FINAL VERSION FOR PUBLICATION

ELMBRIDGE COMMUNITY SAFETY PARTNERSHIP

DOMESTIC HOMICIDE REVIEW

EXECUTIVE SUMMARY

Report into the death of Bishakha

May 2016

Independent Chairs: Jessica Donnellan and James Rowlands

Author of Report: James Rowlands

Associate Standing Together Against Domestic Violence

Date: August 2018

1. Executive Summary

1.1 The Review Process

1.1.1 This summary outlines the process undertaken by the Elmbridge Community Safety Partnership (CSP) Domestic Homicide Review (DHR) panel in reviewing the homicide of Bishakha, a resident in the area.

1.1.1 This review has been suitably anonymised in accordance to the statutory guidance. The specific date of death has been removed, as has the sex of the child involved (to further protect their anonymity, they are referred to as Child A).

1.1.2 The following pseudonyms have been in used in this review for the victim and perpetrator (and other parties as appropriate) to protect their identities and those of their family members:

- Bishakha – victim (38 at the time of the homicide)
- Manav – perpetrator (46 at the time of the homicide)
- Antariksh – father of victim
- Anemone – mother of perpetrator
- Ish – brother of victim
- Rajni – sister of perpetrator
- Ella – colleague and friend
- Maria – colleague
- Nandita – friend
- Orpita – friend
- Ulka – colleague and friend.

1.1.3 These pseudonyms were selected by the chair but were agreed with Bishakha's father, Antariksh.

1.1.4 As per the statutory guidance, the chair(s) and the Review Panel are named, including their respective roles and the agencies which they represent.

1.1.5 Agencies who provided information to the review are also identified, with the exception of five agencies which have been anonymised. Of these, four were sited nearby, and so naming them could provide location information which could be used to identify the subjects of the review. These are:

- A General Practice (where Bishakha, Manav and Child A were registered). This is referred to as the 'Medical Centre'.
- A (Fee Paying) Pre-Prep and Nursery School (attended by Child A)
- Two Private Mental Health Providers (who were approached in relation to treatment for Manav).

1.1.6 Additionally, Manav worked as a contractor at a large international bank. This bank has not been named as this information could be used to identify the subjects of the review.

1.1.7 The criminal trial concluded in October 2016. Manav was found not guilty of murder on the grounds of diminished responsibility but was found guilty of manslaughter. Sentencing was delayed until the 1st December 2016 for psychiatric reports for the defence and prosecution to be completed. Manav was sentenced to life imprisonment with a minimum term of nine years and 172 days. During the course of the review, Manav informed the chair that he was appealing on the grounds that the sentence was 'manifestly excessive'. At the time this report was handed to the CSP the outcome of that appeal was unknown.

1.1.8 Antariksh told the chair that he was angered by the outcome of the criminal trial, being unsatisfied with the conviction for manslaughter. Friends have also expressed their dissatisfaction with the criminal justice outcome.

1.1.1 The process began when the CSP made the decision to hold a DHR. The Home Office were notified of the decision in writing on 9th June 2016. As revised '*Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*' was issued at the end of 2016, the review was subsequently completed in line with the new guidance.

1.2 Contributors to the Review

1.2.1 Agencies were asked to check for their involvement with any of the parties concerned and secure their records. The approach adopted was to seek Individual Management Reviews (IMRs) for all the organisations and agencies that had contact with Bishakha, Manav or Child A. A total of 14 agencies were contacted to check for involvement. Six agencies returned a nil-contact. Seven agencies submitted IMRs and chronologies, with the General Practice submitting three stand-alone chronologies for Bishakha, Manav and Child A respectively. The chronologies were combined, and a narrative chronology developed.

1.2.2 The following agencies were contacted, but recorded no involvement with the victim or perpetrator:

- Surrey County Council Adult Social Care Services
- Surrey County Council Children's Social Care Services
- National Probation Service (NPS)
- Citizens Advice Elmbridge (West) and North Surrey Domestic Abuse Outreach Service[1]
- Substance misuse services
- Victim Support.

1.2.3 The following agencies and their contributions to this review are:

Agency	Contribution
NHS 111 Service (Care UK)	Chronology and IMR

[1] The North Surrey Domestic Abuse Service is managed by Citizens Advice Elmbridge (West). The service provides free, confidential, independent and impartial advice to anyone aged 16 or above affected by domestic abuse living in the boroughs of Epsom & Ewell, Elmbridge or Spelthorne. For more information, go to: http://www.nsdas.org.uk/about-us/.

