abuse was present, whether community support was obtained, and whether any obstacles were encountered in her receiving support.

1.1.9 In October 2022, Anis informed Sam's preschool that she had been the victim of domestic abuse. This disclosure was referred to Surrey Children's Social Care (CSC).

1.1.10 Anis was a child victim of exploitation, sexual exploitation, and grooming since 2012, and the DARDR panel discovered that she had experienced domestic abuse in previous relationships.

1.1.11 Therefore, to better understand and support the learning process, agencies were asked to submit a summary of their involvement before the review period, ensuring that all facets of agency support are identified.

1.1.12 The cause of death was Acute Fatal Propranolol Toxicity.

1.1.13 The review does not replace the functions of criminal or coroner's courts or resemble a disciplinary proceeding.

1.2 Case Summary

1.2.1 In March 2024, Anis overdosed on sertraline and propranolol, leading to her cardiac arrest and death despite resuscitation efforts.

1.2.2 The examination of Anis's case illustrates systemic deficiencies in multi-agency safeguarding responses and significant lost opportunities for early intervention.

1.2.3 Despite numerous reports from professionals, neighbours, and Anis herself, concerns regarding mental health, domestic abuse, and child welfare were not adequately addressed, thereby exposing Anis to potential harm.

1.2.4 Although the individual concerns may not have met the intervention thresholds, they collectively indicated significant risks.

1.2.5 The review also disclosed obstacles associated with disguised compliance, resulting in Anis's intermittent engagement with services without achieving sustained progress.

1.2.6 This emphasised the importance of more professional curiosity and a greater willingness to challenge when working with families contending with complex issues.

1.3 Background Information about Anis

1.3.1 Anis's family history, as recounted by her and her mother to Surrey and Borders Partnership NHS Foundation Trust (SaPB), presents differing perspectives on her early experiences.

1.3.2 Her mother, Rosemary, met Anis's father, Herb, around 1993, and they had an on-and-off relationship until their final separation in 1998.

1.3.3 According to Anis, Herb was violent, reportedly locking the children in a cupboard and depriving them of food before he went to prison and later died in a car accident. However, Rosemary denied that Herb was violent and stated that no such abuse occurred.

1.3.4 Following the separation, Rosemary formed a relationship with Sage, a longtime supportive friend, which brought their two families together. From an early age, Anis exhibited behavioural challenges.

1.3.5 According to Rosemary, Anis developed a storytelling pattern during her first year of primary school, which caused difficulties both at home and at school. The family sought

support from CSC, but they were provided with general parenting resources rather than direct intervention.

1.3.6 Information held by Child and Adolescent Mental Health Services (CAMHS) indicated that Anis's home environment was further destabilised by her older brother, who exhibited severe behavioural difficulties and was frequently aggressive towards her.

1.3.7 On one occasion, he reportedly attempted to suffocate Anis by placing a plastic bag over her head. Anis herself also displayed challenging behaviour, including frequent altercations with peers and an allegation that she had physically assaulted a teacher.

1.3.8 Anis was the second of four children and identified as White British. She lived with her family in Surrey until February 2016, when, at seventeen, she left home and moved to Hampshire.

1.3.9 Soon after, she became homeless and received support from the youth homelessness prevention service, which helped her transition into a supported accommodation in Surrey in March 2016.

1.3.7 In later years, Anis resided in Surrey with her two children, Sam and Charlie, from October 2020 to March 2024.

1.4 Timescales

1.4.1 The DHR Statutory Guidance outlines the review chairs and authors' requirements in sections 36 through 39. In this review, the responsibilities of the chair and author were merged.

1.4.2 The DARDR independent chair/author was commissioned in October 2024. The SSHCP approved the final report on 24th September 2025.

1.4.3 The first panel meeting was held on 11 November 2024.

1.4.4 A second panel meeting reviewed the agencies' detailed chronologies and determined that three reports would be required. Subsequent meetings reviewed agencies' reports and the overview report.

1.4.4 The Statutory Guidance stipulates that DHRs, including the overview report, should be concluded within six months of notification. In this case, the timeframe was exceeded to allow the panel and chair sufficient time to review and analyse the information thoroughly, and for the chair to complete the report to the required standard.

1.5 Confidentiality

1.5.1 The review is confidential until the Home Office Quality Assurance Panel approves the release of the overview report. Only contributing officers, professionals, and line managers are authorised to access confidential information.

1.5.2 The review has been appropriately anonymised following the DHR Statutory Guidance. Additionally, the date of death has been removed to protect anonymity.

1.5.3 The following terms are used throughout the report.

- The victim: Anis
- Mother: Rosemary
- Recent Partner: Thyme
- Child One: Sam
- Anis's Stepfather: Sage
- Ex-Partner: Sorrel, Charlie's father
- Child Two: Charlie
- Anis's Father: Herb
- Ex-Partner: Bay

1.6 Terms of Reference/Key Lines of Enquiry

1.6.1 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.

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

1. **Trauma and Mental Health**
   - How is trauma-informed practice embedded in your organisation?
   - What was known about Anis's background, and how might this have affected her resilience or vulnerability?
2. **Access to Services and Domestic Abuse**
   - What domestic abuse services are accessible to your organisation?
   - Does your organisation have policies and procedures to identify and address domestic abuse?
   - How did your agency respond to the information that Anis was a victim of domestic abuse?
   - Did your organisation promptly communicate all relevant information to all appropriate parties?
   - Have any obstacles to your organisation's capacity or resources impeded your ability to provide services or access to Anis or other relevant individuals?
3. **Poverty and Domestic Abuse**
   - What support is provided to families experiencing financial difficulty?
4. **Holding Perpetrators to Account**
   - What services are available in Surrey for perpetrator disruption?
   - What is known about Bay and Sorrel's background? What perpetrator disruptions were offered?
5. **Learning**

- Determine effective strategies for areas where your organisation's responses may have exceeded or fallen short of standard practice.
- What changes have occurred in your organisation since Anis's death?

1.7 Methodology

1.7.1 The DHR Statutory Guidance outlines the procedure for conducting a review.

1.7.2 The primary objective of the review is to establish a coordinated multi-agency approach that ensures the effective identification and response to domestic abuse as soon as possible.

1.7.3 Anis resided in Surrey at the time of her death; therefore, the review panel consisted of representatives from Surrey agencies. The panel discovered that Anis had lived outside the county, and sought information from agencies outside Surrey.

1.7.4 Panellists confirmed their agency engagements for Anis at the first review panel meeting.

1.7.5 The review's approach required agencies to submit a chronology to determine which agency would be required to conduct an Independent Management Review (IMR) or submit a summary report; seven IMRs were requested.

1.7.6 The IMR/summary authors can be the same as panel members but must be independent of care received by both victim and perpetrator. They should provide an overview of their agency and interactions with both parties, address the TOR, and summarise relevant contacts before the review period.

1.7.7 The reports were presented to the panel. All panel members had access to all IMRs and the summary review to analyse and comment on the support provided and provide feedback on areas for improvement and good practice.

1.7.8 The IMR/summary authors and panel members identified their agency's learning and provided recommendations, as necessary.

1.7.9 The chronologies, reports, and panel influenced the recommendations in the review.

1.7.10 The panel met a total of five times.

1.8 Involvement of Family and Friends

1.8.1 The involvement of families in the review process is essential, as research indicates that they frequently serve as the victim's most effective advocates. Families and close connections can provide insights not found in agency records, offering a more comprehensive picture of the victim's experiences, identity, and the support required.

1.8.2 The Chair and panel recognised the vital role Anis's family and friends could have in ensuring her voice was central to the review, helping to shape a more compassionate and informed response to victims of domestic abuse.

1.8.3 Family members and those close to the victim can help bring the individual's story to light, adding depth to their story and helping the panel understand their personality, hopes, and aspirations. This input can be invaluable in identifying missed opportunities for intervention and informing more effective and empathetic future practice.

1.8.4 **On 6 November 2024, the Community Safety Officer hand-delivered a letter to Anis's parents.** The letter included information on advocacy services, such as Advocacy After Fatal Domestic Abuse (AAFDA), and a Home Office leaflet outlining the purpose and process for a DHR.

1.8.5 The officer also provided a verbal explanation of the review process to both parents, who indicated a willingness to engage and expressed appreciation for the opportunity to contribute

1.8.6 Despite this initial expression of interest, Anis's family did not contact the panel further. The panel acknowledges the profound emotional toll of such circumstances and fully respects the family's decision not to pursue further engagement.

1.8.7 Participation in a review process can be intensely emotional and, for some, re-traumatising. Where engagement does occur, it may offer therapeutic value, creating space for reflection, understanding, and healing.

1.8.8 Anis's family did not participate in this review, but their perspective remains essential. The panel has worked with sensitivity and a strong commitment to ensuring Anis's experiences inform the review's findings.

1.8.9 All conclusions and recommendations have been shaped by this intent and grounded in the best available evidence from professional records and those who knew Anis through their work.

1.8.10 The chair and panel agreed to write to Anis's family again once the report had been approved by the panel, providing a further opportunity to contribute before publication. Should they choose to engage in the future, their involvement would be welcomed with deep respect and gratitude.

1.8.11 A letter was sent to the family on 3 September 2025. Following this, on 10 September 2025, Rosemary emailed the Chair requesting further information.

1.8.12 A response was provided on 11 September 2025, explaining the reasons for the review, offering her the opportunity to contribute to the process and to review the report, and suggesting a telephone call if that would be more appropriate for her.

1.8.13 Rosemary was sent the report on 11 September 2025. She confirmed that she had read the review and wished to clarify several points. She explained that the medication Anis ingested was propranolol and sertraline, not paracetamol as previously stated.

1.8.14 She also noted that Anis's biological father was not involved in her life at any stage until Anis herself contacted him while she was living in Reigate.

1.8.15 In relation to Anis's time in care, Rosemary stated that this decision arose from conflict at home, particularly restrictions placed on Anis's use of the computer and phone.

1.8.16 Rosemary emphasised that Anis had rebelled against these boundaries and chose to run away, but that the family never permitted her to stay with the man whose house she later went to.

1.8.17 Rosemary was clear that she had never physically assaulted Anis. She acknowledged that there were occasions when she had to restrain her and explained to the police that any marks on Anis's wrists were caused when preventing her from taking hold of a knife during a period of crisis.

1.8.18 She further acknowledged that the home environment was sometimes untidy, but explained that Anis did not permit her to help with cleaning. Rosemary recalled advising Anis not to worry about tidying while the children were awake, but rather to do this once they were in bed.

1.8.19 She highlighted that throughout Anis's pregnancy with Charlie, Anis lived with her and her husband. During this time, they provided care and support, often caring for Charlie while Anis worked at a care home. Rosemary stated that she was always available when Anis needed her.

1.8.20 Finally, Rosemary confirmed that the family did not know about domestic abuse in Anis's later relationships, other than the abuse she experienced from Charlie's father. On that occasion, Rosemary's husband went to collect Anis, after which she lived with them throughout her pregnancy until she chose to move into her own property.

1.9 Contributors to the Review

1.9.1 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 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)

1.10 The Review Panel Members

1.10.1 Section 9 of the 2004 Act emphasises the same agencies as Community Safety Partnerships as panel members.

1.10.2 The independent review panel members consisted of 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 NHS Foundation Trust
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 Social Care

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

1.11 Chair and Author of the Overview Report

1.11.1 The DHR Statutory Guidance outlines the skills and expertise required to chair a review effectively. The chair must be independent of the family, friends, and agencies involved in the review.

1.11.2 The chair is expected to understand domestic abuse and its associated issues comprehensively. They must be aware of the research, guidance, and legislation applicable to both adults and children, as well as the various laws in place to safeguard these groups, including the Equality Act (2010). These are typically illustrated by the chairs' professional experience and/or previous reviews on safeguarding and domestic abuse-related deaths.

1.11.3 The Home Office anticipates that all chairs will have completed the DHR training provided by AAFDA. The training equips potential chairs with the necessary information to conduct reviews and emphasises the importance of ensuring ongoing development.

1.11.4 Parminder Sahota is an independent reviewer who has worked in Safeguarding and Domestic Abuse for eleven years and obtained DHR Chair training from AAFDA in 2021 and 2024.

1.11.5 Parminder has worked in the NHS for over 20 years as a Mental Health Nurse, focusing on crisis work and working with individuals diagnosed with personality disorders. She was previously employed as the Director of Safeguarding, Prevent (Counterterrorism) and the Domestic Abuse Lead for an NHS Trust in London.

1.11.6 Before this review, Parminder had no contact with Anis's family or friends. Parminder had completed a previous DARDR and a Safeguarding Adult Review for Surrey; however, she is independent of the agencies and Surrey Safer Communities.

1.12 Parallel Reviews

1.12.1 Anis's death was referred to the Independent Office for Police Conduct (IOPC) due to Surrey Police's emergency response and the circumstances surrounding Anis's death. The referral was returned to Surrey Police with no further action needed.

1.13 Equality and Diversity

1.13.1 The DHR Statutory Guidance states that equality and diversity issues must be considered and incorporated into the scope and process of the review. The chair and panel considered all protected characteristics under the Equality Act, which legally safeguards individuals from discrimination.

1.13.2 Anis's life experiences are best viewed through an intersectional lens, which acknowledges the impact of numerous overlapping factors, including sex, socio-economic status, cultural heritage, mental health, and trauma experiences, on her interactions with services and vulnerabilities.

Sex and Domestic Abuse

1.13.3 Anis was exposed to gendered risks that were linked to domestic abuse and coercive control due to her sex. Systemic barriers, such as victim-blaming attitudes, inconsistent professional responses, and a lack of trauma awareness, are frequently encountered by women who are victims of domestic abuse.

1.13.4 Despite evidence of abuse in Anis's relationships, the safeguarding response did not fully address coercive control or cumulative harm. The Domestic Abuse Statutory Guidance highlights the importance of recognising coercive control as a serious risk factor, yet in practice, these dynamics are often overlooked.

Mental Health and Disability Discrimination

1.13.5 Anis's mental health struggles were a significant factor in her interactions with health, social care, and criminal justice agencies. Individuals with mental health conditions often experience discrimination, including being dismissed, misjudged, or held to inconsistent safeguarding thresholds.

1.13.6 The Mental Capacity Act (2005) outlines the need for professionals to ensure that decisions are made in the best interests of individuals with mental health conditions. However, research suggests that individuals with trauma histories are often labelled as "difficult to engage" rather than receiving appropriate, sustained support.

Socio-Economic Disadvantage and Homelessness

1.13.7 Anis's experience of homelessness as a young person placed her at a heightened risk of exploitation and further marginalisation. Socioeconomic deprivation is a key risk factor for domestic abuse, with financial instability often acting as a barrier to leaving abusive

relationships. Structural inequalities in housing provision, welfare access, and mental health support may have contributed to her continued vulnerability.

Adverse Childhood Experiences (ACES)

1.13.8 ACEs refer to traumatic events occurring before the age of eighteen that can have long-term effects on mental and physical health, behaviour, and life outcomes. Anis's early experiences included several ACEs that likely contributed to her distress and vulnerabilities.

1.13.9 Anis disclosed that her biological father, Herb, was violent, confining her and her siblings in a cupboard and denying them sustenance. Her emotional development and trust in carers may have been influenced by these experiences, whether real or perceived, even though her mother subsequently refuted these reports.

1.13.10 Anis's behavioural difficulties were evident from early childhood, yet requests for support from social services resulted in signposting to parenting resources rather than direct intervention. This reflects a potential missed opportunity to recognise early neglect and emotional harm.

1.13.11 Anis's brother exhibited aggressive behaviour, including placing a plastic bag over her head in an apparent attempt to harm her. Exposure to sibling aggression and lack of parental protection could have reinforced feelings of fear, instability, and hypervigilance.

1.13.12 Following childhood instability, Anis left home at seventeen, experienced homelessness, and later moved into supported accommodation. These disruptions exacerbated her social isolation and increased her reliance on external systems for survival.

1.13.13 Anis's reported history of emotional distress, self-harm, and suicidal ideation aligns with research showing that cumulative ACEs increase the risk of mental health disorders, suicidal behaviour, and substance misuse.

Motherhood and Child Welfare Considerations

1.13.14 As a mother, Anis faced scrutiny regarding her ability to parent while managing her own mental health and trauma history. Research indicates that mothers experiencing domestic abuse are often judged more harshly by child protection services, with safeguarding processes sometimes not recognising the complexities of coercive control.

