Domestic Homicide Review
Executive Summary

Report into the death of Adult A

Report produced by Mark Reed
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Chair of Domestic Homicide Review Panel

Date: 5 March 2013

1. Introduction

1.1 This domestic homicide review follows the death of Adult A (male) on 2 March 2012 at his home. South East Coast Ambulance Service attended the address on that date in response to a telephone call from his female partner, Adult B. A paramedic pronounced Adult A dead at the scene at 03:44. Adult B was found guilty of the murder of Adult A at Guildford Crown Court on 30 October 2012 and sentenced to life imprisonment, with a minimum tariff of 17½ years.

2. Conduct of review

2.1 Domestic homicide reviews were established on a statutory basis under Section 9 of the Domestic Violence, Crime and Adults Act 2004 and came into force on 13 April 2011. The Act requires a review "of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom he was related or with whom he was or had been in an intimate personal relationship or a member of the same household as himself".

2.2 Following notification by Surrey police of the death of Adult A and consultation with partners, the Chairman of the Safer Guildford Partnership confirmed that the circumstances met the criteria set out in the statutory guidance for a domestic homicide review on 1 May 2012. The Home Office was informed of the intention to conduct a review on the same day.

2.3 A Panel comprising senior representatives of relevant partner organisations was convened to oversee the review. Following consultation with partners, Mark Reed, a Strategic Director at Guildford Borough Council, was appointed by the Chairman of the Safer Guildford Partnership to chair the review. Mark's background as an environmental health officer has provided him with extensive experience in regulation, enforcement, investigative procedures and joint agency and partnership working. Full membership of the Panel is set out below:

Pauline Disley, Manager, South West Surrey Domestic Abuse Outreach Service
Caroline Jones, Senior Manager, Adult Social Care, Surrey County Council
Susan Lawes, Associate Director of Quality and Safeguarding Children, NHS Hampshire
DCI Colin Matthews, Head of Northern Area Public Protection Department, Hampshire Police
Lin Pedrick, Service Director, Surrey and Sussex Probation Trust
Mark Reed, Strategic Director, Guildford Borough Council
DS Jon Savell, Head of Public Protection, Surrey Police
Diane Woods, Associate Director Commissioning, Mental Health & Learning Disabilities, NHS Surrey

2.4 Stephen Benbough, Policy and Partnerships Officer at Guildford Borough Council, acted as assistant to the Chair of the Panel throughout the review and provided advice and support to the organisations involved.

2.5 The Panel agreed that an Individual Management Review (IMR) should be conducted by each agency in accordance with the statutory guidance. As the review progressed and further possible contacts with Adult A and Adult B by various agencies emerged, IMRs were also commissioned from the following additional organisations:

Frimley Park Hospital NHS Foundation Trust
Hampshire County Council
Hampshire Probation Trust
Rushmoor Borough Council
South Central Ambulance Service NHS Foundation Trust
South East Coast Ambulance Service NHS Foundation Trust
Southern Health NHS Foundation Trust
Surrey and Borders Partnership NHS Foundation Trust

2.6 The Panel gave detailed consideration to and challenged robustly the IMRs submitted by individual agencies and the final documents contributed significantly to the full overview report. This documentation was supplemented by:

- information provided by the general practices attended by Adult A and Adult B;
- discussions with and information provided by Surrey Police's Senior Investigating Officer in relation to the murder of Adult A;
- discussions with members of Surrey Police's Ash Neighbourhood Team;
- attendance at the trial of Adult B and review of the evidence given, including by neighbours and acquaintances; and
- post-trial discussions with Adult A's parents and their Family Liaison Officer.