Health Visiting Service (Central Surrey Health) (CSH)		Chronology and IMR
General Practice	in relation to Child A	Chronology only
	in relation to Manav	Chronology only
	in relation to Bishakha	Chronology only
Improving Access to Psychological Therapies Service (IAPT)[2] (Provided by Healthy Minds Surrey, Virgin Care)[3]		Chronology and IMR
Midwifery Service (Kingston Hospital NHS Foundation Trust)		Chronology and IMR
(Fee Paying) Pre-Prep and Nursery School		Chronology and IMR
South East Coast Ambulance Service (SECAmb)		Chronology and IMR
Surrey Police		Chronology and IMR

1.2.4 Additionally, a Lone Private Mental Health Provider submitted a Chronology and brief IMR. This was possible because, while the contact related to Manav, the approach to this practitioner was by Bishakha. This information was shared as a result of contact initiated by the then chair (Jessica Donnellan). When the chair (James Rowlands) attempted to establish contact, no response was received.

1.2.5 During the course of the review, a further Private Mental Health Provider (a Psychiatric Hospital) was identified from information provided by the Medical Centre (which had written a referral for Manav). However, as there was no evidence that Manav had attended an appointment, the Review Panel decided not to approach this provider.

1.2.6 Lastly, Manav worked as a contractor at a large international bank. Information about Manav's employment was collected as part of the murder enquiry and this was made available to the Review Panel in the Surrey Police IMR. While attempts were made to contact Manav's manager at the bank, these were not successful. Additionally, because of the time taken to secure consent for an interview with Manav the Review Panel recognised the difficulty in approaching the bank for information relating to him. Consequently, it was decided to approach the bank and seek general

[2] IAPT provides help and support for people over 18 years (who are registered with a GP in Surrey) who are experiencing mild to moderate mental ill-health. This can include stress, low mood, anxiety, panic attacks, depression (including pre and post natal), obsessive compulsive disorder, phobias, post traumatic stress and eating difficulties (not severe).

[3] Virgin Care ceased to provide IAPT services in Surrey as of April 2017. Since that date, IAPT provision in Surrey is provided by any one of six providers. Each provider works on an activity-based contract, responding to either self-referrals and referrals from other sources. For further information, go to: http://www.nwsurreyccg.nhs.uk/your-health/looking-after-your-mental-health/iapt.The findings of this DHR will be shared with Virgin Care, local mental health commissioners and the other IAPT providers in Surrey.

information from them as an employer. This enabled consideration of the bank's approach to employee welfare, including mental health and domestic violence, as well as in relation to the management of contractors like Manav.

1.2.1 *Independence and Quality of IMRs*: The IMRs were written by authors independent of case management or delivery of the service concerned. The IMRs received were comprehensive and enabled the panel to analyse the contact with Bishakha, Manav and Child A, and to produce the learning for this review. Where necessary further questions were sent to agencies and responses were received. Four IMRs made recommendations of their own and evidenced that action had already been taken on these. The IMRs have informed the recommendations in this report. The IMRs have helpfully identified changes in practice and policies over time, and highlighted areas for improvement not necessarily linked to the Terms of Reference for this review.

1.3 The Review Panel Members

1.3.1 The Review Panel included the following agency representatives:

Name	Agency
Adam Colwood, Detective Chief Inspector	Public Protection, Surrey Police
Annabel Crouch, Policy Manager, Community Safety Partnership	Elmbridge Borough Council
Christopher Raymer, T/Detective Superintendent	Public Protection – Surrey Police
Dr Caroline Warren, National Medical Director for 111	Care UK
Clare Stone, Chief Nurse	North West Surrey Clinical Commissioning Group (CCG)
Conor Walsh, Safeguarding Support Officer	SECAmb
Debra Cole, Safeguarding Adults and Domestic Abuse Lead	Surrey and Borders Partnership NHS Foundation Trust (Mental Health)
Gordon Falconer, Senior Manager	Surrey Community Safety Team, Surrey County Council
Helen Blunden, Safeguarding Lead	North West Surrey CCG
Helen Mott, Senior Probation Officer	National Probation Service
Kerry Randle, Serious Review Group Chair	Local Children's Safeguarding Board (LSCB)
The Head[4]	(Fee Paying) Pre-Prep and Nursery School

[4] Not named to enable anonymity, see 1.1.5.