1.13.15 The 'Think Family' approach advocated by Working Together to Safeguarding Children 2023 emphasises the need for holistic, family-centred interventions that address parental support and child welfare, an approach that may have benefited Anis.

1.13.16 Anis's life was shaped not only by her childhood exposure to abuse but also by her own experiences of domestic abuse as an adult.

1.13.17 Anis's interactions with services suggest she experienced coercive control, which may have impacted her ability to engage consistently with support systems. Domestic abuse victims often experience disempowerment, trauma bonding, and emotional exhaustion, limiting their capacity to seek sustained help.

1.13.18 The fragmented recognition of her struggles meant that concerns, ranging from mental health crises to housing instability and suspected abuse, were often viewed in isolation rather than as part of a broader pattern of risk.

1.13.19 Like many survivors of domestic abuse, Anis's sporadic engagement with services may have been misinterpreted as resistance or disengagement rather than an indication of ongoing coercion, fear, or learned helplessness.

1.14 Dissemination

1.14.2 After the Home Office grants permission to publish, this report will be widely disseminated, including, but not limited to:

- Anis's family
- Members of the Surrey Heath Community Safety Partnership
- Panel Agencies represented.
- Local Safeguarding Children Partnership
- Domestic Abuse Commissioner
- Local Police and Crime Commissioner
- A copy of the Summary report will also be published on the Healthy Surrey Website.

2.1 The Facts

2.1.1 In March 2023, Surrey Police received a 999 call from Rosemary, reporting that Anis had contacted her, threatening to take her own life. Officers attended the scene and established that Anis was suspected to have taken a significant overdose of paracetamol and propranolol. She was left in the care of Rosemary and her aunt while awaiting the arrival of the South East Coast Ambulance Service (SECAMB).

2.1.2 While awaiting medical assistance, Anis began vomiting and experiencing seizures. Upon SECAMB's arrival, she had gone into cardiac arrest.

2.1.3 SECAMB received a Category 2 call from the police regarding Anis's suspected overdose and suicide attempt.

2.1.4 Anis's partner (Thyme) contacted SECAMB to request that the ambulance be cancelled; however, the crew maintained the call as a Category 2 priority because they could not establish direct contact with Anis. Due to increased concern, the incident was upgraded to Category 1.

2.1.5 An ambulance crew arrived at the scene. Anis's family was outside, visibly distressed. On arrival, the family reported Anis had overdosed following a domestic incident. The ambulance crew found Anis lying on her back, non-responsive. A clear plastic bag containing several pills was located near her. CPR commenced immediately.

2.1.6 A second ambulance crew arrived. Despite resuscitation efforts, Anis's condition deteriorated.

2.1.7 Surrey Police were unable to locate Thyme, who was believed to be Anis's friend/partner at the time of her death.

2.2 Key Events from September 2022 to March 2024

A summary of agency contact before the agreed-upon review timeframe was provided to help the DARDR panel understand Anis's life history and the potential challenges she faced.

March 2013

- Anis (14 years old) attempted self-harm at home, linked to prior grooming victimisation by Suspect A.
- Anis's mental health was deteriorating, with visible self-harm scars.
- Discharged from Frimley Park NHS Foundation Trust (FPH) following a mental health assessment.
- School counselling was offered, but there was no mention of specialist trauma support.
- Suspect A was convicted of offences; forensic evidence found hundreds of child exploitation videos.

January 2016

- At age 17, Anis was reported missing by her family to Surrey Police and was assessed as high risk due to her history of self-harm and experiences of bullying.
- Anis was located with 29-year-old Adult 'A'. Anis refused to return home.
- Anis disclosed that her mother had physically assaulted her the previous summer.
- The case was filed without further action; domestic abuse was recorded.
- The parents agreed to a trial arrangement for Anis to stay with Adult 'A'.
- Adult 'A' had a recent arrest for child grooming offences.

February 2016

- Anis was assaulted by Adult 'A' (punched, knocked unconscious, threatened with a knife).
- Adult 'A' was charged with assault. Domestic Abuse, Stalking, and Honour-Based Violence (DASH) risk assessment was completed, and a Multi-Agency Risk Assessment Conference (MARAC) Referral was made.
- Anis was reported missing and later found by police, staying with three Albanian males in Hampshire.
- Surrey Police determined no immediate risk, and Anis remained at the property.

- A Single Combined Assessment of Risk Form (SCARF) was shared with CSC, Health, and Education, but no report was available for review.
- Anis presented to the Surrey and Sussex Healthcare NHS Trust Emergency Department (ED) with abdominal pain and vaginal bleeding. She was not pregnant, was discharged home, and did not require follow-up. A domestic abuse enquiry was made, and Anis stated, 'No.'

March 2016

- Anis discussed at the MARAC (Hampshire Police referral).
- Anis was reported missing and found with her boyfriend, Adult 'B', in Hampshire.
- SCARF shared with CSC.

April 2016

- Police intelligence indicated Albanian males at the Hampshire address were dealing drugs.
- Anis returned to Camberley due to fear of harm.
- Anis was potentially pregnant by Adult 'A' (who had a prior child protection-related arrest in 2015).

May – August 2016

- Youth Services in Surrey contacted Hounslow CSC, informing them Anis had returned to Hounslow and was three weeks pregnant.
- Anis had previously received Child in Need (CIN) support under Section 17 of the Children's Act (1989) in Surrey.
- Hounslow requested Surrey's most recent assessment before agreeing to transfer the case, but did not follow up.

2.2.1 The lack of follow-up on the transfer request could indicate a breakdown in inter-agency communication. This delay may have contributed to a gap in oversight at a critical time for Anis.

2.2.2 Given Anis's vulnerability (pregnancy and previous CIN involvement), the best practice would have been for Hounslow to seek the information and progress the case more swiftly and proactively.

- A further referral was made to Hounslow in May 2016, clarifying that Anis was not an open case to Surrey CSC but was accessing early intervention.
- In response to the pregnancy, Hounslow progressed and completed the assessment in August 2016.

2.2.3 The timing of the assessment raises concerns, as a delay from May to August could have resulted in missed opportunities, especially when Anis was pregnant or in a vulnerable situation.

2.2.4 The resulting miscarriage might have affected Anis emotionally. While she had the right to decline early intervention, a short-term follow-up could have provided reassurance that she was coping well post-miscarriage.

2.2.5 **Summary of Safeguarding Concerns:**

2.2.6 Anis, a victim of grooming and abuse, exhibited mental health issues and self-harm, yet no trauma response or effective safeguarding plan was implemented. CSC did not monitor her exposure to high-risk situations, and responses to her missing episodes were inadequate. Staying with Adult 'A', a known risk, was a significant oversight.

2.2.7 Concerns about Child Criminal Exploitation (CCE) and Child Sexual Exploitation (CSE). During the Hampshire incident, the risk assessment applied to Anis, who was still a minor (17 years old) and may not have been as comprehensive as it could have been.

2.2.8 Anis was unable to disclose her trauma to agencies and did not receive specialist support for mental health. There was no coordinated multi-agency safeguarding despite several high-risk incidents.

2.2.9 **Key Learning Points for Multi-Agency Response:**

I. Missing episodes should trigger immediate risk assessments to avoid reactive responses.
II. CSC must adopt a proactive role in safeguarding.
III. Trauma-informed approaches are essential for victims unable to disclose abuse.
IV. Stronger interventions are necessary for young people at risk of CSE/CCE.

2.2.10 Anis's case highlights challenges in trauma-informed support, missing person protocols, and multi-agency coordination.

2.2.11 In 2018, Anis gave birth to her first child, Sam, followed by the birth of her second child, Charlie, in 2021.

The following outlines the key events that occurred within the agreed review timeframe.

September 2022

2.2.12 Sam told a preschool staff member, *"I don't want my daddy back home because he is at work."* While neutral, this statement may indicate an underlying concern about the stepfather's presence at home. The preschool appropriately informed Anis, demonstrating good communication between professionals and the parent.

2.2.13 Anis disclosed an incident to the preschool involving Sam's stepdad, Sorrel, and Charlie's biological father, the previous night. Sam had said, *"Daddy, I miss you,"* Sorrel responded, *"That's your mother's fault."* Sorrel insulted Anis *("selfish prick"*), which suggested verbal abuse in Sam's presence. Sam then stood at the top of the stairs and said, *"I don't want you in my home."*

2.2.14 Sam appeared to be responding to parental conflict and may be mirroring language they have heard. Parental disputes in the presence of a child can contribute to emotional harm, particularly if the child is being exposed to blame-shifting and distressing arguments.

2.2.15 Anis's disclosure suggests high levels of stress, possibly linked to ongoing difficulties in co-parenting. Her reassurance that she has support from the preschool is positive, but it was unclear whether this support was effective or adequate.

2.2.16 The staff's response, *"Go home, have a cup of tea with biscuits",* shows empathy. Still, it may have minimised the seriousness of the situation and did not indicate whether any further safeguarding steps were taken. If Anis struggled emotionally, this could affect her long-term capacity to meet Sam's emotional needs.

October 2022

2.2.17 The events of October 2022 highlight significant safeguarding concerns surrounding domestic abuse, emotional harm, coercive control, and child welfare. The situation escalates from harassment and intimidation to allegations of sexual and physical violence, leading to multi-agency interventions.

2.2.18 Anis disclosed to the preschool that her ex-partner, Sorrel, was harassing her and making threats, including intimidation and aggression.

2.2.19 The staff advised Anis to call 101 to report the harassment, and they would contact Surrey Children's Single Point of Access (C-SPA) to provide support.

2.2.20 Anis disclosed to the police that Sorrel had raped, physically assaulted, and harassed her during a relationship characterised by coercive control. Although the relationship ended in July 2022, Anis reported that Sorrel continued to let himself into her home without permission, initiated arguments in front of the children, and employed manipulative tactics, such as blaming her for the conflict.

2.2.21 Anis was unable to provide a formal statement of evidence. The described pattern of coercive control and post-separation harassment indicated that Anis remained at significant risk even after the relationship had ended.

2.2.22 Anis asked that Sorrel not be arrested, expressing concern that it *"would make things more complicated and aggravate her situation."* Due to insufficient evidence for an evidence-led prosecution and a lack of a realistic prospect of conviction, the case was closed with no further action.

2.2.23 Sorrel was deemed ineligible for a Sexual Risk Order owing to a lack of previous convictions, which created a gap in safeguarding Anis. She also declined an outreach referral, stating that she had support from friends and family.

2.2.24 A Public Protection Notice (PPN) was completed for Anis, incorporating a standard risk DASH assessment, which concluded that there were no immediate signs of a serious threat of harm or death; therefore, a MARAC referral was not deemed necessary.

2.2.25 Previous PPNs had raised concerns regarding Anis's history of self-harm and mental health challenges. However, at the time of this assessment, she was prescribed medication and was not receiving additional support. Her overall level of need was assessed as 'Level 1'—the lowest tier, indicating the need for universal services only.

2.2.26 The police did not have direct contact with Sam but assessed their level of need as Level 1. Charlie was assessed at Level 3 due to concerns about unclean living conditions, including the state of the bedroom and cot. A 'Child to Notice' (CTN) assessment was completed for both children, who were subsequently deemed to be at medium risk due to the environmental concerns within the home.

2.2.27 Anis later withdrew from the investigation, citing past trauma she experienced at the age of 14. Her reluctance to proceed reflected underlying fear and potential re-traumatisation. However, this decision also left her vulnerable to further harm by limiting the protective actions agencies could take on her behalf.

2.2.28 The subsequent events offer critical insight into the persistent nature of domestic abuse, its emotional and developmental impact on Sam, and the effectiveness of the multi-agency response to the emerging safeguarding risks.

2.2.29 The preschool informed CSC that Anis was distressed by Sorrel's disruptive behaviour, which affected Sam, who became reclusive and aggressive. This raised concerns and prompted a Level 4 support request for safeguarding.

2.2.30 The Level 4 request suggests that practitioners believed there was an imminent safeguarding risk to Charlie and Sam.

2.2.31 Sam's regression in behaviour, aggression, and withdrawal is a clear indicator of emotional distress and potential trauma. Exposure to arguments, intimidation, and emotional abuse would likely impact Sam's emotional stability.

2.2.32 Anis informed the preschool during Sam's pickup that the police had just visited her home regarding incidents of sexual, physical, and emotional domestic abuse. The police were returning that evening to set up a domestic abuse kit.[1] This suggested that the police indicated Anis was at continued risk.

2.2.33 The Surrey Children's Single Point of Access (C-SPA) referral was updated. The preschool acted appropriately, instructing the staff to release Sam only to their mother; otherwise, they should notify the manager immediately.

[1] Personal and home security,

2.2.34 It was unclear whether the preschool manager's pickup arrangement was based on Anis's request or advice from C-SPA or the police. The safeguarding decision should be clearly accountable and indicate potential legal implications regarding who has parental responsibility.

2.2.35 The rise in domestic abuse, Sam's regression, and Anis's distress indicated a critical need for ongoing multi-agency safeguarding. Although immediate protective measures had been implemented, long-term strategies are essential to support Sam's emotional well-being and protect Anis from harm.

2.2.36 The following highlights serious safeguarding concerns regarding Anis's new partner, Bay, and the potential risk he posed to her children. The key focus was on the disclosure process, risk assessment, and gaps in the safeguarding response.

2.2.37 Anis requested a Domestic Violence Disclosure Scheme (DVDS) from Surrey Police about her partner, Bay, after learning of his past assaults. The police disclosed Bay's previous offences to Anis within the 28-day timeframe, reporting two allegations from August 2021 that were later filed with no further action taken because the victims and witnesses were unable to assist the investigation.

2.2.38 The allegations from two individuals suggest a potential risk to children. The absence of charges does not mean Bay is safe, as victims may struggle to engage with investigations due to fear or trauma, as was demonstrated by Anis's inability to provide a statement concerning Sorrel.

2.2.39 The response to the disclosure was unclear, especially whether Anis was advised on risk management or if her children were at risk.

2.2.40 A DASH was completed but not shared with CSC. Niche recorded the referral; however, the outreach form was missing, and no SCARF was required, indicating that no immediate safeguarding intervention was necessary.

2.2.41 Improved safeguarding and communication were needed for Charlie and Sam's safety.

2.2.42 Anis used propranolol for anxiety and tremors, which she had been prescribed since 2015. Frequent use may suggest unmanaged anxiety, possibly related to domestic abuse and parenting stress.

2.2.43 A safeguarding intervention was initiated following concerns raised by the preschool's Designated Safeguarding Lead (DSL) regarding Anis's emotional distress, ongoing domestic abuse by Sorrel, and the resulting impact on the children, particularly Sam.

2.2.44 CSC commenced a Child and Family Assessment (CFA), indicating that the concerns were significant enough to warrant a formal evaluation of the family's needs and risks.

2.2.45 The CFA is crucial in determining whether further safeguarding action, such as a CiN Plan or a Child Protection Plan, is needed.

2.2.46 Emotional distress over time suggests an escalating situation where Anis may feel trapped, fearful, or unsupported. There is a risk of parental mental health deterioration, which could affect her ability to care for the children safely.

2.2.47 Sorrel's sister expressed concerns to CSC about the children's bedrooms, pointing to potential neglect and poor home conditions. This may relate to parental mental health issues, especially if Anis was experiencing stress or coercive control, along with a breakdown in her support system, affecting home maintenance.

2.2.48 Sorrel's sister expressed concerns to CSC about Anis's new partner, Bay, moving in. It was reported that Bay had restricted contact with his children, suggesting a possible history of safeguarding concerns and that Sorrel had requested a DVDS concerning Bay.

2.2.49 CHCS documented a Multi-Agency Partnership Enquiry (MAPE), involving coordinated input from multiple agencies to assess concerns and determine appropriate action. This was initiated after the school raised concerns with CSC regarding domestic abuse and noticeable changes in Sam's behaviour. Relevant health information was shared in response to the enquiry, demonstrating effective multi-agency collaboration in safeguarding risk.

2.2.50 CHCS teams are not routinely notified when an MAPE is completed; only a summary and alert are recorded in the child's EMIS (Electronic Medical Information System) record. Given the high volume of over 1,000 MAPEs per month, sending individual email notifications is impractical and places pressure on services.

2.2.51 The rationale for an MAPE is often not fully substantiated at completion, and health practitioners may not be able to act on the information immediately. When further action is needed, such as a CFA or Initial Child Protection Conference, health professionals are formally invited to contribute. The EMIS alert informs clinical decision-making by indicating that an MAPE has been completed.