3. Terms of reference of review

3.1 The intention on the Panel was to reflect on significant and relevant events leading up to Adult A's death, analyse the actions of relevant agencies and make recommendations, where appropriate, to ensure that lessons are learnt. The detailed terms of reference of the review, as agreed by the Panel following consultation with members of the Safer Guildford Partnership, were as follows:

1. To review significant and relevant events up to the date of the death of Adult A on 2 March 2012, unless it becomes apparent to the Chairman that the timescale in relation to some aspect of the review should be extended. Agencies should begin their Individual Management Reviews from the time of their first contact with the victim and alleged perpetrator.
2. To review the actions of the agencies defined in Section 9 of the Domestic Violence, Crime and Victims Act 2004 who were involved with Adult A and/or his partner Adult B and, at the initiative of the chairman and subject to their agreement, any other relevant agencies or individuals.
3. To seek to involve family and friends in contributing to the review where appropriate.
4. To produce a report which:
    - summarises concisely the relevant chronology of events, including the actions of all involved agencies;
    - analyses and comments on the appropriateness of actions taken; and
    - offers recommendations, where appropriate, that ensure lessons are learnt by relevant agencies.
5. To have regard to any specific equality and diversity issues.
6. To complete a final overview report in a suitable timeframe following the conclusion of the criminal investigation and court proceedings relating to the death of Adult A. The timeframe will be negotiated and agreed with the Safer Guildford Partnership as necessary.

3.2 As referred to previously, the Chair of the Panel met Adult A's parents on 24 January 2013. The review also considered evidence provided by Adult A's family, friends and acquaintances at Adult B's trial. Further interviews with friends were not considered necessary as part of the review.

3.3 Adult A and Adult B commenced their relationship in February 2008. The primary focus of the review was, therefore, from that date until 2 March 2012. However, where relevant information from before that period was identified, this was included to provide background and context to the relationship and the individuals concerned, particularly where it helped to understand how Adult A viewed the world around him and why he may have made the decisions he did in the months leading up to his death.

4. Background

4.1 Adult A, who was born in December 1974, had an extensive criminal record. The majority of his offences were committed in Hampshire and Surrey and both police forces had frequent contact with him for over 20 years. Adult A's behaviour deteriorated whilst he was still at school. He was expelled from three secondary schools for fighting and truancy and left education at the age of 15 without any qualifications. He started mixing with older people and quickly got into drugs, alcohol and criminal activities.

4.2 Police involvement with Adult A dates back to 1991 when he was convicted of shoplifting. Since then, he was arrested and charged on numerous occasions in Hampshire and Surrey, mainly for theft, violence, criminal damage and public order offences. Most offences were committed whilst Adult A was drunk. In the period up to April 2008, Adult A had been convicted on more than 50 occasions of over 100 offences. He also had a tendency to behave violently towards the police when drunk and, over the years, often assaulted officers when being arrested for other offences.

4.3 Adult A was first prescribed with anti-depressants by his GP in 1995 (aged 21 years) and was seen twice by medical practitioners that same year following overdoses. He continued to receive various prescription drugs to treat depression over the years. A third overdose in 2000 resulted in a serious life-threatening episode and treatment in intensive care at Frimley Park Hospital. He was treated for Tuberculosis in the same year.

4.4 In December 2006, Adult A was taken to Frimley Park Hospital having overdosed with Naxproxen and alcohol. He had also self-harmed by cutting his arm and was feeling suicidal. He was seen at Frimley Park Hospital on two further occasions in June 2007 with injuries to his arm caused by self-harm.

4.5 As Adult A's dependency on drugs and alcohol increased, his lifestyle became more chaotic. It appears that he was never in any form of sustained employment and that he was financially dependent on benefit payments. He took little care of himself and lived most of his life in an alcohol and drug induced stupor. He associated with other adults with similar issues, which made him vulnerable to abuse, usually through drunken brawls. Adult A had attended the Emergency Department at Frimley Park Hospital on over 20 occasions by 2008, often presenting with head or facial injuries as a result of fights and assaults.

4.6 Adult B, who was born in October 1967, also has an extensive criminal record and, again, the majority of offences were committed in Hampshire and Surrey. Both police forces have had frequent contact with her for the last 30 years or so.