Margaret Bourne, Chief Executive	Citizens Advice Elmbridge (West) and North Surrey Domestic Abuse Outreach Service
Marion Songhurst, Safeguarding Advisor Adults	Virgin Care
Ian Vinall, Head of Safeguarding	Children, Schools and Families Directorate, Surrey County Council
Melanie Bussicott, Head of Community Support Services (Equalities)	Elmbridge Borough Council
Rebecca Wilbond, The Safeguarding Midwife	Kingston Hospital NHS Foundation Trust
Sinéad Dervin, Senior Mental Health Commissioning Manager	NHS England
Steve Hams, Interim Director of Clinical Performance and Delivery	Surrey Downs CCG

1.3.2 *Independence and expertise*: Agency representatives were of appropriate level of expertise and were independent of the case.

1.3.3 The Review Panel met a total of four times, with the first meeting of the Review Panel on the 2nd September 2016. There were subsequent meetings on 12th December 2016, 13th October 2017 and the 12th April 2018. Draft reports were reviewed at the latter two meetings with the Review Panel subsequently receiving updates from the chair and signing off the report electronically in August 2018.

1.3.4 The chair(s) of the review wishes to thank everyone who contributed their time, patience and cooperation to this review.

1.4 Chair of the DHR and Author of the Overview Report

1.4.1 The initial chair of the review was Jessica Donnellan, Senior Projects Manager at STADV. Jessica has received Domestic Homicide Review Chair's training from STADV and has chaired and authored three DHRs.

1.4.2 For reasons unrelated to this case itself, Jessica was unable to draft the report. Consequently, in September 2017 James Rowlands was engaged by STADV as a report writer. While Jessica chaired the third Review Panel meeting, which discussed the draft report in October 2017, shortly thereafter it was agreed she would stand down from the role of chair.

1.4.3 In January 2018, James was appointed by STADV as chair of the review. A fourth panel meeting was scheduled for April 2018 to enable sufficient time for James to pick up the review.

1.4.4 James has received Domestic Homicide Review Chair's training from STADV and has chaired and authored three previous DHRs and has previously led reviews on behalf of two Local Authority areas in the South East of England. He has extensive experience in the domestic violence sector, having worked in both statutory and voluntary and community sector organisations.

1.4.5 STADV is a UK charity bringing communities together to end domestic abuse. We aim to see every area in the UK adopt the Coordinated Community Response (CCR). The CCR is based on the principle that no single agency or professional has a complete picture of the life of a domestic abuse survivor, but many will have insights that are crucial to their safety. It is paramount that agencies work together effectively and systematically to increase survivors' safety, hold perpetrators to account and ultimately prevent domestic homicides.

1.4.6 STADV has been involved in the Domestic Homicide Review process from its inception, chairing over 60 reviews, including 41% of all London DHRs from 1st January 2013 to 17th May 2016.

1.4.7 *Independence:* Neither Jessica Donnellan nor James Rowlands have any connection with the Borough of Elmbridge or any of the agencies involved in this case.

1.5 Terms of Reference for the Review

1.5.1 At the first meeting, the Review Panel shared brief information obtained from a 'summary of engagement' exercise about agency contact with the individuals involved. At this early stage it was clear that there had been limited contact with statutory services and no previous disclosures of previous domestic violence and abuse. As a result, the Review Panel agreed that, although Bishakha and Manav had been married since 2005, the time period for the DHR would be from May 2011 to the end of May 2016 (the date of Bishakha's death). This five-year time period was chosen as it covered the period of Bishakha's pregnancy through to her homicide, allowing for an in-depth consideration of the relationship in recent years. Where appropriate, information about the relationship outside of this time period is included to provide context.

1.5.2 The Review Panel comprised of agencies from Elmbridge, as the victim and perpetrator were living in that area at the time of the homicide. Agencies were contacted as soon as possible after the review was established to inform them of the review, their participation and the need to secure their records.

1.5.3 Additionally, as Bishakha and Manav had limited contact with public services, consideration was given to how to engage with private sector providers. At the outset this included a (Fee Paying) Pre-Prep and Nursery school, which was invited to be on the Review Panel. During the course of the review, two Private Mental Health Providers and a large international bank were also identified. Where possible, these organisations were contacted for information and involved remotely in the review.