2.2.52 Sam reported to the CSC Social Worker (SW) that Sorrel makes them sad and shouts at mum. This testimony is vital for safeguarding assessments as it reveals the child's lived experience. Emotional abuse and exposure to domestic abuse are ACEs that can affect long-term emotional well-being.

2.2.53 Sam's disclosure raises immediate safeguarding concerns about their emotional and psychological well-being. A safety plan existed to protect Anis and the children from further domestic abuse, but it lacked clarity on specific measures.

2.2.54 CSC planned a follow-up visit to discuss domestic abuse without the children present. This allowed Anis to speak more openly about risks, barriers to leaving, and safety concerns.

November 2022

2.2.55 Anis informed the SW that she had met Sorrel through a dating site, and he moved into her home after nine weeks. She described their two-year relationship as 'toxic,' characterised by shouting, belittling, and so-called 'play-fighting' that resulted in bruising. Anis ultimately ended the relationship, acknowledging that it had harmed her and her children.

2.2.56 The SW made a referral to Early Help and agreed to speak with Bay as part of the intervention.

2.2.57 The SW completed agency checks. GP records indicated Anis had a diagnosis of anxiety and depression and was prescribed propranolol and sertraline (antidepressant).

2.2.58 She did not attend the scheduled 'Mothers and Well-being Group' and, following unsuccessful attempts to contact Anis, was discharged. Anis's non-engagement with group counselling could indicate emotional distress or fear of disclosure.

2.2.59 CSC recorded no follow-up discussion with the GP.

2.2.60 The SW contacted Bay, who confirmed that he and Anis had separated after she had learned of his risk to children, demonstrating protective action on Anis's part. This marks a key turning point, but her mental health and risks from ex-partners required ongoing multi-agency support.

2.2.61 CHCS scheduled Charlie's development review. However, due to safeguarding concerns from an MAPE about domestic abuse, a Health Visitor (HV) was assigned, and a home visit was scheduled instead of a clinic visit. A letter was sent to Anis offering a home visit in February 2023, as this approach would better assess Charlie's development and safeguard risks in the home environment.

2.2.62 CHCS received a notification that Sam visited the ED for a possible foreign body in their ear. No object was found, and Sam was discharged with Anis. The form mentioned Hampshire CSC involvement and listed professionals working with the family.

2.2.63 The Community Staff Nurse (CSN) planned to email the HV about Charlie's developmental review. There was no record of the CSN or HV seeking more information from Hampshire CSC about the family's social care involvement.

2.2.64 This represents a missed opportunity for safeguarding. Sam's attendance at the ED could have indicated potential neglect or risk of injury, particularly in the context of the family's known history of domestic abuse.

2.2.65 While the hospital report referenced involvement from Hampshire CSC, there is no recorded confirmation that CSC was contacted. This reflects a potential critical gap in inter-agency communication, as professionals are expected to actively seek updates from all agencies involved in safeguarding assessments and plans.

2.2.66 ED staff are responsible for raising safeguarding concerns with CSC following their assessment, where appropriate. In this case, the Information Sharing Form from ED to CHCS did not indicate any safeguarding concerns or suggest the incident resulted from neglect. It is noted that young children often insert objects into their ears or noses, and medical attention has been sought appropriately.

2.2.67 The HV's home visit to Charlie did not explore the broader safeguarding context, and potential concerns about Sam's safety and emotional well-being were unaddressed.

December 2022

2.2.68 Anis's rent account was in arrears (according to Aster, the arrears were low-level), and Aster Group sent a letter to advise Anis, which resulted in the arrears being paid. Rent arrears can be an indicator of financial hardship or economic abuse.

2.2.69 The Family Support Worker (FSW) and Anis attended a Team Around the Family (TAF) meeting. The meeting focused on Anis's mental health, the need for support due to poor home conditions, and direct work with the children, especially since Charlie was too young to communicate verbally. They also discussed a referral to Early Help, and the preschool received the meeting minutes. There was no discussion concerning domestic abuse.

2.2.70 TAF provides a multi-agency approach to reviewing Anis's mental health needs and offering the right support. Mental health support is crucial as poor parental mental health can impact children's emotional well-being, stability, and attachment.

January 2023

2.2.71 The FSW informed Anis about a domestic abuse support programme; however, Anis reported that she was unable to afford it. It was unclear who was providing this programme and what, if any, payment was required, as many domestic abuse programmes are offered free of charge.

2.2.72 This perceived financial barrier highlights a significant concern: miscommunication or lack of clarity around service accessibility can prevent victims from engaging with essential support, leaving them vulnerable as they navigate trauma, childcare responsibilities, and efforts to ensure their safety.

2.2.73 The DARDR panel felt that, had payment been required, CSC should have funded it.

2.2.74 Anis informed the FSW that she was experiencing significant conflict with Sorrel regarding childcare arrangements, which caused her considerable emotional distress and led her to cry during the phone call. She told Sorrel that, moving forward, any contact with Sam would need to take place through a supervised contact centre.

2.2.75 The panel felt FSW should have communicated this information to Sorrell and noted his absence in the TAF meetings. Research highlights that CSC services often under-engage

fathers in key processes, including meetings and decision-making. Fathers are frequently excluded from assessments, case conferences, and planning sessions, which can lead to incomplete risk evaluations and missed opportunities for support.

2.2.76 Barriers include professional bias (viewing fathers primarily as risks), lack of practitioner confidence and training, and systemic practices that focus predominantly on mothers. This marginalisation can harm children's outcomes.

2.2.77 In cases involving domestic abuse, engaging fathers and father figures is not solely about supporting parental involvement; it is also about assessing and managing risk, challenging harmful behaviours, promoting accountability, and ensuring that safeguarding interventions address the actions of those who may be causing harm.

2.2.78 The FSW provided Anis with details of Mind Matters (talking therapies).

2.2.79 Anis's distress over child care with Sorrel highlights the emotional toll of ongoing custody arguments and past abuse. Her crying during a call with the FSW reflects possible trauma and current stress.

February 2023

2.2.80 During a video consultation with her GP, Anis discussed her emotional difficulties and labile mood. She expressed concern that she might have Borderline Personality Disorder (BPD), noting similarities between her own experiences and those of a friend who had received the diagnosis. In response, the GP increased her dosage of sertraline and made a referral to SaBP for a mental health assessment and support.

2.2.81 Anis's request for a BPD assessment was a significant step toward understanding her mental health. Such an assessment could help her make sense of her emotional experiences, particularly as BPD is frequently associated with complex trauma and histories of emotional abuse within intimate relationships.

2.2.82 The GP's recognition of Anis's emotional struggles and the referral for mental health support were a positive step. The decision to increase her sertraline dosage reflected an effort to manage her mood and anxiety.

2.2.83 This approach aligns with the NHS Treatment for Depression in Adults, which recommends that talking therapies should be offered in conjunction with pharmacological treatment.

2.2.84 A review appointment with the GP was scheduled within a week, but Anis declined the video consultation twice. Anis's recurring pattern involves initially engaging with services and attending appointments, followed by withdrawal from ongoing support.

2.2.85 From a trauma-informed perspective, such disengagement may reflect trauma-related responses, including difficulty trusting professionals, fear of judgment, or becoming overwhelmed by sustained involvement. This pattern highlights the importance of

consistent, empathetic engagement and flexible support strategies within safeguarding practice to minimise re-traumatisation and promote sustained engagement.

2.2.86 Anis contacted NHS 111 to report an injury she sustained during an argument with her child's father (Sorrel) after a handover. She was advised to attend a walk-in centre for medical assistance. A safeguarding form was completed for the child, and relevant information was shared with appropriate agencies for potential follow-up.

2.2.87 However, the incident was not explored in the context of domestic abuse, and Anis was not referred to any specialist support services, representing a missed opportunity to provide targeted safeguarding and emotional support.

2.2.88 SaBP received a referral from Anis's GP to their Single Point of Access (SPA), citing Anis appeared emotionally dysregulated on the background of depression, anxiety and Post-Traumatic Stress Disorder (PTSD).

2.2.89 She was referred to the Community Mental Health Team (CMHT) for a new patient assessment. Anis missed her first appointment and did not respond to phone calls. A home visit was conducted, and a second appointment was scheduled, which she did not attend.

2.2.90 After her continued disengagement, the case was discussed in a Multi-Disciplinary Team (MDT) meeting, leading to her discharge from the mental health service and a return of care to her GP, in line with the engagement and disengagement policy. The GP was kept informed throughout the process.

2.2.91 The GP's involvement ensured Anis's health was monitored. Her non-attendance at appointments may indicate unmet needs. Therefore, it is essential to explore the reasons for her disengagement to support her mental health and safety.

2.2.92 The HV reported no unmet health needs for Anis, Sam, or Charlie.

2.2.93 CHCS are not responsible for following up on referrals made by other agencies. This responsibility lies with the originating service and referrer. While CHCS encourages engagement and may note missed appointments, they do not provide targeted follow-up unless it falls within their remit. A trauma-informed approach continues to guide practice and is reinforced through team training.

2.2.94 The HV contacted CMHT to provide Anis's updated phone number before her discharge from CMHT. CMHT confirmed that they had the correct number on record.

2.2.95 In response to concerns about Anis's social isolation, anxiety, depression, and deteriorating home conditions, the HV referred her to Home Start for emotional and parenting support, and to the Woking Furniture Project for assistance with furniture.

2.2.96 However, no documented evidence indicated whether Anis engaged with or accessed these services, leaving it unclear whether the intended support was received or had any impact.

2.2.97 The HV reported no unmet health needs for the family; however, significant concerns about Anis's social isolation, mental health, and deteriorating home conditions suggested otherwise, potentially impacting the children's welfare.

2.2.98 Despite these risk factors and indicators of domestic abuse, no referral was made to CSC. Anis's non-attendance at appointments and limited engagement with services may indicate disguised compliance, highlighting the need for a more thorough assessment of her situation.

March 2023

2.2.99 Anis missed the TAF meeting, which may reflect the impact of her depression on her engagement with services, indicating a need for targeted support to help her re-engage with services.

2.2.100 Anis shared with the FSW that she felt stressed about rehoming her cat due to a flea infestation. She also expressed that her low mood and symptoms of depression had led to her missing TAF meetings. This openness about her mental health demonstrated a degree of self-awareness regarding her mental health needs and the challenges she was facing.

2.2.101 Anis disclosed to the FSW that Sorrel had physically injured her by grabbing her hand, an act constituting physical abuse. She did not report the incident to the police, potentially due to fear, shame, concern about possible repercussions, or a continued emotional attachment to the perpetrator.

2.2.102 This highlights the complexities of domestic abuse and the significant barriers victims often face in seeking help. A referral was made to the National Centre for Domestic Violence (NCDV) for specialist support.

2.2.103 Anis self-referred to Mind Matters, demonstrating her initiative to seek help for her mental health. Having a female friend staying with her also provided valuable social support.

2.2.104 The preschool staff reported supporting Sam to the toilet and noted that they were not wearing underpants. This raises concerns about neglect and parental capacity, particularly regarding Sam's clothing. This incident may suggest issues in parental concerns linked to domestic abuse, mental health challenges, or poverty.

April 2023

2.2.105 Aster Group received a report concerning the accumulation of rubbish outside Anis's property. In response, they emailed Anis, attempted a home visit, and left a voicemail requesting that the waste be removed.

2.2.106 The presence of rubbish, combined with unsuccessful contact attempts, may indicate underlying issues with household management or potential signs of neglect. Alternatively, it may reflect Anis' feeling overwhelmed and lacking the emotional capacity to manage day-to-day tasks, highlighting the potential impact of stress, trauma, or unsupported parental responsibilities.

May 2023

2.2.107 Anis's rent account was in arrears, and Aster Group sent a letter to advise Anis, which resulted in the arrears being paid.

2.2.108 Preschool staff observed mould in Sam's lunchbox, raising significant concerns about food safety and nutritional neglect. This incident may reflect inadequate resources or inconsistent care in meeting Sam's basic needs.

2.2.109 Additionally, Sam reported experiencing pain while using the toilet and was found not to be wearing underpants, suggesting possible hygiene issues or an underlying health concern. Anis was informed of Sam's discomfort, but it was unclear whether any follow-up action was taken.

2.2.110 Anis told the FSW that she had been struggling emotionally following the death of her dog, but was beginning to feel better with support from a friend.

2.2.111 The loss of a pet can be emotionally distressing, particularly for individuals with pre-existing mental health conditions such as depression. Anis's response to this grief illustrates both her emotional vulnerability and the positive role of her informal support network, which appeared to provide some resilience during a difficult time.

2.2.112 Whilst harm to pets can be associated with coercive control and domestic abuse, the review did not identify evidence that either animal was deliberately harmed or used as part of abusive behaviour.

2.2.113 She reported good mental health and used cooking as a coping mechanism. Anis showed self-awareness regarding her mental health, recognising that she had difficulties. Her cooking served as a positive coping mechanism, indicating she actively sought constructive ways to manage her emotions, which can contribute to long-term resilience.

2.2.114 Anis was closed to Early Help after completing the Graded Care Profile assessment, and the preschool was notified of the closure. Anis was also referred to the Family Information Service for additional support; however, it was unclear whether she accessed or engaged with this service.

June 2023

2.2.115 A housing officer conducted a tenancy check to assess the condition of Anis's property and engaged with her. The property was deemed to meet basic housing standards, and the check was marked as 'passed,' with no immediate safety risks identified.

2.2.116 While such checks help assess physical housing conditions and tenancy compliance, they may overlook underlying issues such as financial hardship, emotional distress, or the cumulative impact of domestic abuse on a tenant's overall well-being.

2.2.117 The GP received notification of Anis's attendance at the ED. Anis reported she had trodden on a piece of glass, which was removed.

August 2023

2.2.118 Anis contacted NHS 111, reporting symptoms of a headache, vomiting, and photophobia. SECAmb attended her address and noted two children present. Concerned for their care, SECAmb contacted the children's grandparents, who arrived and transported Anis to the ED at Ashford & St Peter's Hospitals NHS Foundation Trust.

2.2.119 However, the ED visit was minimally documented, limiting insight into Anis's condition and any safeguarding considerations.

2.2.120 Three days later, Anis returned to the ED by SECAmb for the same issue, received medication, and was advised to return if there was no improvement.

September 2023

2.2.121 CSC received an anonymous referral outlining serious concerns about Anis's living conditions and behaviour. Allegations included children being heard screaming, being smacked and sworn at, and living in a home described as 'filthy,' with overgrown gardens, rats, accumulated rubbish, and a 'rancid' swimming pool.

2.2.122 Additional concerns were raised regarding the children's hygiene and claims that Anis had attempted suicide, with ambulances reportedly attending the property twice within two weeks. It was also reported that Anis had been seen drinking alcohol while walking her children to school.

2.2.123 Although agency checks were initiated, attempts to contact Anis for consent were unsuccessful. The case was closed without discussion with the GP or housing services, highlighting a significant gap in multi-agency information-sharing and safeguarding escalation.

2.2.124 The concerns raised, including neglect, emotional abuse, mental health difficulties, and potential substance misuse, were serious and warranted a comprehensive multi-agency investigation. However, missed opportunities for collaboration and a lack of follow-up with key partners, such as GPs, HCPs, and housing services, limited the ability to assess the risks thoroughly.

2.2.125 Closing the case solely due to the inability to obtain parental consent may have been premature, particularly given the significant safeguarding concerns relating to the children's welfare and Anis's mental health.

2.2.126 Surrey Police received an anonymous report alleging that children were screaming inside Anis's home and that she had been seen walking with her children while drinking alcohol. Upon attending the scene, officers found Sam and Charlie safe and uninjured. Surrey Police shared information in accordance with MAPE.

2.2.127 Sam engaged appropriately with the officers, and although the home was somewhat untidy, no immediate safeguarding concerns were identified. Anis denied consuming alcohol and stated that Sam had autism. The incident was recorded on a SCARF and assessed as low risk (Level 1), with no safeguarding action taken.

2.2.128 Officers suspected the report may have been malicious and possibly linked to a neighbour dispute and advised Anis to keep a record of further incidents. In accordance with the Police Single Point of Access protocol, no referral was made to Surrey CSC.

2.2.129 CHCS recorded an MAPE in response to concerns regarding parental neglect, poor child presentation, and substandard home conditions. CSC offered Level 3 (CIN) support, which the family declined, and it was determined that escalation to Level 4 (Child Protection) was not warranted at that time.