4.7 During the period 1981 to 1984, from the age of 13, Adult B was subject to a court care order and referred to Fairfield Lodge Observation and Assessment Centre in Southampton. This was the result of persistent non-attendance at school and disruptive behaviour at home.

4.8 Police involvement with Adult B dates back to 1982 when she was convicted of shoplifting. Since then, she was arrested and charged on numerous occasions in Hampshire and Surrey, mainly for theft, drugs, fraud, violence and driving offences. In the period up to April 2008, Adult B had been convicted on 26 occasions for 46 offences.

4.9 Adult B had alcohol and drug addiction problems and was a client of the Acorn Drug and Alcohol Service operated by Surrey and Borders Partnership NHS Foundation Trust.

4.10 Adult A and Adult B met and commenced their relationship in February 2008. He soon moved in with Adult B at her privately rented flat in Ash. Both Adult A and Adult B were unemployed and living on benefits.

4.11 From March 2008, Surrey Police and Hampshire Police attended 18 domestic incidents involving Adult A and Adult B either at their home in Surrey or in Aldershot town centre. Nine of these involved allegations by Adult A that he had been assaulted by Adult B. On five occasions, Adult A contacted or advised the police himself about the alleged assault and, on the other occasions, they were notified initially by neighbours or attending ambulance crews. Four of these incidents resulted in him being taken to hospital by ambulance.

4.12 On 26 November 2008, Adult A was thought to have suffered a stroke. He presented at Frimley Park Hospital with a right-sided weakness and reported falling frequently. His health continued to deteriorate from this point, particularly during the last two years of his life. His balance became much worse and he walked with a walking stick. He often fell over in public places.

4.13 Adult A would drink around eight to ten cans of super-strength lager every day, starting early in the morning. He was rarely seen sober and would often be extremely drunk. He also took un-prescribed methadone and other illicit drugs when he could access them.

4.14 Following an alleged assault on Adult A by Adult B at their home on 23 October 2010, the frequency of domestic incidents involving Adult A and Adult B reported to Surrey and Hampshire Police reduced significantly. In the 16 months leading up to his death, the only domestic incident involving the police was when Surrey Police responded to a call about a relatively minor argument on 9 February 2012. Rather than this being the result of the relationship between Adult A and Adult B becoming more harmonious, it seems more likely that this was due to episodes of violence no longer being reported.

4.15 South East Coast Ambulance Service attended Adult A and Adult B's home in the early hours of 2 March 2012 in response to a telephone call from Adult B. Adult A was pronounced dead at the scene at 03:44. A post-mortem examination concluded that Adult A had died of severe abdominal, head and chest injuries, including traumatic sheering damage to the brain, bowel haemorrhage bleeding, ruptured liver and abdominal tears. There were no defence injuries.

4.16 Adult B was found guilty of the murder of Adult A at Guildford Crown Court on 30 October 2012 and sentenced to life imprisonment, with a minimum tariff of 17½ years. A history of domestic abuse and Adult A's disability and vulnerability were cited as aggravating factors in the sentencing.

5. Key issues arising from review

5.1 Responsibility for Adult A's death rests solely with Adult B. Both Adult A and Adult B also made their own lifestyle choices and failed to engage with the support they were offered or received from various agencies, whether in connection with alcohol, drugs, domestic violence or medical treatment. In fact, Adult A's unwillingness to address his 20 year alcohol dependency was perhaps the principal cause of his failure to engage with society and live a more normal life.

5.2 Adult A's parents confirmed the adverse and striking impact that alcohol would have on Adult A's personality and behaviour. This is borne out by the fact that, whilst Adult A often visited and was invited into his parents' home, they still felt that a restraining order was required to control his behaviour when drunk. His mother described him as a "Jekyll and Hyde" character. Due to his

lifestyle, his premature death did not come as a surprise to his parents. Whilst they certainly did not anticipate his murder by Adult B, they were acutely aware of the risks of Adult A experiencing a traumatic event or his alcoholism causing irreparable damage to his body.