1.5.4 *Key Lines of Inquiry:* The Review Panel considered both the 'generic issues' as set out in the statutory guidance and identified and considered the following case specific issues:

- Set out the facts of their involvement with Bishakha, Manav and Child A
- Critically analyse the service they provided in line with the specific terms of reference
- Identify any recommendations for practice or policy in relation to their agency
- Consider issues of agency activity in other areas and review the impact in this specific case.

1.5.5 To inform the panel's understanding of equality and diversity issues, consideration was given to engaging with specialist Black, Asian and Minority Ethnic (BAME) groups. Unfortunately, it was not

possible to identify representation from a local service that had expertise on BAME issues. To address this gap the Review Panel accessed advice from the Surrey Police Diversity Directorate, as well as STADV's Safety Across Faith and Ethnic (SAFE) Communities Project[5]. Additionally, this local gap in terms of BAME specialist provision led to a recommendation.

1.5.6 As it was identified that there had been extensive contact with mental health services, STADV contacted the NHS England Mental Health Homicide Team. They agreed to commission a report to assist the deliberations of the Review Panel and ensure that the NHS England representative on the panel had appropriate expertise.

1.6 Summary of Chronology

Bishakha

1.6.1 Bishakha had limited contact with statutory services, with some contact with a number of private providers. This contact related to education and health.

1.6.2 In relation to education, Bishakha had contact with the Pre-Preparatory and Nursery School in relation to Child A, although Child A had not been enrolled for long at the school. Bishakha's contact related to Child A's attendance at nursery. There was little additional information in the records and no concerns were identified at the time.

1.6.3 In relation to health, Bishakha had contact with a range of health services around pregnancy and maternity, as well as general practice. While the health care provided by Maternity Services was appropriate, there is no record of Bishakha being asked about domestic abuse at her 28 and 34-week appointments. Her contact with Health Visiting was also appropriate but, similarly, routine enquiry about domestic violence was not always undertaken.

1.6.4 Bishakha also had contact with a general practitioner (GP) at the Medical Centre. This related to a range of routine medical issues, either for herself or Child A. Bishakha did speak with her GP once about mental health issues, following the both of Child A, and received appropriate advice.

1.6.5 Bishakha had brief contact with at least one private mental health practitioner (a Lone Practitioner), who she contacted when looking for help and support for Manav. This contact was limited, with a single introductory meeting being held.

Manav

1.6.6 Manav also had relatively limited contact with statutory services, although in period before the homicide he had a range of contact with mental health providers.

1.6.7 In relation to mental health, Manav had contact with General Practice, NHS 111 and an IAPT service.

1.6.8 In his contact with a GP at the Medical Centre, the health care he received was appropriate, including the prescription and review of medication in relation to his Depressive Disorder.

[5] For more information, go to: http://www.standingtogether.org.uk/local-partnership/safety-across-faith-and-ethnic-safe-communities-project

1.6.9 Manav's contact with both NHS 111 and the IAPT service has identified a number of issues. These included the extent and quality of enquiry around suicide ideation and hopelessness, and whether these informed the assessment of risk (the issue for NHS 111 was inadequate probing around suicidal ideation. In contrast, the IAPT service discussed suicide ideation and protective factors but it is not clear whether the staff member acknowledged and understood the significance of hopelessness as a suicide risk factor).

1.6.10 A further issue identified for NHS 111 is that staff are limited to giving a patient advice about either attending Accident & Emergency (A&E) (in order to access Psychiatric Liaison staff) or going to their GP, rather than being able to refer directly to these services. This was the case for Manav who received advice but did not always take this up. This means the pathways that join up mental health support for someone experiencing mental health crisis are not as robust as they could be.

1.6.11 Manav also had some contact with Private Mental Health Providers, but this appears to have been limited to an initial meeting with the Lone Practitioner and a referral to the Psychiatric Hospital (there is no evidence to indicate this was taken up).

Domestic violence and abuse

1.6.1 Bishakha died as a result of a single, fatal act of domestic violence during a sustained assault by Manav. Considering the government definition of domestic violence and abuse, which describes a pattern of incidents of controlling, coercive or threatening behaviour, the Review Panel was not able to determine where there was a broader history to this single act. However, given Bishakha and Manav's limited contact with public services, it is important to note that the absence of evidence is not the same as being able to say such violence or abuse did not occur. It may simply be that it was not reported.