2.2.130 Anis submitted an online report to Surrey Police that her neighbour had thrown cold water over the fence at her and her partner. Initial investigations revealed no CCTV footage or witnesses to support her report, resulting in the case being filed with no further action. Anis was advised to document any further incidents and report them to Housing or the Police as needed. It was unclear if police officers visited the address, which would limit the investigation.

2.2.131 A housing officer visited Anis about rubbish in the gardens. Anis reacted with anger, shouting and slamming the door, indicating possible stress, emotional dysregulation, or vulnerability related to her mental health or domestic issues. A follow-up email reminded her of the tenancy terms on garden usage.

2.2.132 Aster Group received an anonymous report regarding Anti-Social Behaviour (ASB) linked to domestic abuse involving children at Anis's property. The individual had already contacted the Police and CSC and was provided with guidance on Aster's reporting procedures, although they expressed reluctance to engage further.

2.2.133 Aster distributed surveys to neighbouring properties to gather additional information, but no responses were received. As a result, the inquiry was closed in December 2023 without further action.

2.2.134 Given the seriousness of the allegations involving both children and domestic abuse, it should have been escalated to the appropriate safeguarding authorities. This represents a missed opportunity to assess and address potential risks to the children's welfare.

October 2023

2.2.135 Anis contacted Aster Group to request a repair to the toilet, which was completed.

2.2.136 Anis reported to Surrey Police that her friend's new partner had harassed her for over two months, including seven abusive social media messages and verbal abuse on a bus. Multiple attempts to contact Anis were unsuccessful, and the case was filed without further action.

November 2023

2.2.137 Anis's rent account was in arrears, and Aster Group sent a letter to advise Anis, which resulted in the arrears being paid in February 2024.

2.2.138 Anis's GP received an online request regarding persistent cluster headaches and a request to increase her sertraline dosage. The practitioner attempted to contact her by phone twice without success and subsequently sent a follow-up text advising her to rebook if further advice was needed. As no appointment was confirmed, Anis's ongoing physical and mental health concerns remained unaddressed, potentially exacerbating her symptoms and overall well-being.

December 2023

2.2.139 Anis was seen in person by the GP practice and prescribed antibiotics; there was no reason for follow-up.

2.2.140 The primary school reported a conversation with X (unfortunately, the panel could not confirm the identity of this individual), who made general observations about the family situation. During a home visit, Anis raised concerns about her child, Charlie, walking on tiptoes. The staff noticed a messy environment, which they speculated might contribute to this behaviour rather than a medical issue.

2.2.141 The primary school delivered a home pack, as Sam had missed a week of preschool due to an ear infection and was prescribed antibiotics, which Anis had forgotten to collect. They also recorded rubbish in front of the house, and Sam appeared 'dirty.' The school expressed concerns that TAF was closed. X advised the primary school to monitor the children's cleanliness and health.

2.2.142 This may indicate challenges in managing Sam's health needs and could be an early indicator of neglect, warranting further monitoring and support.

2.2.143 The TAF's closure left school staff to manage serious issues without support, highlighting a pattern of neglect that warranted a referral to CSC or closer monitoring by involved services.

January 2024

2.2.144 A meeting with Anis at the primary school. Anis expressed concern about Sam's self-harm behaviours, such as hitting the tumble dryer or dropping to the floor, often triggered

by requests or transitions, like after school or before dinner. School staff recommended using putty to help Sam calm down and create a safe space with activities that can help prevent meltdowns.

2.2.145 Anis noted that Sam tended to go under the table during meltdowns and shared that they participate in activities such as dancing and baking. They discussed a structured timetable for Sam and monitored her social interactions at school, where Sam prefers one-on-one play and often plays alone.

2.2.146 Anis mentioned that Sam sometimes "zones out" and walks on tiptoes, prompting the school to advise seeking medical advice. Sam is also a fussy eater, consuming only a limited variety of foods, and the school agreed to monitor their eating habits. Anis planned to update the school after consulting with Sam's GP.

2.2.147 Sam's self-harming behaviours, meltdowns, and zoning out indicate possible emotional regulation issues that require evaluation by a professional. Sam's preference for one-on-one play and discomfort in group settings may suggest social difficulties.

February 2024

2.2.148 Anis shared with the primary school staff that Sam had sustained a neck injury while wearing a tie and role-playing with their younger sibling the previous night. She showed the teacher a photo of the mark. Sam confirmed to the teacher the following day that the injury resulted from the role-playing incident.

2.2.149 Anis's decision to inform the school about Sam's injury shows good communication with staff, which is essential for Sam's safety. However, the role-playing with a tie may indicate that Anis was unaware of the risks involved. Guidance on safe play could help prevent future incidents.

2.2.150 Anis filled out an online form for her GP, stating her children had persistent coughs for three weeks. A telephone triage was scheduled, and she received a confirmation text. However, the GP practice was unable to reach her despite multiple attempts. Her engagement with healthcare providers demonstrated a willingness to seek care; however, unknown barriers related to communication and follow-up remained.

2.2.151 Anis reported ongoing disruptive behaviour from a neighbour to Aster Group, including loud music, slamming doors, and nighttime disturbances affecting her children's well-being. She also expressed concerns about suspected drug-dealing activity, noting the presence of intoxicated individuals at her property during the early hours of the morning and frequent vehicle traffic consistent with illicit behaviour.

2.2.152 Anis requested anonymity due to fear of retaliation. Aster Group provided her with guidance on safely documenting and reporting these incidents.

2.2.153 Anis's reports of persistent noise disturbances and suspected criminal activity had a detrimental impact on her family's well-being, contributing to a distressing and potentially unsafe living environment.

2.2.154 Her expressed fear of retaliation was a significant barrier to seeking further help or intervention. Aster Group played an essential role in acknowledging her concerns and providing guidance, although the extent to which this support improved her living conditions remains unclear.

3.1 Analysis of Agency Involvement

3.1.1 This section examines the agencies' involvement.

Aster Group, Housing

3.1.2 Safe and stable housing is a critical component in supporting survivors of domestic abuse. The Domestic Abuse Act (2021) recognises victims as a priority need for housing, removing the requirement to demonstrate additional vulnerabilities to access support.

3.1.3 Under initiatives like the Sanctuary Scheme, local authorities can implement practical security measures, such as reinforced doors, locks, and safe rooms, to help survivors remain safely in their homes where appropriate.

3.1.4 The Care Act (2014) strengthens social housing providers' responsibility to safeguard vulnerable adults, complementing their duty to protect children and young people. The Act establishes a statutory framework for local authorities, housing, and health services to work collaboratively to identify and support individuals at risk of abuse or neglect. It emphasises the importance of clear roles, shared accountability, and multi-agency coordination to ensure effective and timely safeguarding interventions.

3.1.5 In April 2019, Woking Borough Council nominated Anis for the tenancy at the property. Subsequently, Anis became a tenant of the Aster Group through the Choice Based Lettings Scheme, a Council system for advertising homes. The tenancy was initiated in June 2019.

3.1.6 Aster maintained a landlord-tenant relationship with Anis; however, the DARDR identified a significant gap in information sharing between Aster and statutory safeguarding agencies concerning Anis's known vulnerabilities, including experiences of domestic abuse.

3.1.7 Had Aster been fully informed of these risks, it may have been able to adopt a more proactive approach to safeguarding, potentially enabling the earlier identification of concerns and timely intervention.

3.1.8 Aster managed routine matters emphasised in the key events, indicating potential areas of concern:

- Reports of rubbish accumulation, poor home conditions, and allegations of ASB were raised but not consistently linked to safeguarding concerns.
- Housing had limited visibility of the broader risks affecting Anis and her children.
- Anonymous reports of domestic abuse and unsafe home conditions were not adequately investigated. Despite documenting concerns and conducting surveys, the lack of responses resulted in no action. The reporting party was advised to contact the police, who missed key safeguarding opportunities.

3.1.9 The DARDR emphasised the need to integrate housing providers into multi-agency safeguarding processes to ensure that they receive timely information on vulnerable tenants.

3.1.10 Aster should improve its protocols for escalating third-party reports to police, social care, and MARAC partners about domestic abuse and safeguarding risks. Additionally, providing domestic abuse training for housing officers would help them identify risk factors and respond effectively.

3.1.11 The Housing Ombudsman Service's "Spotlight on Attitudes, Respect and Rights" report highlights the critical need for improved information sharing between local authorities and housing associations. It underscores that effective partnership working is fundamental to supporting vulnerable households and maintaining service quality. It also points to a gap in understanding among social landlords regarding their statutory obligations.

3.1.12 To address this, housing providers must ensure compliance and proactively tailor their services better to reflect the complex and evolving needs of their residents.

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

3.1.13 The earliest record (March 2013) identifies Anis as a young person at risk, with documented self-harm, suicidal intent, and experience of sexual abuse. The involvement of hospital services and police between 2014 and 2017 indicated that Anis's vulnerabilities were known across multiple agencies. Still, it was unclear whether early intervention or safeguarding actions were effectively coordinated.

3.1.14 Repeated reports suggest potential gaps in follow-up support or multi-agency safeguarding planning.

3.1.15 Anis had agency involvement during both pregnancies (2018 and 2021), allowing professionals to assess her well-being and parenting capacity. She engaged with the Health Visiting Service, attended all scheduled appointments, and shared personal information, demonstrating trust in the service. While structured reviews were in place to identify risks, it remained unclear if domestic abuse risks were explored or documented.

3.1.16 The continuity of care, through pregnancy and early childhood reviews, allowed professionals to maintain contact with her over a significant period.

3.1.17 The Family Health Needs Assessment (February 2023) highlighted Anis's isolation, lack of family support, and challenges as a single parent, with no support, which impacted her well-being. Anis sought help, presenting an opportunity for intervention

3.1.18 The referral to Home-Start addressed her isolation and connected her with community support. However, the absence of follow-up documentation leaves uncertainty about whether Anis received this assistance, representing a missed opportunity for effective intervention.

3.1.19 Anis's deteriorating mental health was noted after she missed an appointment with the CMHT. While the HV appropriately updated CMHT with her new contact details and left a voicemail, underlying factors such as domestic abuse, financial stress, or social isolation were not explored. Furthermore, the HV neither documented the information shared with CMHT nor sought Anis's consent to inform her GP, missing an opportunity for a more coordinated mental health response.

3.1.20 The home presented safeguarding concerns related to hygiene and safety, including clutter, food waste, and a soiled cat litter tray within reach of a young child. The absence of flooring due to pet damage further reflected challenges in home maintenance. However, protective factors were also present: the children had clean beds, age-appropriate toys, and a visibly strong emotional bond between Anis and Charlie.

3.1.21 Despite these positives, the HV missed a key opportunity to assess Anis's ability to manage the home and explore potential underlying causes, such as poverty, poor mental health, or social stressors, which is crucial for early intervention and holistic safeguarding.

3.1.22 Given the deteriorating home environment, Anis's declining mental health, and limited support network, a referral to CSC should have been considered. The absence of such a referral reflects a missed safeguarding opportunity and is not aligned with Working Together to Safeguard Children. This underscores the importance of clear multi-agency communication and proactive intervention.

3.1.23 It also falls short of the NHS Long-Term Plan's commitment to integrated care pathways for vulnerable families.

3.1.24 The Maternal New Birth Review in February 2022 does not indicate that a Domestic Abuse Enquiry was conducted, despite it being part of the templates for new births. If practitioners could not enquire, documentation was required. The reasons for the lack of enquiry and recording remain unclear.

3.1.25 A disclosure to Sam's preschool in October 2022 indicated continued risk, yet no follow-up enquiry was made. CHCS are often not made aware of safeguarding concerns raised by early years settings unless multi-agency processes are initiated. Subsequently, CHCS were not aware of this disclosure.

3.1.26 It is expected that the preschool will follow its internal safeguarding procedures, with CHCS only becoming involved once concerns are escalated through formal channels.

3.1.27 Professional discussions with Anis focused on the financial aspects of her relationship with Charlie's father (Sorrel), overlooking potential safety and emotional concerns. Additionally, no new partner was explored despite clear contextual indicators warranting further inquiry.

3.1.28 The HV did not fully consider Anis's wider support needs, missing a holistic assessment that integrated mental health and domestic abuse history. Considering past disclosures and ongoing concerns, support from the Universal Plus Health Visiting Service should have been initiated, enabling more frequent contact, safeguarding supervision, and coordinated multi-agency input.

3.1.29 Additionally, the level of concern warranted discussion with the Clinical Lead or Safeguarding Team, in line with professional safeguarding responsibilities.

3.1.30 In 2018, Anis was appropriately placed under the Universal Plus due to significant vulnerabilities, including depression, suicidal ideation, and online grooming. This aligned with the Healthy Child Programme (HCP), which provides enhanced support for families with additional needs, such as parental mental health concerns.

3.1.31 NICE guidelines (NG76 Child Abuse and Neglect) further highlight the importance of perinatal mental health history in assessing risk and enabling timely intervention.

3.1.32 During Anis's pregnancy in 2021, Anis was incorrectly recorded as receiving Universal Health Visiting Support rather than Universal Plus, despite a known history of self-harm and mental health issues. This classification, based solely on the absence of current symptoms, did not take past vulnerabilities into account.

3.1.33 Such oversight highlights a breakdown in continuity of care and breaches the Working Together to Safeguard Children requirement for accurate record-keeping to inform appropriate service allocation decisions.

3.1.34 This misclassification contradicts the HCP, which states that prior mental health vulnerabilities should guide decisions.

3.1.35 NG76 recommends enhanced perinatal support for women with severe mental health histories. During pregnancy, maternity services lead care and allocate specialist midwives to vulnerable women. CHCS is not commissioned to provide multiple antenatal visits to pregnant women under the care of maternity services. Working Together emphasises the importance of proactive, early intervention.

3.1.36 The HV will offer a targeted antenatal visit from 28 weeks for families with documented safeguarding concerns. In Surrey, the health visiting service receives pertinent information

from the midwifery service through maternity liaison meetings or antenatal safeguarding forms.

3.1.37 During these visits, the HV will conduct a Health Needs Assessment that encompasses physical, mental, and emotional health. Discussions will focus on the transition to parenthood, enhancing parent-child bonding, and supporting early development.

3.1.38 The HV will also assess for mental health issues and risk factors such as domestic abuse and substance misuse. Appropriate referrals will be made if concerns arise, and relevant information will be shared with the relevant services.

3.1.39 Best practice indicates that Anis should have been offered an antenatal visit to establish a therapeutic relationship and ensure prompt access to care.

3.1.40 Although Anis's history of suicide attempts and grooming was acknowledged, it was not meaningfully integrated into decision-making. The absence of a domestic abuse enquiry, coupled with the decision not to offer Universal Plus support, limited opportunities to explore her experiences, despite prior disclosures. This fragmented approach contradicts national guidance, which stresses the importance of holistically assessing vulnerabilities and parental risk factors rather than in isolation.

3.1.41 The DARDR highlights the requirement for multi-agency reviews in high-risk pregnancies, in line with Working Together to Safeguard Children. HVs do not lead these reviews but attend antenatal vulnerability meetings, which are led by maternity services, who are the lead professionals for pregnant women.

3.1.42 HVs also contribute to pre-birth assessment meetings, which CSC leads. There is no record indicating that maternity identified Anis as requiring discussion at either forum.

3.1.43 For individuals with a history of PTSD, such as Anis, NICE guideline NG116 recommends proactive perinatal mental health referrals. Maternity services are responsible for making these referrals after the booking appointment, where indicated. The absence of a referral represents a missed opportunity for early intervention and coordinated safeguarding.

3.1.44 HVs offer targeted antenatal visits at 28 weeks in line with current service delivery. If there are any concerns, they will consult with maternity and make appropriate referrals as needed.

3.1.45 NICE guideline NG76 states that routine domestic abuse enquiries must be conducted at multiple points, not solely at the New Birth Visit.

3.1.46 Antenatal assessments should consider cumulative risk factors, as highlighted in the HCP and Working Together to Safeguard Children. HVs rely on clear information to apply Universal Plus support appropriately.

3.1.47 A history of mental illness alone does not trigger a targeted antenatal visit if the woman is currently reported as well by maternity services. In Anis's case, there was no information shared with CHCS indicating a history of mental illness since age 15.

3.1.48 Since 2022, routine enquiries have been appropriately embedded into assessment templates and conducted at every safe opportunity.