5.3 To a large extent, Adult A chose to remain in a relationship with Adult B despite being the victim of frequent domestic violence. Unless a victim wishes to leave a violent relationship, the opportunities for agencies to intervene successfully are restricted significantly. Ultimately, unless they lack competence, the acceptance of care and support rests with the individual. Adults are in charge of the decisions that affect their lives, even when those decisions might not be thought by others to be in their best interests.

5.4 However, the assault that led to Adult A's death was not a one-off. There were clear warning signs. The purpose of this review was, therefore, to learn lessons and assess what actions could be taken to prevent or, at least, reduce the risks of such incidents in future.

5.5 The Home Office's multi-agency statutory guidance for the conduct of domestic homicide reviews includes the following statement:

> "*Domestic violence is frequently repeated by the perpetrator and the violence can escalate over time. A domestic violence incident which results in the death of the victim is often not the first attack and is likely to have been preceded by psychological and emotional abuse. Many people and agencies may have known of these attacks – neighbours, for example, may have heard violence, a GP may have examined injuries, housing organisations may have been called repeatedly for repairs to homes, the police may have been called, there may have been previous prosecutions, or injunctions, and so on. This can sometimes make serious injury and homicide in domestic violence cases preventable with early intervention. Therefore, it follows that local agencies should have adequate policies and procedures in place to instruct agency staff on how to intervene in domestic violence cases."*

5.6 Much of this is true in the case of the relationship between Adult A and Adult B. A number of agencies were aware of the violent nature of the relationship, responded to alleged assaults and, in the case of Adult A, treated his injuries. Neighbours also reported violent altercations to the police on a number of occasions. The incidents documented in the full overview report and known to the various agencies are likely to represent only a small minority of the attacks on Adult A. For example, Adult B is now known to have beaten Adult A frequently with his walking stick. On this basis, it could be argued that it was entirely predictable that Adult A's life would end in the way it did or as a result of some other traumatic event. In fact, Hampshire Police received intelligence from a source in April 2009 predicting this outcome as being likely.

5.7 As referred to previously, police in Surrey and Hampshire responded to 18 domestic incidents involving Adult A and Adult B. Nine of these involved allegations by Adult A that he had been assaulted by Adult B, a number of which had resulted in significant injury. In most cases, Adult A would not pursue a formal complaint or consent to the use of relevant medical evidence and there were no witnesses to support a prosecution. In some cases, counter-allegations were made by Adult B and both were always drunk. After each alleged assault, Adult A would resume his relationship with Adult B. Given these circumstances, it is extremely unlikely that Adult A would have cooperated with any prosecution and his willingness and ability to testify at a trial is highly questionable. The police, therefore, had little option other than to close investigations rather than seek prosecutions against Adult B.

5.8 However, there was evidence of a clear risk of serious harm to Adult A that was not identified by relevant agencies, shared with others or acted upon in accordance with agreed procedures. Adult A was an alcoholic and persistent drug user, who was rarely seen sober. He experienced a weakness to the right side of his body and walked with a stick. He was unsteady on his feet,

extremely so when drunk, and often fell over in public places. When drunk, he was not able to get up again without help. Over the years, he had been assaulted frequently in public places in Aldershot and suffered persistent attacks by Adult B. He always had facial injuries, including black eyes, cuts and bruises, due to falls, fights and assaults. Despite this, there is little evidence to suggest that agencies recognised his vulnerability and opportunities to implement appropriate safeguarding procedures were repeatedly missed.

5.9 Whilst Adult A's death may have been largely predictable, the timing might be considered less so. Following his alleged assault by Adult B at home on 23 October 2010, the frequency of domestic and other incidents reported to Surrey and Hampshire Police reduced dramatically. At the same time, there is some indication that Adult B was doing more to reduce her alcohol and illicit drug use.