1.6.2 Regardless of whether there was a wider pattern of domestic violence and abuse or not, it is clear that there was an increasing amount of tension, as well as some relationship conflict, between Bishakha and Manav. Furthermore, shortly before the homicide, Bishakha stated she wanted to separate from Manav.

1.6.3 Tragically, it is not possible to build a picture of Bishakha's perspective of the relationship. Bishakha has been described as both professionally and personally active and outgoing. She was juggling family and work commitments and, from the accounts of her family and friends, she was successful, dynamic and well liked. Based on these same accounts, Bishakha appears to have been concerned about Manav and was finding his difficulties around employment and mental health increasingly challenging. As noted above, Bishakha also told Manav she wanted to separate. This issue of separation in relation to risk is discussed further in the Overview Report.

1.6.4 However, if Bishakha did have wider concerns about the relationship, or had experienced any domestic violence and abuse from Manav, she appears to have kept this to herself. While it is not possible to know either way, if Bishakha did have concerns which she did not share, this could have been for reasons of embarrassment or shame, or a feeling that she should be able to cope.

1.6.5 In contrast, Manav is reported to have been reserved and struggling with his mental health and his work, with his resignation early in 2016 likely exacerbating worries about money. This financial pressure is something Manav confirmed when interviewed by the chair.

1.6.6 It is possible to consider Manav's perspective, although in doing this, the Review Panel in no way sought to minimise Manav's responsibility for Bishakha's homicide. Manav may have perceived

his world as 'caving in', as well as feeling increasingly marginalised. Bishakha and Manav were part of a family network that was geographically and emotionally close. While Bishakha was actively trying to help him access help and support, this included the involvement of a number of family members and suggests Manav's personal circumstances had become a 'family matter'. Manav may also have felt indebted to those family members who had provided financial support.

1.6.7 In the absence of evidence as to whether there was a wider pattern of domestic violence and abuse, the Review Panel considered the ways of understanding the circumstances of this case. Considerations included:

- Manav's mental health, specifically on whether this could account for the homicide
- Exploring the homicide through another lens, specifically the sex of those involved, and the applicability of ideas about the 'masculine self' and of 'aggrieved entitlement'
- The potential presence of 'homicide triggers'. While the limited information in this case means it is difficult to be certain as to the presence of these markers, some appear to have been present. This case included: the prospect of 'separation/ rejection'; 'financial ruin'; and 'failing mental health'.

1.6.8 Other issues explored by the Review Panel in the context of domestic violence and abuse have included: training for professionals; work in a school setting (including fee paying schools); and the role of employers, and other awareness raising activity.

1.7 Conclusions and Key issues arising from the review

1.7.1 Bishakha was a caring daughter, sister and mother. She was also a loyal friend and successful businesswomen. Her death was a tragedy and has affected her family and friends deeply.

1.7.2 For many of those close to Bishakha, this tragedy is made more difficult because it appears so inexplicable. Those closest to Bishakha knew that Bishakha and Manav were having difficulties, not least because of Manav's issues at work and his mental health, and that this had led to some tension and relationship conflict. However, no one had any concerns that domestic violence and abuse was an issue or imagined that a homicide might be the outcome.

1.7.3 That has been a challenge for the Review Panel. It may be that there was no prior history of domestic violence and abuse. Alternatively, it may be that Bishakha had experienced domestic violence and abuse from Manav but had, for a number of reasons, not disclosed this to friends, families or agencies. Sadly, it is not possible to know.

1.7.4 However, whatever the situation, this homicide was not 'out of the blue'. There were ongoing difficulties between Bishakha and Manav and, in the run up to the homicide, there was a confrontation relating to separation. This latter issue is a well-established risk indicator in domestic homicide.

1.7.5 Manav's mental health was also deteriorating in the early part of 2016. While he and Bishakha sought help for this, and he accessed a range of services, it seems that the extent of his suicide ideation was not fully identified. Manav's deteriorating mental health, particularly around feelings of hopelessness, could have been more fully explored. If this had happened, this might have led to

him receiving a more comprehensive assessment and possibly treatment. This is also important given that mental health is a risk indicator in domestic homicide.