Children's Social Care (CSC)

3.1.49 Surrey CSC was involved with Anis between February 2013 and April 2016, and later re-engaged with her regarding her children, Charlie and Sam, from October 2022 to September 2023.

3.1.50 In 2013, Anis came to CSC's attention after being found in a hotel with a 47-year-old man who had groomed and sexually assaulted her. A strategy meeting and police investigation followed, resulting in the perpetrator being charged with 17 sexual offences involving underage girls. While Anis received therapeutic input from CAMHS, there was no long-term, multi-agency safeguarding plan to address her ongoing vulnerability.

3.1.51 Her mental health decline following the assault was foreseeable, yet support remained narrowly focused on CAMHS. There was limited parental engagement and no evidence of a coordinated response to help the family understand the nature of grooming or coercion.

3.1.52 Additionally, there were no referrals to CSE services or an online safety plan, which are critical in managing risk and promoting recovery. This reflects a significant gap in holistic safeguarding practice and multi-agency coordination.

3.1.53 The Tackling Child Sexual Abuse Strategy (2021) highlights the need for long-term, trauma-informed support for CSE survivors, extending beyond the initial criminal justice response. In Anis's case, factors such as social media and peer networks contributed to her exploitation.

3.1.54 The Contextual Safeguarding Framework reinforces the importance of proactively addressing these wider environmental risks, which were not sufficiently considered.

3.1.55 Despite early and significant concerns, including Anis introducing her sister to unsafe online spaces and repeated episodes of going missing, there was no sustained, coordinated safeguarding response. The lack of a Multi-Agency Risk Management Meeting (MARM), specialist CSE referrals, and the missed opportunity to engage in contextual safeguarding approaches reflected systemic gaps in risk assessment and intervention planning.

3.1.56 Anis's behaviour, including normalising unsafe online activity, aligns with known CSE victim responses such as trauma, control-seeking, and desensitisation. However, these were not adequately recognised or addressed. Key opportunities for proactive, trauma-informed, multi-agency intervention were repeatedly missed.

3.1.57 Later involvement by CSC and Early Help improved, but core safeguarding functions remained inconsistent. Risk factors, including domestic abuse, poor home conditions, and Anis's deteriorating mental health, were not robustly assessed or escalated. Critical tools, such as the Graded Care Profile (GCP), were lacking, which weakened intervention planning.

3.1.58 The absence of a MARM to complete basic safeguarding checks during the initial social work assessment and early help phases led to a fragmented response. Referrals to domestic abuse services were made, but lacked follow-up, and the impact on the children was not sufficiently explored.

3.1.59 Professionals did not act decisively despite the case meeting safeguarding thresholds. Working Together to Safeguard Children and data-sharing legislation (GDPR / Data Protection Act 2018) permit information sharing without parental consent when a significant risk is present (Sections 17 and 47, Children Act 1989).

3.1.60 The decision not to escalate the case or share information reflected a misunderstanding of statutory responsibilities and resulted in missed opportunities to protect Anis and her children.

Education: Sam's preschool and primary school

3.1.61 Inconsistencies in Sam's preschool attendance records between agency systems signal wider data accuracy and information sharing issues, undermining the early identification of safeguarding risks. Reliable education records are vital, as gaps can delay interventions and obscure patterns of harm.

3.1.62 Preschool staff demonstrated good practice in responding promptly and sensitively to Anis's disclosure in October 2022. However, the absence of a Child Protection chronology and the lack of continued documentation from October to December 2022 indicate gaps in monitoring ongoing risk and coordinating follow-up actions.

3.1.63 The preschool's non-attendance at the December TAF meeting, combined with the lack of evidence of CSC engagement before it, further limited the effectiveness of multi-agency planning.

3.1.64 In early to mid-2023, preschool records revealed fragmented documentation and inadequate follow-up regarding Anis's relationship risks and home environment. While concerns such as Sam's attendance, hygiene, and health were acknowledged, these were not consistently escalated or formally recorded, and no evidence of structured action or escalation was found. The preschool's verbal advice to the primary school lacked formal information transfer, posing a significant risk at transition.

3.1.65 The primary school's home visit in October 2023 identified visible safeguarding concerns, including home neglect and poor personal hygiene among children. However, inadequate

record-keeping, noting only staff initials and no documented follow-up or referral plan, again demonstrated missed safeguarding opportunities.

3.1.66 Without clear accountability, structured planning, or escalation, early warning signs were inadequately addressed, leaving Anis and her children without timely or coordinated support.

GP Practice

3.1.67 Anis was registered with her final GP practice from 2019 until her death, but had minimal contact, with only five clinician appointments over four years, resulting in no continuity of care.

3.1.68 Frequent changes in GP practices over the previous decade suggest a lack of stable engagement with primary care, limiting opportunities to build trust or monitor health trends.

3.1.69 Her case reflects broader challenges in engaging individuals with mental health needs, particularly those affected by domestic abuse. Although she appeared stable in late 2022, her mental health deteriorated significantly in early 2023. Despite increased medication and referrals to secondary care, no follow-up occurred after her disengagement, a critical missed opportunity in care continuity.

3.1.70 She disengaged from services, missed several appointments, and received no follow-up from her GP, raising concerns about accessibility and intervention strategies. Research indicates that individuals with anxiety and depression often disengage due to stigma and perceived ineffectiveness. Non-attendance is linked to avoidance behaviours common in anxiety and trauma. Digital care models, such as text check-ins or home visits, could enhance engagement.

3.1.71 Crucially, Anis disclosed domestic abuse in February 2023, an overlooked safeguarding red flag that should have prompted integrated action between mental health and safeguarding teams.

3.1.72 NICE guideline NG222 recommends active follow-up for individuals with self-harm history or recent medication changes, particularly when safeguarding risks are present.

3.1.73 The GP practice did not act on this, further emphasising the need for better alignment between primary care, mental health, and safeguarding systems.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.1.74 Anis's referral to CAMHS in 2013 followed significant trauma linked to online grooming, leading to suicidal ideation and self-harm.

3.1.75 Research shows that exposure to online grooming significantly increases the risks of PTSD, depression, and self-harm among young people. Eye Movement Desensitisation and Reprocessing (EMDR), a type of psychotherapy that helps people process traumatic memories, was effective in her case, aligning with studies that show EMDR's success in treating trauma-related symptoms in adolescents.

3.1.76 CSC made a further referral in 2014. Anis's parents declined participation in a Sexual Assault Assessment, Recovery and Support group, a missed opportunity for trauma-informed intervention.

3.1.77 Studies indicate that parental engagement is a key factor in the effectiveness of mental health treatment in young people. Declining support services may have contributed to Anis's disengagement from therapy.

3.1.78 By 2016, Anis had been in a domestically abusive relationship and lived with individuals involved in criminal activities. The link between ACEs and adult victimisation in abusive relationships is well-established. CAMHS were unable to establish contact, which led to case closure, reflecting research showing that at-risk youth often struggle to engage with formal mental health services.

3.1.79 MARAC was informed of risks, but limited follow-up suggests gaps in multi-agency collaboration. Effective MARAC interventions often require persistent engagement strategies, including assertive outreach, which was not evident in this case.

3.1.80 While MARACs improve multi-agency responses to high-risk domestic abuse cases, there are challenges regarding victim involvement, regional disparities, and long-term effectiveness.

3.1.81 FPH referred Anis in November 2021 during her second pregnancy. The plan was for her to remain under the specialist mental health midwife who could re-refer to Perinatal services if Anis's mental health declined.

3.1.82 Pregnancy-related mental health referrals indicate service recognition of her risk factors. Perinatal mental health risks are heightened in those with histories of trauma and psychiatric admissions.

3.1.83 Although a specialist midwife monitored Anis, her discharge from Perinatal services might reflect an underestimation of her long-term vulnerabilities. NICE guidelines emphasise continued monitoring of perinatal mental health, especially for those with previous crisis episodes.

3.1.84 Anis's referral to the SPA in February 2023 was for a diagnostic assessment due to emotional dysregulation alongside depression, anxiety, and PTSD.

3.1.85 The sequence of events highlights systemic gaps in mental health service engagement and follow-up for safeguarding. While standard procedures were followed, the approach may not have been sufficient for someone with complex trauma and emotional instability.

3.1.86 Strengthening proactive follow-up mechanisms, trauma-informed engagement strategies, and multi-agency collaboration could help prevent similar outcomes in the future.

Surrey Police

3.1.87 Anis had 22 police interactions, including seven intelligence submissions, with seven related to child sexual exploitation, domestic abuse, and missing episodes.

3.1.88 In 2013, the police national computer recorded Anis's father reporting her to be struggling with her mental health and self-harming. Her father informed officers that she had expressed suicidal thoughts over the past three years. Anis also underwent a mental health assessment at FPH after an incident involving self-harm with a knife, requiring her parents to restrain her.

3.1.89 In January 2016, her parents reported Anis as a high-risk missing person, and police found her at Adult A's home despite Adult A's criminal background.

3.1.90 Anis's interaction with Adult A in 2016, despite his criminal background, was assessed within the narrow framework of immediate risk. Anis was 17, and still a child under the age defined by the United Nations Convention on the Rights of the Child.

3.1.91 The decision not to use police protection was legally defensible but reflects limited contextual safeguarding and a lack of professional curiosity regarding her living arrangements and associations with adults linked to criminality.

3.1.92 The absence of a MARM, inadequate documentation, and poor cross-border information sharing (e.g., with Hampshire) led to a disjointed safeguarding approach. Risks linked to CSE, online grooming, and drug activity were not robustly addressed, leaving Anis without coordinated support.

3.1.93 Anis's October 2022 DVDS request regarding Bay revealed significant procedural gaps. A SCARF was not submitted, preventing partner agency involvement, and the DASH risk assessment was incomplete.

3.1.94 Despite serious allegations from previous partners, Bay's risk was underestimated. This indicates that existing domestic abuse protocols were not thoroughly followed and that specialist services such as MARAC or Your Sanctuary were not effectively engaged. The missed opportunity to connect Anis with holistic domestic abuse support, including emotional, legal, and safety planning, left her without protection during escalating risk.

3.1.95 Anis reported rape and coercive control by ex-partner Sorrel in 2022, but Anis declined to pursue prosecution, likely due to trauma-related barriers, a known issue among survivors. The police response, opting for no arrest or interview, was influenced by her mental health and the lack of additional evidence.

3.1.96 While partially trauma-informed, the case relies on victim-led disclosure rather than a proactive, safeguarding-led approach. This underscores the need for trauma-informed policing and multi-agency safeguarding responses that do not rely solely on victim-led disclosures or prosecutions to trigger protective action.

3.1.97 A 'standard risk' DASH assessment, lack of partner agency alerts, and no MARAC or Your Sanctuary referral all contributed to a missed opportunity for protective intervention.

3.1.98 In 2023, Anis experienced verbal abuse and threats from a friend's partner but did not engage with the police. Despite multiple contact attempts, the lack of alternative trauma-informed approaches, such as mental health or social care outreach, limited engagement and risk assessment. This underscores a broader issue: victim non-engagement should not equate to case closure when safeguarding concerns persist.

3.1.99 SCARFs, CTNs, and risk assessments were not consistently shared with relevant agencies, including during the September 2023 malicious referral and domestic abuse incidents, indicating gaps in information-sharing contrary to Working Together and data protection requirements. These gaps undermined coordinated safeguarding efforts, leaving Anis and her children vulnerable to harm.

3.1.100 Key Issues Identified

- Over-reliance on Anis's engagement despite known trauma and risk.
- Incomplete use of risk assessment tools (DASH) and under-utilisation of domestic abuse and CSE pathways (e.g., MARAC, specialist referrals).
- Missed opportunities for multi-agency action due to weak information sharing.
- Inconsistent adherence to national guidance (Working Together, NG76, DVDS, SCARF policies).

3.2 Analysis of the Terms of Reference

3.2.1 This section analyses the Terms of Reference (ToR) to confirm whether they have been fully addressed and appropriately met within the scope of the review.

TOR 1: Trauma and Mental Health

How is trauma-informed practice embedded in your organisation?
What was known about Anis's background, and how might this have affected her resilience or vulnerability?

3.2.2 Anis was a known victim of sexual exploitation and grooming from 2013, with multiple CSC referrals between 2013 and 2015. She was diagnosed with depression and engaged with CAMHS for self-harm and suicidal ideation, marking the onset of complex mental health needs.

3.2.3 She later experienced two known domestic abuse relationships. In 2021, after her second pregnancy, Anis was referred to SABP but discharged after self-reporting stable mental health. However, by February 2023, her GP re-referred her due to symptoms of depression, anxiety, and PTSD.

3.2.4 She was prescribed sertraline and propranolol and sought assessments for BPD and Attention Deficit Hyperactivity Disorder (ADHD). Though her last self-harm incident was seven months prior, she expressed distressing thoughts, including seeing ghosts, indicative of possible trauma-related symptoms, though not psychosis.

3.2.5 This history reflects a longstanding pattern of complex trauma, fluctuating mental health, and repeated exposure to abuse, which warranted sustained, trauma-informed and multi-agency intervention, much of which was inconsistently delivered.

Aster Group

3.2.6 Aster acknowledges having safeguarding and domestic abuse policies in place, supported by mandatory staff training. However, the absence of a dedicated trauma-informed policy has been identified as a significant gap, particularly for effectively supporting individuals experiencing domestic abuse or mental health challenges.

3.2.7 Without a clear trauma-informed framework, staff may lack the tools to recognise or respond appropriately to trauma-related disclosures. Trauma-Informed Practice (TIP) involves understanding the impact of trauma, preventing re-traumatisation, and embedding this awareness into service design and delivery. While Aster has begun rolling out a trauma-informed approach for frontline staff, this initiative is still in its development stage.

3.2.8 Current reliance on self-disclosure during assessments limits early identification of trauma and mental health issues, as tenants may fear stigma or struggle to articulate their experiences. A proactive, routine inquiry about trauma and mental health would improve support for vulnerable tenants.

3.2.9 Furthermore, Aster's limited collaboration with specialist services, particularly in domestic abuse and mental health, reduced opportunities for coordinated safeguarding responses. Strengthening partnerships with these providers would enable a more holistic and responsive support system

3.2.10 This aligns with the "Changing Futures Evaluation: Trauma-Informed Approaches" report, which stresses that TIP improves engagement, well-being, and service outcomes for

individuals with multiple disadvantages. Key enablers include organisational commitment, consistent staff training, and cross-sector collaboration:

Community Health Children's Services (CHCS)

3.2.11 Documents from 2014, 2016, and 2017 indicate Anis was a highly vulnerable teenager, experiencing:

- Missing episodes
- Abusive relationships
- Family breakdown
- Severe mental health impact

3.2.12 Health practitioners' engagement with Anis lacked a straightforward TIP approach. Although she consented to multiple referrals (Home Start, Woking Furniture Project, CMHT), there is no evidence that her capacity to engage or understanding was assessed, highlighting a flawed assumption that consent equates to effective support. This oversight reflects a broader need to shift from transactional to relational, trauma-informed care.

3.2.13 Follow-up was inconsistent. After a February 2023 visit, the HV did not re-engage with Anis. Although an MAPE was held in September 2023, HVs were not routinely notified, weakening the safeguarding response. While the enquiry was recorded in the electronic patient record, the lack of proactive information-sharing highlights systemic barriers to joined-up care.

3.2.14 Since 2022, CSH has strengthened practice by embedding routine domestic abuse inquiries, using structured tools like GAD-7 and the Edinburgh Postnatal Depression Scale to identify maternal mental health risks. These initiatives support earlier identification of trauma and postnatal depression, which are critical for child development, maternal bonding, and safety.

3.2.15 Postnatal depression can affect bonding, infant development, and maternal well-being. Early identification through the depression scale allows timely support and intervention from healthcare professionals. These measures aim to enhance trauma identification and improve responses to trauma.

3.2.16 However, wider implementation of TIP remains inconsistent. While Trauma-Informed Awareness Workshops are available through SaBP, the cancellation of the Family Nurse Partnership TIP training in 2025 due to a provider change represents a setback to ensuring workforce-wide consistency in trauma-informed approaches.

3.2.17 The provision of Trauma-Informed Awareness training will be explored with the new provider of Children's Community Health Services.

Children's Social Care (CSC)

3.2.18 CSC acknowledges that being trauma-informed means responding to individuals and families in a non-judgmental, non-blaming, and strengths-based manner. Key focus areas:

- Building trusting relationships to avoid re-traumatisation.
- Recognising past trauma and its impact on current circumstances.