5.10 However, during this period, neighbours continued to hear arguments between Adult A and Adult B several times a week. The argument on the day of his death, which included shouting for three or four hours, threats to kill and loud bangs, was not considered exceptional. During her trial, Adult B also admitted that she regularly hit Adult A with his walking stick. Adult A also told an old friend on 1 March 2012 that he left the house early each day because Adult B would start hitting him once she started drinking.

5.11 Fights between Adult A and Adult B would also have become increasingly one-sided with his deteriorating health and increased vulnerability. Adult A's lack of access to a telephone and reduced ability to notify neighbours would have made it increasingly difficult for him to inform the police of assaults by Adult B. This, together with the reluctance of neighbours to get involved, is likely to be part of the explanation for the reduced reporting of incidents to the police rather than of the relationship becoming less volatile and violent.

5.12 The chaotic and violent nature of the lifestyles of Adult A and Adult B meant that they had extensive contacts with various public services, including Surrey Police, Hampshire Police, Frimley Park Hospital and South East Coast Ambulance Service. As such, there were many potential opportunities for agencies to intervene and, in particular, to reduce risks arising from the relationship and Adult A's vulnerability.

5.13 Despite the large number of incidents and extensive and frequent injuries received by Adult A, Surrey Police failed to refer the case to the West Surrey MARAC[1] on multiple occasions despite it clearly meeting the necessary criteria. On only one occasion did Surrey Police act upon Adult A's vulnerability by forwarding a 39/24 (Vulnerable Adult) form to Surrey County Council's Adult Social Care Team. However, due to errors in the way this was handled by Surrey County Council, this opportunity to implement multi-agency safeguarding arrangements was missed.

5.14 Hampshire Police appeared to treat alleged assaults by Adult B on Adult A in Aldershot town centre as drunken brawls rather than domestic abuse. Contrary to its policy, no domestic abuse risk assessments were completed by Hampshire Police following incidents and details of alleged assaults were not forwarded to Surrey Police to enable action to be taken on the basis of the fullest available information.

5.15 The review highlights the need for a mechanism for sharing information and intelligence relating to domestic incidents between police forces. This is particularly relevant where incidents occur outside the police force area where the people involved live. Surrey Police and Hampshire Police will introduce appropriate information sharing procedures to notify other police forces of such

[1] A Multi Agency Risk Assessment Conference (MARAC) is a meeting where information about high risk domestic abuse victims (those at risk of murder or serious harm) is shared between local agencies. By bringing all agencies together at a MARAC, a risk focussed, coordinated safety plan can be drawn up to support the victim.

incidents. However, a similar approach is required at a national level to ensure that the relevant force has full knowledge of a case when determining the most appropriate course of action and a recommendation has been made to the Home Office to this effect.

5.16 Frimley Park Hospital and South East Coast Ambulance Service also dealt with Adult A on numerous occasions following falls and domestic and other assaults. Again, despite frequent contacts and attendances, together with Adult A's alcohol and substance misuse problems and overall deteriorating health, his vulnerability was not recognised and appropriate safeguarding procedures were not instigated.

5.17 Adult A did not disclose any domestic abuse to his GP and Frimley Park Hospital did not notify the practice of his attendances at its Emergency Department following alleged domestic assaults. However, given the existence of various known risk factors, including Adult A's alcohol and drugs misuse, poor and deteriorating health and frequent injuries, there may have been opportunities for GPs to have been more proactive in enquiring about potential domestic abuse.

5.18 Relevant agencies did have policies and procedures in place for dealing with domestic violence and vulnerable adults, although some changes have been recommended as part of this review. However, the review demonstrates a failure of the operation of such procedures. The evidence suggests that policies and procedures were either not adequately understood or followed (or both) and that staff from various agencies were not aware of what to do if they had concerns about domestic violence.

5.19 Clearly, Adult A was not an easy person to deal with, often being abusive to staff trying to help him and failing to engage with any support being offered. However, his drug and alcohol misuse and chaotic lifestyle appear to have acted as a barrier to him being identified as vulnerable and treated accordingly by police, health and caring professionals. This is a cultural issue to be addressed by agencies as part of domestic abuse and safeguarding training and awareness.