1.7.6 In approaching learning and recommendations, the Review Panel has sought to do two things. First, to try and understand what happened and consider the issues in Bishakha and Manav's lives that might help explain the circumstances of the homicide. Second, to use this case to consider a wider range of issues locally, including provision for victims of domestic violence and abuse from BAME communities.

1.7.7 The Review Panel would like to extend their sympathies to all those affected by Bishakha's death.

1.8 Lessons to be learned

1.8.1 The most important learning in this case relates to mental health provision. Manav sought support from a number of different health providers. For the most part the response was appropriate. However, the review has identified important learning for both NHS 111 and IAPT services relating to both assessment, the management of risk and onward referral into secondary care.

1.8.2 The review of this case has also thrown a light on aspects of the local partnership response, suggesting that existing work could be further developed. This includes developing work in primary care, as well as work with fee charging schools to build on the existing response to domestic violence and abuse.

1.8.3 Examples of good practice have been identified, including the existing work locally around employer policies relating to domestic violence and abuse. It is also clear that Bishakha, Child A and Manav were, for the most part, able to access timely and appropriate health provision.

1.8.4 This review has identified wider learning relating to domestic violence and abuse. This has included exploring issues of male entitlement, as well as increased awareness of triggers that could indicate a domestic homicide risk, and how the intersection of different aspects of someone's identities (including Race, Sex and Socio-Economic status) might impact their experiences and the help and support they seek. In this case it is hard to know whether, if Bishakha had experienced a wider pattern of domestic violence and abuse, she would have faced barriers associated with her Socio-Economic status or her Race. The Review Panel has considered both issues and also the specific matter of specialist provision for BAME communities more generally. This has led to recommendations for work on these issues locally and across Surrey. That work should include ensuring that awareness raising campaigns and services are accessible, as well as equipping professionals to respond appropriately to domestic violence and abuse in these communities.

1.8.5 Following the conclusion of a DHR, there is an opportunity for agencies to consider the local response to domestic violence and abuse in light of the learning and recommendations. This is true for agencies both individually and collectively. The Review Panel hopes that this work will be underpinned by a recognition that the response to domestic violence is a shared responsibility as it really is everybody's business to make the future safer for others.

1.9 Recommendations from the review

1.10 IMR Recommendations (Single Agency):

1.10.1 The following single agency recommendations were made by agencies in their IMRs:

SECAmb

1.10.2 In line with a concurrent DHR in Kent and Medway, following the success of the SECAmb Domestic Abuse pilot, consideration would be given into scoping with other agencies [about] how SECAmb can feedback into the Multi-Agency Risk Assessment Conference (MARAC) in the absence of a Domestic Abuse coordinator / specialist.

1.10.3 The SECAmb Safeguarding Team and Safeguarding Lead will also look into additional training for those working for the Helicopter Emergency Medical Service (HEMS) to support their VP referral writing to ensure sufficient information is recorded for the local authority to record and address their concerns. Given the chaotic nature of incidents attended by HEMS, acquiring information for social care can be distracting when addressing an immediate clinical need, however SECAmb will strive to work with HEMS in order to improve quality referrals in future and how to work with SECAmb colleagues for information sharing following an incident such as the one centred around this IMR.

Maternity Services

1.10.4 The importance of the routine enquiry into the presence or potential for pregnant women to be the victim of domestic abuse should continue to be asked at the booking in appointment and at 28 weeks and 34/36 weeks to identify if the domestic abuse has started in pregnancy or escalated.

1.10.5 The importance of contemporaneous record keeping needs to remain a high priority in order for the potential risks to mother and her unborn to be clearly identified within the patient health records, so an appropriate multi-agency plan can be formulated to safeguard and support the victim.

1.10.6 The value of asking the routine enquiry questions prior to discharge home from the postnatal ward to be explored.

Health Visiting

1.10.7 CSH Surrey Breast Feeding Clinics offer the opportunity for privacy however this will be explicit within literature and discussions with parents so that there can be no misunderstanding about an expectation to feed in a public area.

1.10.8 Continuing support from Learning and Development team to further develop the Domestic Abuse training offer across the service and incorporate within mandatory training for all clinical employees and to monitor DA training compliance across CSH Surrey.