3.2.19 Anis communicated her feelings about her relationship with Sorrel to her SW and FSW. In November 2022, she described her relationship as “toxic”, highlighting verbal abuse (Sorrel shouting and making her feel small). Physical harm (covered in bruises from "play fighting").

3.2.20 She endured this for two years before recognising it was not healthy for her or her children and ended the relationship. She met Sorrel on a dating site, and he moved in after nine weeks, potentially indicating a coercive, fast-paced relationship.

3.2.21 Anis’s views were sought during the Core assessment process, aligning with Surrey Children’s Procedures, which emphasises child-centred assessments. These procedures require clear articulation of the child’s perspective and informed decision-making based on the child’s age and developmental stage.

3.2.22 While Anis's input was considered, it is unclear if professionals explored her trauma history beyond what she disclosed or used trauma-informed strategies to help her process her experiences. The availability of trauma-informed interventions to support her emotional recovery and parenting capacity is also uncertain.

3.2.23 CSC practitioners can access training on the effects of childhood trauma on the brain and attachment, which informs best practices. Training on TIP and Domestic Abuse is also available, aimed at enhancing understanding and promoting a trauma-informed approach. Those involved with Anis participated in the Surrey Academy, the Surrey Safeguarding Children Partnership (SSCP) training, and the Children’s Procedure.

3.2.24 CSC was aware that Anis had experienced childhood trauma from a sexual assault by a man she met in a chat room. This trauma likely contributed to a mental health crisis in February 2013, when her father called 999 due to concerns about suicidal threats. Anis had a social worker and support from CAMHS as a child.

3.2.25 GP records indicate she was diagnosed with anxiety and depression and prescribed propranolol and sertraline, but Anis’s disengagement with Mind Matters was not explored.

3.2.26 Propranolol is increasingly linked to overdose and suicide, particularly among patients with mental health conditions. Despite its everyday use for anxiety, it is highly toxic in overdose. GPs should see patients prescribed propranolol regularly to assess risk, ensure safe use, and provide trauma-informed care. In-person reviews support early intervention, safer prescribing, and better coordination with mental health services.

3.2.27 The GP practice was not invited to TAF meetings, creating gaps in care. SSCP procedures require collaboration between adult mental health services and CSC, which was not effectively implemented.

3.2.28 The FSW assisted with her referral to talking therapies but did not verify her engagement or improvement in mental health. The FSW lacked regular supervision, which is necessary for good practice. Additionally, there were no records of auditory hallucinations or her request for a BPD assessment.

3.2.29 Practitioners can access training on supporting parents with poor mental health and self-harm through the Academy and SSCP. However, in Anis's case, best practices were not followed, including an absence of assessment of how mental health affected parenting, inadequate collaboration between CSC and mental health professionals, and insufficient supervision of the FSW.

3.2.30 The Children Act (1989), amended by the Adoption and Children Act (2002), defines harm, including exposure to domestic abuse. This legal definition is well understood within Surrey's safeguarding framework, ensuring professionals recognise the risk domestic abuse poses to children. The SSCP procedures provide clear guidance on working with families affected by domestic abuse.

3.2.31 Domestic abuse concerns were acknowledged in the Core and Early Help assessments. Anis was signposted to domestic abuse support services on two occasions, but there was no follow-up to confirm whether she engaged with the services. The impact of these services on Anis and her children was unknown.

3.2.32 Practitioners are required to complete a domestic abuse risk assessment when children are present in the household, using an approved tool such as the DASH assessment.

3.2.33 There was no evidence that the DASH tool was used in Anis's case. Safety planning was discussed, but not explicitly related to Anis's relationship with Sorrel. There was no contingency plan if domestic abuse reoccurred. The strategy focused on ensuring the children were not exposed, but did not specify how this would be achieved.

3.2.34 Claire's Law disclosure revealed that Bay posed a risk to children. This led Anis to end her relationship with Bay, demonstrating effective use of safeguarding information. However, there were no recorded details of the specific risk Bay posed.

3.2.35 There was no evidence of police SCARF notifications regarding domestic abuse in the children's files. Despite ongoing concerns in Anis's relationships, there were no referrals to MARAC. No documented reports of rape or harassment by Sorrel, nor any reference to Anis's new relationship with Thyme.

GP Practice

3.2.36 Anis's history of childhood trauma was not known to her GP practice due to multiple registration changes. Between 2009 and 2019, Anis was registered at five different GP practices, limiting continuity of care. The electronic medical records at her final practice only dated back to 2019, with earlier records stored in hard copy archives, making access difficult unless clinicians had a specific reason to search.

3.2.37 Lack of consistent GP contact meant no trusting relationship was formed, reducing opportunities to explore past trauma. Historical electronic record transfer issues further limited access to key information, although IT systems have since improved.

3.2.38 The Surrey-wide GP safeguarding policy requires trauma-informed care reinforced through safeguarding supervision for GP leads.

3.2.39 Integrating trauma-informed care into GP practices can significantly improve the quality of care for patients like Anis, who may have experienced complex trauma. Building trusting relationships, maintaining consistent communication, and implementing trauma-sensitive practices can help healthcare professionals address trauma's impact, leading to better outcomes for vulnerable patients.

3.2.40 Previously missed opportunities for mental health intervention were noted earlier in the review. No apparent decline in Anis's mental health was identified by the GP practice leading up to her death.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.2.41 SaBP provided trauma-focused support, including EMDR, when Anis was a child. This approach is used for addressing trauma and is a known intervention in her history.

3.2.42 In 2023, SaBP attempted to engage Anis through phone contact and a home visit, but she did not respond. Following its Engagement and Disengagement Policy, SaBP verified her contact details and invited her to re-engage. Despite these efforts, Anis declined to engage, limiting the assessment of her needs.

3.2.43 As part of her new patient assessment, the clinicians intended to explore Anis's background, including the impact of domestic abuse, but this could not be completed due to her disengagement.

3.2.44 Engaging patients who often disengage requires thoughtful, flexible approaches tailored to their unique challenges. By employing a trauma-informed approach and techniques such as Motivational Interviewing (MI), peer support, and collaborative care, healthcare providers can foster a safer and more accessible environment for these patients.

3.2.45 MI is an effective tool for engaging patients who are ambivalent or resistant to treatment, particularly those with mental health challenges or experiences of domestic abuse.

3.2.46 SaBP introduced a Safeguarding Springboard in its electronic records system. This tool provides prompts and tools for risk assessments, safety planning, and referrals to Domestic Abuse Services.

3.2.47 SaBP also plans to embed routine enquiry into all assessment and consultation templates. This will ensure that all assessments consider domestic abuse and risk factors systematically.

3.2.48 SaBP's Care Planning Principles incorporate trauma-informed practices, and staff members receive regular training on effectively implementing this approach. Partner agencies are also included in this training, ensuring a consistent approach to trauma-informed care across services.

Surrey Police

3.2.49 Surrey Police's trauma-informed approach, supported by ongoing training and awareness, played an essential role in understanding and addressing Anis's vulnerabilities, including her mental health and previous trauma. However, there were gaps in follow-through, such as incomplete referrals to partner agencies and missed opportunities to better engage Anis with the support services she needed.

3.2.50 The police recognised the trauma history in Anis's case but, at times, did not provide consistent, collaborative support with specialised agencies. This, combined with gaps in safety planning and referrals, may have affected the long-term care and support Anis could have received.

3.2.51 Surrey Police recognises the importance of adopting a trauma-informed approach in all its interactions, acknowledging that trauma is a common experience for many individuals. The approach is designed to:

- Recognise signs and symptoms of trauma.
- Understand the impact of traumatic experiences.
- Avoid re-traumatising individuals.
- Incorporate an understanding of trauma and resilience into practices and policies. This approach ensures that officers not only respond to incidents but are also mindful of the potential trauma involved, which can inform their investigations and interactions with victims.

3.2.52 Surrey Police Officers receive specialised training from the University of Sussex to recognise trauma and enhance safety and trust when interacting with victims such as Anis, who have a history of sexual exploitation. This training also focuses on supporting officers' well-being after traumatic experiences.

3.2.53 In their interactions with Anis, Surrey Police applied a trauma-informed approach, considering her mental health and past traumas. Officers made accommodations to ensure she felt heard, respecting her wishes in a serious sexual assault case where she opted not to

pursue further action against the perpetrator. There was no evidence of discrimination, and referrals to partner agencies.

3.2.54 The police acknowledged the connection between domestic abuse and mental health, using the DASH Risk Assessment Tool to identify risk factors. However, Anis's serious assault was classified as non-high risk. While immediate support was provided, specialised long-term care was lacking, with insufficient follow-up on MARAC referrals.

3.2.55 Concerns about Anis's mental health and vulnerability were noted due to her history of child sexual exploitation. Although trauma triggers were recognised, it remained unclear if they were adequately addressed, which could have contributed to her suicide. Despite using risk assessment tools like SCARF and DASH effectively, gaps in following through on referrals and safety plans limited support from partner agencies.

TOR 2: Access to Services and Domestic Abuse

What domestic abuse services are accessible to your organisation?
Does your organisation have policies and procedures to identify and address domestic abuse?
How did your agency respond to the information that Anis was a victim of domestic abuse?
Did your organisation promptly communicate all relevant information to all appropriate parties?
Have any obstacles to your organisation's capacity or resources impeded your ability to provide services or access to Anis or other relevant individuals?

Aster Group

3.2.56 Aster has made efforts to provide information on domestic abuse resources through its website, including listing agencies that can assist with domestic abuse and sharing its own domestic abuse policy and guidance for staff. This is a positive step in making resources accessible for those who may need help and ensuring staff are equipped to support victims of domestic abuse.

3.2.57 When a domestic abuse report is made to Aster, they acknowledge it and use the DASH risk checklist to plan support for the victim. They prioritise children's safety by referring cases involving children to the local authority, ensuring that appropriate agencies manage the associated risks.

3.2.58 Aster's involvement with Anis was minimal and reactive, as Anis did not directly report domestic abuse, limiting Aster's ability to intervene.

3.2.59 A third party reported the potential domestic abuse and ASB, highlighting a gap in direct communication. Aster advised the third party and sent out surveys to gather more information from Anis and others, but received no follow-up responses. This suggests a lack of engagement from Anis or her community, indicating that Aster's strategy may not have effectively addressed her needs.

3.2.60 If Aster had been aware of the background concerning Anis and domestic abuse, either from the Local Authority or from Anis at the time of the letting, its response may have been different and more inquisitive.

3.2.61 While Aster recorded the initial report, good practice for accuracy, there were no further reports, likely due to the lack of additional responses. Overall, Aster's systematic approach did not sufficiently promote engagement or address the underlying issues.

Community Health Children's Services (CHCS)

3.2.62 CHCS has a well-structured response to supporting children and families through trauma-informed practices, safeguarding supervision, and comprehensive training. They focus on record reviews, referral follow-up, and ensuring practitioners can access expert safeguarding advice when needed. The approach to safeguarding supervision and competency monitoring is robust, aiming to ensure staff are adequately equipped to manage complex cases.

3.2.63 However, recruitment and retention challenges, combined with increased caseloads and the need for temporary staff, may strain the system and impact the quality of service provided. These staffing challenges could hinder the organisation's ability to consistently and thoroughly support families, especially those with complex needs.

Children's Social Care (CSC)

3.2.64 The following are the domestic abuse resources all agencies can signpost or refer domestic abuse victim-survivors to:

- Surrey Against Domestic Abuse (SADA) is available Monday through Sunday from 9 a.m. to 9 p.m.
- The Surrey Domestic Abuse helpline is available Monday to Friday between 09:00 and 21:00
- East Surrey Domestic Abuse Services covers Mole Valley, Reigate & Banstead & Tandridge East Surrey Domestic Abuse Services
- Your Sanctuary covers Woking, Runnymede and Surrey Heath.
- North Surrey Domestic Abuse Services covers Epsom and Ewell, Elmbridge and Spelthorne North Surrey Domestic Abuse Services
- South West Surrey Domestic Abuse Services covers Guildford and Waverley South West Surrey Domestic Abuse Services

3.2.65 The Surrey Domestic Abuse Partnership (SDAP) is a group of independent charities in Surrey that provides free and confidential support to anyone affected by domestic abuse, regardless of age, ethnicity, orientation or sex. SDAP offers practical help, emotional support, and information on housing, benefits, safety planning, and the needs of children and their families. It can also help find safe accommodation if victims need to leave their homes.

3.2.66 The Surrey County Council Family Information Service also details resources available to children and families.

3.2.67 CSC practitioners support parents experiencing domestic abuse to self-refer to domestic abuse services. There is good publicity in council buildings and the community, promoting contact numbers and websites for domestic abuse services.

3.2.68 Practice guidance is outlined in the Surrey Safeguarding Children Partnership procedures.

3.2.69 The Surrey Against Domestic Abuse Strategy 2024-2029, shared with senior leadership and front-line staff, has three key priorities: provide support to victims, hold perpetrators accountable to reduce harm, and collaborate for a comprehensive response to prevent domestic abuse.

3.2.70 Surrey County Council has a Domestic Abuse Programme Manager overseeing four outreach workers. CSC practitioners can access these workers for support and training on domestic abuse.

3.2.71 From August to December 2024, 23 courses were offered to 322 delegates across three training levels. The outreach providers also support children who have witnessed domestic abuse. Additionally, specialist practitioners work with families involved in child-in-need or child-protection plans as part of the family safeguarding model.

3.2.72 Domestic abuse perpetrators can seek support through Respect, a national organisation that helps them change. Outreach workers and practitioners offer guidance on change programs. Interventions Alliance offers a voluntary Domestic Abuse One-to-One Programme.

3.2.73 The response from CSC in this case reveals several areas where improvements could have been made:

- More consistent use of risk assessment tools (e.g., DASH, SCARF).
- Proactive follow-up on referrals to domestic abuse support services.
- Better documentation and communication across agencies to ensure comprehensive care.
- More robust engagement with Anis despite her reluctance to seek help.

3.2.74 CSC's trauma-informed approach is crucial, but its application needs to be more consistent, particularly in high-risk cases like this. A holistic understanding of the victim's history and current situation could lead to more effective safeguarding and interventions for the whole family.

GP Practice

3.2.75 Anis was not identified as a victim of domestic abuse at her GP practice, with only a mention from a walk-in centre in February 2023. The practice follows the Surrey-wide GP safeguarding policy, which includes guidelines on domestic abuse. Their website also provides information and local contact details for victims and survivors.

3.2.76 No information was requested by or received from any other agencies concerning Anis's history of domestic abuse.

3.2.77 The GP's response to Anis's access to services, particularly in the context of domestic abuse and mental health, reveals several key issues:

- There was limited engagement between Anis and the GP practice, resulting in a lack of comprehensive understanding of her lived experience, including her trauma history and indicators of risk. This hindered the ability to assess needs holistically and offer timely interventions.
- Although the GP practice had received training in trauma-informed approaches, this was not consistently implemented in practice. Anis's complex presentation required a more attuned and sensitive approach that recognised avoidance or disengagement as potential trauma responses.
- Referral pathways and follow-up processes were inadequate, particularly in response to the domestic abuse concerns raised in February 2023. These deficiencies contributed to missed opportunities for safeguarding and multi-agency support. The panel noted that this matter reflects a wider systemic challenge involving multiple agencies.
- The lack of proactive safeguarding action and poor information-sharing across agencies, evident in the GP not being involved in the TAF meetings, resulted in a fragmented response and limited Anis's access to the support services necessary for recovery and safety.

3.2.78 A more effective response would involve proactive and sustained engagement with at-risk patients; use of available safeguarding tools, including professional judgment and consultation with domestic abuse outreach services; improved inter-agency information sharing; and a more holistic approach to addressing domestic abuse and mental health within general practice settings.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.2.79 Domestic abuse training is included in the Safeguarding Adults level 2 and 3 training for all staff. SaBP has an Ambassadors Against Domestic Abuse Group, led by the Safeguarding Adults and Domestic Abuse Lead, which meets at least four times a year to share resources and improve practices. Ambassadors relay information to their teams. The public website and internal intranet provide information on Domestic Abuse and links to outreach services.

3.2.80 SaBP implemented a Safeguarding Springboard in its electronic records for clinicians to document domestic abuse concerns. The springboard includes links to Healthy Surrey web pages, referral reminders, and CSC. The safeguarding team reviews all safeguarding

concerns reported through the incident reporting system to ensure that appropriate actions are taken.