5.20 The question of gender also needs to be addressed. In this case, the victim was a man and the principal perpetrator of the domestic abuse in the relationship was a woman. It is widely accepted that domestic abuse against men is an under-reported problem, especially by victims themselves. Reasons for the apparent reluctance of men to report domestic abuse may include a fear of not being believed and a perceived prejudice against male victims in the criminal justice system. Adult A's mother also felt that he would have been embarrassed to admit that he was being attacked repeatedly by a woman. Despite this and whilst estimates vary, the British Crime Survey suggests that men were the victims of just over a quarter of incidents of domestic violence in 2010.

5.21 In this particular case, lack of reporting was not the primary issue, at least up until October 2010. Adult A reported several alleged assaults to police in both Surrey and Hampshire. However, the Panel is of the view that his gender, together with agencies' perceptions of him and his lifestyle, played a part in the failure to recognise Adult A's vulnerability and implement appropriate safeguarding arrangements. Given the number of domestic incidents and the level of violence involved, it is inconceivable that the case would not have been referred to the West Surrey MARAC had the victim been a vulnerable woman. This is a further cultural issue which needs to be addressed in training and guidance provided to staff of relevant agencies.

5.22 Whilst there were clearly opportunities to instigate multi-agency arrangements to manage risks in this relationship, it is clear that there were not necessarily any easy solutions to prevent Adult A's death. Any strategy put in place would have required some engagement by Adult A (and possibly Adult B) and there are few signs that this would have been forthcoming.

5.23 Arguments between Adult A and Adult B had led some neighbours to believe that their relationship had ended about 18 months before Adult A's death and that Adult B wanted him out

of their flat. The fact that Adult A submitted 40 unsuccessful bids for social housing, principally to Rushmoor Borough Council and Guildford Borough Council, between 19 February 2010 and 12 March 2011 provides evidence that he was looking for a place of his own. When asked by a friend on the day of his death why he put up with being hit by Adult B, Adult A also responded that he had nowhere else to go and was looking for a one bedroom flat.

5.24 If the case had been referred to the West Surrey MARAC in accordance with the agreed criteria, it is not clear whether a difference could have been made, but at least housing issues could have been explored, including his apparent desire to secure his own accommodation. This might have resulted in a different outcome by precipitating the end of the relationship or, at least, by offering a release from moments of increased tension.

5.25 It should be noted though that Adult A's search for housing did not involve him disclosing that he was the victim of domestic violence and this was never given as a reason for his need for accommodation. It is also clear that some form of domestic relationship and arrangements continued with Adult B and that Adult A's main place of residence remained at their shared home.

5.26 The terms "love-hate relationship" and "can't live together, can't live apart" were heard frequently during the review and in court by Adult A's own mother. This gives a sense that the end was almost inevitable and that agencies could have done nothing to prevent Adult A's death. However, what is also clear is that procedures and opportunities to avert this tragic conclusion were not tested in this case.

6. Recommendations

General

6.1 That training and guidance provided to staff of relevant agencies on domestic abuse and safeguarding vulnerable adults, including training recommended by this review, cover issues relating to woman-on-man violence and the identification of vulnerable adults in the context of alcohol and drug abuse.

Surrey Police

6.2 That Surrey Police ensure that:

(a) training on the DASH risk assessment process is undertaken by all Surrey Police staff new to frontline duties or to the Public Protection Investigation Unit Supervisor role;

(b) all Public Protection Investigation Unit Supervisors have received the requisite DASH risk assessment process training and are able carry out effective risk assessments, including the identification of cases that should be referred to a MARAC;

(c) all officers employed in the role of Public Protection Investigation Unit or Central Referral Unit Supervisor carrying out DASH risk assessments recognise that domestic incidents involving either partner as a victim within the previous 12 months would meet the repeat incident criteria for a MARAC referral;

(d) Police Public Protection Investigation Units report all incidents of domestic abuse that take place in Surrey involving persons who do not normally reside in the county to their home area police force using the intelligence reporting system; and

(e) the definition of vulnerable adults (adults at risk) used by Surrey Police in its policies and procedures is amended to use the definition set out in the Surrey Safeguarding Adults Multi-Agency Procedures, Information and Guidance 2011 and that appropriate guidance and training be provided to all relevant staff.