1.10.9 Availability of materials to support Domestic Abuse awareness is recognised as a current issue. Whilst posters can be duplicated, flyers, cards and discrete information cards are in more limited supply locally. CSH Surrey will continue efforts to source a regular supply for professionals, clinics and public areas.

Virgin Care

1.10.10 Service to review adding prompts on impact of ethnicity/ culture to client/patient records.

1.10.11 Service to review how to encourage appropriate professional curiosity and more detailed examination and recording of issues which may impact upon the patient and the family such as the emotional and cultural impact of unemployment.

1.11 Overview Report Recommendations:

1.11.1 The Review Panel has made the following recommendations:

1.11.2 **Recommendation 1:** The SADA partnership to assure itself that the local training strategy, and professional development for Domestic Abuse Champions / Mentors, adequately:

- Reflects the gendered dynamics of domestic violence, including the concept of 'aggrieved entitlement'
- Enables professionals to identify potential triggers associated with escalation, including financial issues, depression and suicide ideation.

1.11.3 **Recommendation 2:** The Home Office to undertake further research into cases where there no known precursors of domestic violence and abuse, and/or the victim/perpetrator have had little contact with statutory services, to develop a profile of these cases.

1.11.4 **Recommendation 3:** The Surrey LSCB to work with all schools, including fee charging schools, to promote the inclusion of information on domestic violence abuse and the help and support available in school literature, including welcome packs for new parents.

1.11.5 **Recommendation 4:** The Surrey LSCB to work with all schools, including fee charging schools, to deliver Operation Encompass and ensure that procedures and training to support staff and children are in place.

1.11.6 **Recommendation 5:** The Surrey LSCB to work with all schools, including fee paying schools, to develop a programme with local specialist domestic abuse services to promote access to effective and high-quality resources for age appropriate teaching about healthy relationships in classroom settings.

1.11.7 **Recommendation 6:** The Department for Education to ensure that the good practice, resources and training developed following the consultation around Sex and Relationship Education and PSHE includes fee charging schools and to work with the sector around its development and implementation.

1.11.8 **Recommendation 7:** Care UK to review the findings from this case and undertake a wider case audit to be assured about the standard of current practice in relation to probing around suicidal ideation and, if issues are identified, to develop an improvement plan to address these.

1.11.9 **Recommendation 8:** Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the Community-Based Crisis Service by developing a mechanism to allow for direct referrals

1.11.10 **Recommendation 9:** Mental Health Commissioners to work with NHS England to ensure there is a robust pathway between NHS 111 and the GPs by developing a mechanism to allow for direct referrals

1.11.11 **Recommendation 10:** Mental Health Commissioners to review the learning from this case and seek assurance that current providers of IAPT services in Surrey have appropriate staff training, procedures and supervision in place in relation to the identification and assessment of risks to self and others.

1.11.12 **Recommendation 11:** Mental Health Commissioners to consider the learning from this case and run an engagement event with private mental health care providers in the county to facilitate the dissemination of the review's findings.

1.11.13 **Recommendation 12:** The Surrey Health and Wellbeing Board to work with the Surrey CCGs to ensure there is a programme available to all GPs providing training, support and a referral pathway (including access to advocacy) to enable a consistent response to domestic violence and abuse.

1.11.14 **Recommendation 13:** The CSP to write to the bank involved in this review to encourage them to develop a domestic violence policy for staff who experience or perpetrate domestic violence and abuse

1.11.15 **Recommendation 14:** The CSP to share the findings from this review with the Corporate Alliance against Domestic Violence and the Employers' Initiative on Domestic Abuse and request further consideration of best practice in relation to staff who are employed as contractors (either through an employment agency or if they are self-employed)

1.11.16 **Recommendation 15:** The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of BAME communities locally.

1.11.17 **Recommendation 16:** The CSP to work with the SADA partnership to develop its training programme to ensure that this addresses the needs of BAME communities locally.

1.11.18 **Recommendation 17:** The CSP to scope the requirement for specialist BAME led provision in the borough.

1.11.19 **Recommendation 18:** The CSP to work with other bodies in Surrey, including the Office of the Police and Crime Commissioner for Surrey, to ensure that there is access to specialist BAME led services.

1.11.20 **Recommendation 19:** The CSP to work with the SADA partnership to develop its awareness raising campaign so that this addresses the needs of victims across the spectrum of Socio-Economic status.