3.2.81 SaBP services made efforts to support Anis, primarily through trauma-informed care and referrals to mental health services. However, barriers to engagement, including Anis's disengagement with services, limited follow-up, and communication challenges with other agencies, hampered the effectiveness of the support provided.

Surrey Police

3.2.82 The following 'categories' of domestic abuse victims must be referred to Outreach (mandatory referral), regardless of whether they consent:

- High-risk victims
- Victims aged 16 to 17 (referrals must be to outreach rather than Victim Support).
- Victims of domestic violence were issued Domestic Violence Protection Orders (DVDS).
- A DVDS disclosure has been authorised. For any DVDS disclosures, an outreach worker should ideally be present for the disclosure, unless it is urgent and outside of working hours.

3.2.83 When addressing cases of domestic or sexual violence, officers can refer victims to an Independent Sexual Violence Advisor or an Independent Domestic Violence Advisor for support, utilising the Rape and Sexual Abuse Support Centre (RASASC) for sexual offences and local domestic abuse outreach services.

3.2.84 Referrals are made via a Mandatory Outreach form on Niche for high-risk domestic abuse cases and require victim consent for medium and standard-risk cases. Victims must be informed about these services, and if they decline consent, their reasons should be documented.

3.2.85 Referrals use the Surrey Police Domestic Abuse Incident Outreach Referral Form, and a SCARF is completed and shared with relevant services. Outreach support is coordinated through the SDAP, which aims to ensure the safety of survivors aged sixteen and over.

3.2.86 The Domestic Abuse Act (2021) Section 3 states that any reference to a victim of domestic abuse includes children who see, hear, or experience the effects of the abuse and are related to either the victim or perpetrator. Children exposed to domestic abuse are considered victims.

3.2.87 For households with children, an SCARF must be completed and shared, and safeguarding concerns should involve strategy discussions for specialist support. Support for children is provided through the Surrey partnership platform.

3.2.88 Domestic abuse is a top priority, and all officers receive training to recognise its signs, risks, and factors. Training varies by role; first responders undergo classroom training covering understanding domestic abuse, risk assessment (DASH), and safety planning.

3.2.89 Special constables, communications staff, and resolution centre personnel receive tailored input, while mandatory online refresher training is provided for all frontline responders up to the Inspector level.

3.2.90 Surrey Police policies are continually updated to reflect legal changes and best practices. Changes can range from minor adjustments to significant revisions, including incorporating trauma-informed practices and considering protected characteristics.

3.2.91 The Police implemented RARA (Remove, Avoid, Reduce and Accept) safety plans at the start of the domestic abuse investigation, following standard risk management protocols. Officers used safeguarding options, such as arrest and target hardening, to enhance victim safety.

3.2.92 Emergency safety kits for Anis included security measures, such as location-of-interest markers, which are crucial for her protection.

3.2.93 CSC was informed through CTN referrals, ensuring Anis's children's safety was part of the risk assessment, reflecting proactive safeguarding steps in domestic abuse cases.

3.2.94 Officers are trained to support and engage with victims from initial contact through investigations, emphasising trust and confidence.

3.2.95 The Codes of Practice for Victims of Crime uphold victims' rights, ensuring they are informed and involved throughout the process. This helps address their emotional and psychological needs during a traumatic time.

3.2.96 Partner agency referrals were offered to Anis, but she declined them, highlighting a significant barrier to effective intervention. This disengagement, possibly due to fear or mistrust, left her without the necessary support. The police's ability to provide meaningful help was limited by Anis's choice not to engage with partner agencies, a common challenge in domestic abuse cases.

3.2.97 While safety measures, such as target hardening, were considered, they may have been reactive rather than based on immediate threats, as there was no clear evidence of an ongoing risk. The police aimed to be empathetic, but building trust with Anis proved difficult, complicating their efforts.

3.2.98 Additionally, the lack of shared information between Surrey Police and partner agencies beyond referrals to CSC suggests that a comprehensive, integrated safeguarding approach was missing, hindering the development of a supportive plan that involved all relevant service providers.

3.2.99 The response emphasises that there is no evidence that external factors, such as COVID-19, impacted the service provided, which suggests that external barriers were not a significant issue in this case. However, this does not address the internal barriers within the police system or the challenges in victim engagement and cross-agency coordination.

3.2.100 While Surrey Police demonstrated an understanding of the importance of victim safety planning and took proactive steps to address Anis's immediate safety needs, significant obstacles to successful engagement and information sharing were present.

3.2.101 Anis's disengagement from available support services and the fragmented communication between the police and other agencies represent key challenges.

TOR 3: Poverty and Domestic Abuse

What support is provided to families experiencing financial difficulty?

Aster Group

3.2.102 Aster's response to Anis regarding her rent arrears indicates a proactive approach to her financial challenges, but also highlights concerns about the interplay between domestic abuse and economic vulnerability.

3.2.103 Rent arrears can signal financial abuse, mainly when linked to domestic abuse issues, which may have hindered Anis's ability to manage her finances.

3.2.104 Research indicates that housing instability, such as rent arrears and eviction threats, is closely linked with domestic abuse. When victims of abuse are unable to afford rent or face eviction due to financial hardship, they may be forced to stay in unsafe housing situations.

3.2.105 A study by SafeLives (2021) highlighted that housing insecurity is a key barrier to leaving abusive relationships.

3.2.106 While Aster resolved the rent arrears swiftly, there was no exploration of the root causes, such as financial abuse or coercive control from her partner. A trauma-informed approach would consider how domestic abuse affects a victim's economic stability and access to resources.

3.2.107 Ultimately, addressing Anis's rent arrears without connecting her to specialist services misses the opportunity to tackle the underlying causes of her financial distress. Referrals to debt management or domestic abuse helplines would have been beneficial in addressing her situation more comprehensively.

3.2.108 During this period, Anis only fell into low-level arrears. As a result, she received a standard letter notifying her of the situation. Subsequently, there was further

communication via email, in which minimum payments were agreed upon to bring her account back into good standing.

3.2.109 During the period across Aster, approximately 9000 customers were in arrears. As Anis's arrears were low, she did not meet the threshold for a referral to financial well-being or a specialist service.

3.2.110 Aster's in-house financial well-being team relies on customer engagement to help customers minimise debt and boost income through welfare benefits or employment support.

Children's Social Care (CSC)

3.2.111 Anis's income and employment were crucial in the child and family assessment, highlighting her financial strain while relying on benefits. Understanding her finances is essential for recognising her family's circumstances and planning appropriate interventions.

3.2.112 Concerns about her home conditions indicate awareness of how poverty can lead to poor living environments, often seen in households facing domestic abuse. Resources like Surrey Home Start and Woking Furniture Project were suggested to help alleviate material poverty.

3.2.113 Referring Anis to the Surrey Family Information Service offered guidance on family finances and connections to supportive resources, potentially providing significant practical assistance.

3.2.114 The Family Information Directory offers vital details on organisations providing financial assistance. It helps impoverished families by connecting them with local and national charities to alleviate financial pressures.

3.2.115 The cost-of-living crisis increases the vulnerability of children living in abusive households. Financial stress may force parents to remain in abusive relationships because they cannot afford to leave, which in turn can lead to a greater risk of child abuse or neglect. Research by Barnardo's found that children living in financially strained households are more likely to experience domestic abuse and emotional trauma.

3.2.116 While the response acknowledges Anis's financial struggles, it overlooks the impact of domestic abuse on her finances. It is vital to consider whether she experienced financial control or coercion, which may have hindered her ability to achieve economic independence. The lack of discussion about her access to finances or her dependence on Sorrel is concerning.

3.2.117 Although resources like Surrey Home Start and the Woking Furniture Project were mentioned, specific domestic abuse services were not included. In cases of suspected domestic abuse, it is essential to ensure that there is a clear pathway to specialised support

that addresses both safety and financial autonomy. Referrals to domestic abuse helplines, economic empowerment programs, or shelters should be integral to the support plan.

3.2.118 Given Anis's financial strain and the potential for abuse, integrating trauma-informed financial services could help her navigate towards independence and access emergency assistance.

GP Practice

3.2.119 The GP practice had no information on Anis's financial situation, only noting in February 2023 that she was *"managing okay with finances."* While GP practices do not directly address economic issues, support services such as social prescribers, food banks, and organisations like Citizens' Advice are available.

3.2.120 The GP's response to poverty and domestic abuse should ideally be proactive in identifying the intersection between the two issues. In cases like Anis's, GPs play a crucial role in recognising the hidden dynamics of domestic abuse, offering sensitive support, and ensuring multi-agency collaboration to maximise access to both health and social services.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.2.121 SaBP clinicians typically refer families to the Citizens' Advice Bureau and StepChange Debt Charity, and can provide food bank vouchers as needed. Additional resources are available on the Healthy Surrey and Surrey County Council websites.

3.2.122 Families in need can be referred to Early Help via the C-SPA. However, this information is spread through experience rather than in a comprehensive resource list. With the ongoing cost-of-living crisis, there is an opportunity to increase awareness of available support.

3.2.123 The cost of living crisis increases financial strain on households, particularly affecting vulnerable populations. Rising costs for essentials such as food, fuel, and housing create high levels of stress, which can trigger or exacerbate domestic abuse.

3.2.124 Victims may become more financially dependent on abusers as they struggle to make ends meet, increasing their vulnerability to financial abuse (e.g., abusers controlling the finances).

3.2.125 The economic strain increases tension and frustration within families, potentially leading to an increase in verbal, physical, or emotional abuse. In times of financial difficulty, victims might be isolated from support networks as they are less likely to seek help for fear of judgment, stigma, or further financial strain.

3.2.126 Several studies have shown the link between financial stress and domestic abuse. A 2022 report by the Office for National Statistics found that financial pressures during the

COVID-19 pandemic were a contributing factor to the increased rates of domestic abuse. The report indicated that economic stress (such as job losses and housing insecurity) exacerbated existing tensions, which led to increased abuse in the home.

3.2.127 The Domestic Abuse Act (2021) in the UK highlights that economic dependency is a significant factor for many victims who stay in abusive relationships.

3.2.128 Financial control can include limiting access to money, controlling spending, or forcing victims into financially dependent situations. The Refuge Report also emphasised the need for more comprehensive support to address economic factors in domestic abuse prevention.

3.2.129 According to a 2020 report by Women's Aid, domestic abuse services reported an increase in demand for support during periods of economic downturn, particularly when housing costs rise or during financial crises. The charity indicated that financial insecurity played a role in keeping victims trapped in abusive situations, particularly those who had children and were unsure how they could afford to live independently.

3.2.130 The cost-of-living crisis also influences the gendered nature of domestic abuse. Women, particularly mothers, are often more financially dependent on male partners, which can increase their vulnerability to abuse.

3.2.131 Financial control by male perpetrators is a common tactic of abuse, where the abuser controls the victim's access to money, limiting their economic independence and increasing their vulnerability.

Surrey Police

3.2.132 Police can assist with submitting timely and comprehensive referrals to partner agencies, using the SCARF when victims, witnesses, or families need financial support.

TOR 4: Holding perpetrators to account

What services are available in Surrey for perpetrator disruption?
What is known about Bay and Sorrel's background? What perpetrator disruptions were offered?

3.2.133 Anis applied for a DVDS in response to the information she had received regarding Bay's violent behaviour towards his former partner's children.

3.2.134 Anis informed the police that Sorrel had harassed and raped her, and he was controlling and abusive.

Children's Social Care (CSC)

3.2.135 Anis informed the police that Sorrel had harassed and raped her, and he was controlling and abusive. This information was not shared with Surrey CSC.

3.2.136 CSC's response reveals some significant oversights in holding perpetrators accountable and ensuring the ongoing safety of Anis and her children. While the DVDS were used to support Anis's decision to end her relationship, several critical steps were missed.

3.2.137 The omission to check with Probation, Multi-Agency Public Protection Arrangements (MAPPA), and CSC Services created significant gaps in understanding Sorrel and Bay's backgrounds. For improved safeguarding, CSC should have pursued better inter-agency collaboration, thorough assessments of perpetrators' backgrounds, and more direct engagement with victims and their children.

3.2.138 The SW did discuss the impact of domestic abuse on the children with Sorrel, and the information recorded was superficial. Sorrel acknowledged that Sam had witnessed verbal conflicts but downplayed their severity, stating that they were calm during these incidents. This conversation was not further explored or corroborated with external checks (e.g., observations or other agency reports).

3.2.139 Sorrel's minimal acknowledgement of the abuse's impact on the children suggests that there was either a lack of depth in the conversation or an underestimation of how the abuse may affect the children emotionally, psychologically, or physically. This limited engagement may have led to an inadequate safeguarding of the children.

3.2.140 The Child Safeguarding Practice Review Panel report highlighted systemic weaknesses in assessing and engaging with fathers in safeguarding situations. It revealed that fathers often remain hidden and unassessed, leading to critical oversights in safeguarding children. This oversight is particularly concerning in cases of domestic abuse, where abusive fathers may go unassessed, leaving potential risks unidentified.

3.2.141 The SW and the FSW inadequately assessed Sorrel's parenting capacity. Despite having regular family time with Sam, Sorrel's relationship with Anis was marked by evident stressors that could impact their parenting.

3.2.142 This lack of assessment led to unaddressed risks for Sam and Charlie, and services to support Sorrel and Anis were not provided. With Sorrel spending time with Charlie, it was crucial to evaluate how these stressors impacted his parenting. Without this, there is a significant risk that unresolved issues could harm the child's welfare.

3.2.143 The review identified opportunities to more actively assess and manage the risks presented by Sorrel and Bay. Whilst Anis received support as a victim of domestic abuse, there was limited evidence of consideration being given to specialist perpetrator interventions or disruption activity. Earlier engagement with appropriate perpetrator services may have promoted accountability, addressed abusive behaviours, and reduced ongoing risk to Anis and the children.

3.2.144 The Child Safeguarding Practice Review Panel's recommendations emphasised that everyone involved in safeguarding children must focus more effectively on working with struggling fathers whose behaviour and backgrounds may pose risks to children. This aligns with the identified lack of adequate assessment of Sorrel in this case.

3.2.145 The report's recommendation to focus on fathers in safety situations contradicts Sorrel's absence of engagement and assessment of his parenting capacity. This oversight could have serious consequences, as Sorrel's behaviour and stressors may have contributed to risks to the children that were not fully addressed.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.2.146 SaBP was unaware of the perpetrators or concerns about domestic abuse during the review period. They support the Safe and Together model in Surrey. The aim is to provide an anti-victim-blaming approach while holding perpetrators accountable.

3.2.147 Information about the Surrey Steps to Change Hub, which supports behaviour change in perpetrators, has been shared with staff and included in Safeguarding training.

Surrey Police

3.2.148 The response highlights police actions and limitations in holding Sorrel and Bay accountable for domestic abuse, focusing on key issues in enforcement powers and decision-making regarding perpetrators. These include:

- **Domestic Violence Protection Notices/Orders:** These are issued to prevent further harm or threats, even when no arrest has been made.
- **Stalking Protection Orders:** To address stalking issues and protect victims.
- **Violent Offender Orders:** For managing perpetrators who pose a significant risk of violence.
- **Criminal Behaviour Orders:** These are used to address anti-social behaviour that harms victims.
- **Non-Molestation Orders:** These orders prevent perpetrators from contacting or harassing victims.
- **Serious Risk Orders:** For managing individuals who pose a significant threat.

3.2.149 These measures can disrupt perpetrators, offering protection for victims and providing legal mechanisms to prevent further abuse.

3.2.150 The police response indicates that Sorrel and Bay did not meet the criteria for protective orders due to their lack of a criminal history, which hindered the gathering of necessary evidence for such measures.

3.2.151 Bay's police involvement was limited to the DVDS application made by Anis, while Sorrel's case of non-recent domestic abuse and serious sexual assault was closed with no action taken.

3.2.152 The police IMR highlights that enforcing protective measures would have conflicted with Anis's wishes, highlighting the complexities in victim cooperation. Additionally, Anis did not report any incidents related to Bay that necessitated police action, limiting what the police could do. This situation reflects a gap in investigative action and emphasises the challenges of holding perpetrators accountable without ongoing reports from victims or evidence.