Hampshire Police

6.3 That Hampshire Police ensure that:

(a) restraining orders are recorded and flagged on its database to highlight the existence of all live court orders to officers and staff, including those from other police forces;

(b) it is made explicit to all frontline officers and staff that the requirement to complete DASH risk assessments includes domestic incidents where the victim is unable or unwilling to respond to the risk assessment questionnaire, in which case the officer or staff member should make the assessment using professional judgement taking into account the circumstances of the incident and by using historical information from recording systems;

(c) when police officers deal with incidents between partners that take place in a public place, these are recognised and treated as domestic incidents and the relevant domestic abuse policy is applied, including the completion of risk assessments and the taking of positive action; and

(d) when domestic incidents occur in the Hampshire Police area involving one or more parties who live in another police force area, the details of the incident, including any risk assessments, should be reported to that other force to enable them to understand the full extent of the risk, provide appropriate support to the victim and recognise repeat offending by the perpetrator.

Home Office

6.4 That the Home Office be made aware of issues raised by this review in relation to the lack of sharing of information between relevant police forces on incidents of domestic abuse and be requested to ensure that a system is established at a national level to address this matter.

Frimley Park Hospital NHS Foundation Trust

6.5 That Frimley Park Hospital NHS Foundation Trust:

(a) ensure that notifications to patients' GPs following attendances at the Emergency Department detail all relevant information, including safeguarding considerations and instances of alleged domestic abuse;

(b) ensure that staff within the Emergency Department record details of advice given to patients on available services, such as drug and alcohol and domestic abuse support;

(c) review the Emergency Department's guidance to staff on safeguarding vulnerable adults to ensure that it is consistent with Trust-wide policies and procedures;

(d) ensure that nursing and medical staff in the Emergency Department receive training on the safeguarding procedure for vulnerable adults, including the requirement to refer domestic abuse cases to the Trust's Lead for Vulnerable Adults; and

(e) ensure that frequent attendees at the Emergency Department are identified as being at high risk to ensure that appropriate safeguarding procedures are considered and implemented.

South East Coast Ambulance Service NHS Foundation Trust

6.6 That South East Coast Ambulance Service NHS Foundation Trust be strongly urged to:

(a) review its safeguarding policy and procedure to ensure that domestic abuse is identified as a standalone factor in assessing the vulnerability of adults;

(b) ensure ambulance staff receive guidance and training on the application of its safeguarding procedures in relation to incidents of domestic abuse, including:

(i) the requirement to make safeguarding referrals in appropriate cases regardless of the actions or interventions of other agencies; and

(ii) the identification of vulnerable adults, including victims of domestic abuse, in the context of alcohol and substance misuse regardless of gender.

Guildford and Waverley Clinical Commissioning Group

6.7 That the strategic lead for domestic abuse of Guildford and Waverley Clinical Commissioning Group ensures that general practices maintain effective procedures and arrangements for dealing with cases of domestic abuse, including to encourage GPs to be pro-active in enquiring about possible domestic abuse in appropriate cases.

Surrey County Council

6.8 That Surrey County Council introduces a process to ensure that Adult Social Care receives confirmation of the correct receipt of a safeguarding referral from relevant service teams.

Surrey and Borders Partnership NHS Foundation Trust

6.9 That Surrey and Borders Partnership NHS Foundation Trust:

(a) require all relevant practitioners to attend mandatory domestic abuse training on a three yearly basis; and

(b) review existing risk assessment processes to ensure that care records and risks are updated to reflect clients' evolving and changing circumstances.