3.2.153 Domestic Violence Protection Notices or Orders can be issued based on reasonable suspicion that a perpetrator poses a threat, even without a conviction. However, these measures were not taken in this case due to insufficient evidence or the victim's unwillingness to engage. This lack of protection can leave the victim vulnerable, especially if the perpetrator remains in the home.

3.2.154 Victim cooperation is crucial, but it is essential for police and support services to understand that victims may feel trapped in abusive relationships. Prioritising victim safety is critical, and proactive support should be provided, even if victims are hesitant to report the incident. Police could also consider preventative measures, such as referring perpetrators to diversion programs or early intervention services to manage risk.

3.2.155 There is a need for specialised training for police officers to understand domestic abuse complexities and victim trauma. Officers should be equipped to manage cases in which victims are reluctant to proceed, but there remains a risk of harm to them and their children.

3.2.156 The police response to holding perpetrators like Sorrel and Bay accountable reveals significant limitations in enforcing protective measures without victim cooperation or sufficient evidence. Despite law enforcement's powers to address domestic abuse, complexities such as victim reluctance and lack of evidence often hinder actions. Emphasising victim safety and enhancing support services are essential for disrupting perpetrators and protecting victims.

3.2.157 Serial domestic abuse perpetrators can be referred to the Multi-Agency Tasking & Coordination, part of Integrated Offender Management, by the High Harm Perpetrator Unit.

3.2.158 This multi-agency approach uses the Seven Pathways rehabilitation model (involving housing, drug and alcohol services, social services, etc.) to reduce re-offending and safeguard individuals at risk. Referrals are for offenders aged sixteen or over with multiple domestic abuse incidents against two or more victims in the last two years.

TOR 5: Learning

Determine effective strategies for areas where your organisation's responses may have exceeded or fallen short of standard practice.
What changes have occurred in your organisation since Anis's death?

Aster Group

3.2.159 Housing providers need to actively address domestic abuse by prioritising early intervention, victim safety, and collaboration with other services. Anis's case highlights the need for improved risk assessments, coordinated services, and the management of housing issues like rent arrears concerning domestic abuse.

3.2.160 Ensuring enhanced training for housing staff, better communication with partner agencies, and a victim-centred approach is crucial for supporting those affected by domestic abuse.

Community Health Children's Services (CHCS)

3.2.161 HVs play a critical role in supporting families, particularly in the early years, and can be instrumental in identifying signs of domestic abuse and safeguarding concerns.

3.2.162 Key lessons from Anis's case include early identification, proactive screening, and effective agency collaboration. HVs should empower victims, support both parents and children and ensure that concerns about child welfare and domestic abuse are addressed.

Children's Social Care (CSC)

3.2.163 Regular supervision and management oversight were lacking throughout the assessment process. This gap hindered opportunities for reflective practice and could have prevented missed risks or necessary changes to the plan.

3.2.164 While a safety plan was in place, it lacked specifics on how Anis would protect her children from future harm. A more detailed safety plan and involvement from domestic abuse services could have ensured better protection and planning.

3.2.165 Coordination with other services (e.g., mental health, domestic abuse services, health professionals) was insufficient. More effective multi-agency collaboration could have led to a more holistic approach to Anis's needs and ensured a comprehensive understanding of her challenges.

3.2.166 Follow-up on referrals to domestic abuse support services was not adequately tracked. CSC should monitor referrals and interventions to ensure victims receive appropriate support and assess any impact.

3.2.167 The case did not adequately explore how Anis's mental health affected her parenting capacity. Future assessments should examine the impact of mental health on parenting and identify support services for both parents and children.

3.2.168 Referrals, such as anonymous referrals and police welfare visits, were not adequately followed up. All alerts and referrals should be promptly investigated to identify potential risks to children.

3.2.169 A Family Group Conference could have been considered to involve the extended family in developing a support plan. This could strengthen the family's ability to care for the children safely.

GP Practice

3.2.170 Anis's frequent registration changes across multiple GP practices over 10 years presented significant challenges in building a coherent understanding of her health and safeguarding history. This case underscores the importance of robust information sharing and continuity of care, particularly for individuals with complex needs or frequent address changes.

3.2.171 Although complete medical records were transferred between practices in line with protocol. Given the nature of the contacts, there may have been no immediate clinical indication to undertake a retrospective review.

3.2.172 However, in cases involving multiple re-registrations or indicators of vulnerability (such as mental health concerns or domestic abuse), it would be good practice for clinicians to review historical information to identify patterns, risk factors proactively, or missed safeguarding opportunities.

3.2.173 This reinforces the need for strengthened protocols and clinical curiosity when patients present with fragmented care histories, principles reflected in GMC guidance on continuity of care.

3.2.174 Two key missed opportunities for timely mental health reviews occurred. After Anis's consultation, medication was increased, and appointments were missed.

3.2.175 In November/December 2023, Anis requested another medication increase, but engagement attempts were unsuccessful, and no further review was conducted. This highlights the importance of proactive follow-up and monitoring, especially after treatment adjustments.

3.2.176 However, the February 2023 consultation demonstrated good practice in terms of timely referrals to mental health services, indicating a prompt response to Anis's needs.

3.2.177 The practice confirmed that Anis was not misusing her medication, but her needs were inadequately explored after she requested a dose increase in December 2023. This highlights the need for a more thorough follow-up to ensure regular review and adjustment of patients' medication needs.

Surrey and Borders Partnership NHS Foundation Trust (SaBP)

3.2.178 SaBP has made positive changes by integrating domestic abuse information into its Safeguarding Adults training. This highlights the organisation's commitment to improving staff awareness and practice in identifying and responding to domestic abuse.

3.2.179 SaBP has expanded domestic abuse training across Surrey through TAYE training (which is available to all health providers) and established an 'Ambassadors Against Domestic Abuse Group.' These initiatives promote continuous learning and enhance staff engagement with domestic abuse issues.

3.2.180 The group has expanded, further enhancing its educational impact. Regular meetings now include training from local DARDRs. Seven-minute learning summaries and quarterly learning events keep staff updated on best practices and reflective learning.

3.2.181 SaBP has introduced a Safeguarding Springboard on their electronic record system, which enhances the visibility of safeguarding concerns across teams and divisions. This tool helps monitor practice, provides guidance, and enhances information sharing for improved safeguarding practices.

3.2.182 In 2025/26, SaBP plans to audit the adherence of services to the Engagement and Disengagement Policy. This policy aims to consistently apply risk assessment, trauma-informed practice, and reasonable adjustments. This audit will identify areas for improvement and help ensure that practices are fully integrated into care delivery.

3.2.183 SaBP's CMHT demonstrated good practice by performing a cold-call home visit when Anis missed an appointment, followed by prompt re-engagement with a new appointment. This proactive approach showed a commitment to maintaining patient engagement and well-being.

3.2.184 When Anis was discharged from services, clear communication with the GP and the option for re-referral provided transparency and clarity about her care options.

3.2.185 SaBP has made significant progress in domestic abuse awareness and support tools, including the Safeguarding Springboard. Continuous learning through new training programs and audits will enhance the management of domestic abuse and safeguarding concerns. Proactive outreach and clear communication with other services also improve patient engagement and safeguarding outcomes.

Surrey Police

3.2.186 The Police IMR emphasises that police officers used trauma-informed practices when engaging with Anis, acknowledging how her past trauma, including childhood sexual exploitation, affected her behaviour and choices. Officers showed awareness of her mental health needs and those of her children during their interactions. It is vital to continue and strengthen this approach, making TIP a core element of police interactions with vulnerable individuals.

3.2.187 The review found missed opportunities in interactions with Anis, where officers did not fully employ professional curiosity in their assessments. While not indicative of systemic flaws, this highlights the need for officers to consistently explore all relevant factors. Increased professional curiosity could have provided a deeper understanding of Anis's situation and revealed significant factors contributing to her vulnerability.

3.2.188 While there is no direct evidence that domestic abuse was the leading cause of Anis's death, the report notes that its cumulative effect, alongside other factors, contributed to her declining mental health.

3.2.189 Police must recognise the impact of multiple stressors, like domestic abuse, mental health issues, and past trauma, when responding to vulnerable individuals, especially when they show signs of mental health decline or behaviour changes.

3.2.190 Anis's history of sexual exploitation was identified as a key factor in her vulnerability, making it difficult for her to engage with officers. This highlights the importance of recognising past trauma and its long-term effects on an individual's responsiveness to help. Police officers should consider how historical trauma can impact current behaviours and adjust their responses accordingly.

3.2.191 The tragic outcome in this case highlights the need for a holistic approach that addresses immediate concerns like domestic abuse and mental health while also considering a person's history and vulnerabilities. It underscores the importance of collaborative responses with agencies such as mental health and domestic abuse support organisations to better assist individuals with complex needs.

4.1 Conclusion

4.1.1 The purpose of this review is to understand the circumstances surrounding the death of Anis and to present her life through the eyes of the victim.

4.1.2 The review reveals significant missed opportunities for intervention and highlights systemic weaknesses in multi-agency safeguarding responses. Despite numerous reports from professionals, neighbours, and Anis herself, concerns about domestic abuse, neglect, mental health, and child welfare were not adequately escalated or addressed, leaving Anis vulnerable to harm. No agency referred Anis to specialist domestic abuse services.

4.1.3 A key learning from this review is the cumulative impact of multiple low-level concerns, which, when considered in isolation, may not appear to meet intervention thresholds.

4.1.4 However, when viewed collectively, they indicate serious risks. The lack of recognition of these patterns and delays in action led to slower safeguarding responses, despite evident indicators of domestic abuse, poor home conditions, child neglect, and parental mental health difficulties. The absence of robust information sharing and follow-up across agencies also contributed to critical gaps in oversight.

4.1.5 This review also highlights concerns regarding disguised compliance, where Anis engaged with services intermittently without sustained improvements. This underlines the need for heightened professional curiosity and a greater willingness to challenge when working with families facing complex issues.

4.1.6 Additionally, the response to domestic abuse and coercive control in the household was insufficient. There is an urgent need for enhanced training, better risk identification, and stronger inter-agency collaboration to address domestic abuse cases more effectively.

4.1.7 In conclusion, this review stresses the importance of adopting a more proactive, trauma-informed, and holistic approach to safeguarding vulnerable individuals. Agencies must enhance their multi-agency training, refine safeguarding thresholds to address cumulative concerns, and develop a more proactive approach to working with individuals who are resistant or disengaged.

4.1.8 By fostering better collaboration, sharing of information, and understanding of the complexities of domestic abuse and mental health struggles, agencies can act earlier, before harm escalates, and provide the necessary support to those at risk.

5.1 Lessons to be Learned

5.1.1 These themes highlight the importance of addressing complex safeguarding issues, identifying missed opportunities for early intervention, and overcoming obstacles to multi-agency collaboration. The cumulative impact of concerns rather than isolated incidents should have prompted a more comprehensive safeguarding response.

Domestic Abuse and Coercive Control

5.1.2 Reports of domestic abuse within the household, including allegations from neighbours. Potentially controlling and coercive conduct within relationships. Verbal abuse, physical discipline of children, and Anis's interactions with friends are all reported.

Neglect and Parental Capacity

5.1.3 Poor living conditions, such as the accumulation of rubbish, the presence of mouldy food, and sanitation issues. Reports of children not wearing undergarments and their appearance

as unkempt or unclean. School attendance, medication management, and sustenance provision are all areas of concern. Lack of follow-up healthcare for both Anis and her children, as well as evidence of missed medical appointments.

Mental Health and Wellbeing

5.1.4 Anis's self-reported mental health challenges and prior crisis points. Potential missed intervention opportunities and reports of suicidal ideation or suicide attempts. By employing food and other coping mechanisms, she managed her emotional distress: possible stress-related health conditions, frequent migraines, and inadequate follow-up care.

Multi-Agency Communication and Response

5.1.5 Variable responses to repeated complaints submitted to agencies (CSC, Police, Housing, Education, Health) and missed opportunities for intervention due to an absence to escalate concerns or lack of consent. There is a lack of interagency information sharing, such as checks with critical agencies. Despite numerous concerns, the intervention thresholds are not being met.

5.1.6 Surrey County Council partners, except CHCS, which shares information via email or phone, have access to the Empowering Communities Integrated Network System (ECINS), a national, multi-agency case management system designed to improve inter-agency communication. Despite its availability and repeated findings from serious case reviews highlighting poor collaboration, uptake by partner agencies remains limited. While information sharing is challenging, ECINS was introduced to support more effective multi-agency communication.

Community and Professional Concerns

5.1.7 Professionals and neighbours consistently express concerns regarding Anis's parental capacity, living conditions, and behaviour.

5.1.8 Police, housing, and CSC cases are frequently closed due to a lack of evidence or non-engagement, despite receiving repeated reports. There is a potential for malicious allegations (e.g., a dispute with a neighbour) to complicate the responsibility.

Substance Use and Risk Factors

5.1.9 Reports of Anis consuming alcohol while walking with her children. The household may be affected by reports of drug trafficking in the local area.

5.1.10 Anis's concerns regarding the detrimental impact of unsocial behaviour in the neighbourhood on the well-being of her and her children.

Child Safeguarding and Emotional Well-being

5.1.11 Concerns regarding Sam's health and behaviour, including self-harm-like behaviours, meltdowns, and furtive walking.

5.1.12 Undiagnosed developmental or neurological conditions are not being adequately investigated. Medical attention for Sam was delayed. The emotional health of children is influenced by family instability and home conditions.

Housing and Environmental Factors

5.1.13 Housing issues, including rubbish accumulation, unsanitary conditions, and complaints of rats. Allegations of harassment, disputes with neighbours, and antisocial behaviour. Anis's opposition to intervention and disputes with housing officers.

5.2 Recommendations

5.2.1 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 includes 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.

5.2.2 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:

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

Trauma-informed and ACE-aware practices should be reinforced within existing safeguarding and frontline work locally, while also being advocated for at the national/system levels.

Responsible Agencies: 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, 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 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

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.

Surrey Heath Community Safety 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.

Acronyms

AAFDA	Advocacy After Fatal Domestic Abuse
ACS	Adverse Childhood Experiences
ADHD	Attention Deficit Hyperactivity Disorder
ASB	Anti-Social Behaviour
BPD	Borderline Personality Disorder
CBL	Choice Based Lettings
CCE	Child Criminal Exploitation
CAF	Child and Family Assessment
CAMHS	Child and Adolescent Mental Health Service
CHCS	Community Health Children's Services
CIN	Child in Need
CMHT	Community Mental Health Team
CSC	Children's Social Care
CSE	Child Sexual Exploitation
CSN	Community Staff Nurse
C-SPA	Surrey Children's Single Point of Access
CTN	Child To Notice
DARDR	Domestic Abuse-Related Death Review
DASH	Domestic Abuse, Stalking and Honour-Based Violence
DHR	Domestic Homicide Review
DI	Detective Inspector
DSL	Designated Safeguarding Lead
DVDS	Domestic Violence Disclosure Scheme
ECiNS	Empowering Communities Integrated Network System
ED	Emergency Department
ELP	Evidence-Led Prosecution
EMDR	Eye Movement Desensitisation and Reprocessing
FPH	Frimley Park NHS Foundation Trust
FSW	Family Support Worker
GAD-7	Generalised Anxiety Disorder
GCP	Graded Care Profile
HCP	Healthy Child Programme
HV	Health Visitor
IOPC	Independent Office for Police Conduct
IMR	Independent Management Review
MARAC	Multi-Agency Risk Assessment Conference
MAP	Multi-Agency Partnership
MAPE	Multi-Agency Public Protection Enquiry
MARM	Multi-Agency Risk Management Meeting
MDT	Multi-Disciplinary Team
MI	Motivational Interviewing
NCDA	National Centre for Domestic Abuse

PNC	Police National Computer
PPN	Public Protection Notice
PTSD	Post-Traumatic Stress Disorder
OiC	Officer in the Case
RASASC	Rape and Sexual Abuse Support Centre
SaBP	Surrey and Borders Partnership NHS Foundation Trust
SCARF	Single Combined Assessment of Risk Form
SDAP	Surrey Domestic Abuse Partnership
SECAmb	South East Coast Ambulance Service NHS Foundation Trust
SPA	Single Point of Access
SRO	Sexual Risk Order
SSCP	Surrey Safeguarding Children Partnership
SSHCP	Safer Surrey Heath Community Partnership
SW	Social Worker
TAF	Team Around the Family
TIP	Trauma-Informed Practice
TOR	Terms of Reference
VA	Voluntary Attendance
VRI	Video Recorded Interview