



Domestic Abuse Related Death Review

Lilly  
Died April 2020

Author: Julie Mackay

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## Family tribute

Lilly was a matriarch in every sense, she had raised seven children and adored her grandchildren and great grandchildren, she ruled the roost, took pride in her home was hardworking, honest and caring.

### 1. Introduction

1.1 The chair and panel wish to extend their condolences to the family of Lilly who died in April 2020. Thanks, are also extended to all those who have contributed for their time, patience, and co-operation.

1.2 This review was commissioned by Spelthorne Borough Community Safety Partnership which sits within Surrey County Council. There had been an incident at the home address of Lilly in February 2020 when she suffered a significant head injury. As services responded to this incident it was identified that domestic abuse was present within the household. When Lilly passed away two months later the decision was taken to commission a review at the conclusion of the Police investigation. There have not been any criminal charges. The decision therefore was taken to refer to it as a Domestic Abuse Related Death Review, conducted in accordance with the Multi-Agency Statutory guidance for the conduct of Domestic Homicide reviews (2016) under s.9(3) Domestic violence, Crime and Victims Act (2004)<sup>1</sup>. The perpetrator of the domestic abuse lived in the same household as Lilly but has never been charged with any offence in relation to this incident or the subsequent death of Lilly.

1.3 The key purpose in undertaking Domestic Abuse Related Death Review's (DARDR's) is to identify the lessons to be learnt from the death (and in cases of homicide and suicide), in which the death of a person aged 16 or over has or appears to have resulted from violence, abuse or neglect or it has been identified that there was domestic abuse present in the household or relationship. Commissioning takes place when:

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<sup>1</sup> <https://assets.publishing.service.gov.uk/media/5a80be88e5274a2e87dbb923/DHR-Statutory-Guidance-161206.pdf>

- (a) *A person to whom s/he was related or with whom s/he was or had been in an intimate relationship, or*
- (b) *A member of the same household as herself/himself*

## **2 Timescales**

2.1 Following the death of Lilly a referral was received on the 21<sup>st</sup> June 2023. The delay in referring was due to the ongoing police investigation. A scoping exercise was carried out by agencies which was concluded in July 2023. On the 27<sup>th</sup> July 2023 a decision was taken to commission a Domestic Abuse Related Death Review (DARDR) under the Domestic Homicide Review Statutory guidance 2016. The Home Office was notified on the 17<sup>th</sup> December 2023. An independent Chair and Author was appointed in December 2023. The panel met in January 2024 and the review was concluded in February 2025.

## **3 Confidentiality**

3.1 The pseudonym for Lilly was selected by the family. The pseudonyms for Andrew and Angela were selected by the chair in conjunction with the family.

3.2 Lilly the victim was an older lady aged in her 80's. She was a white female who had roots in the traveller community. She was a widow and the grandmother of Andrew. Andrew the perpetrator of the domestic abuse is a white male aged in his 20's. No other protected characteristics have been identified. Angela also resided in the house; she is a white female aged in her 50's. She is the daughter of Lilly and mother of Andrew. She too was a victim of domestic abuse by Andrew.

3.3 In the absence of any engagement by the perpetrator of domestic abuse, and any consent being given, consideration has been given to European Court of Human Rights (ECHR) articles 2 (right to life) and 8 (right to private life)<sup>2</sup>. The principles relating to General Data Protection Regulation (GDPR)<sup>3</sup> have been adhered to and the report has been anonymised.

## **4 The Terms of Reference**

4.1 The Home Office has indicated that a DHR should be undertaken. This is a case where the circumstances of the death of the victim have not resulted in any criminal proceedings. It will be referred to as a domestic abuse related death review (DARDR). The victim is a lady in her 80's. The perpetrator is her grandson, aged in his 20's. Also residing in the house was the victim's daughter, and mother of the perpetrator, she is considered a key individual for the purpose of this review. As such the Review Panel (and by extension, IMR authors) will consider the following:

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<sup>2</sup> <https://www.equalityhumanrights.com/human-rights/human-rights-act>

<sup>3</sup> <https://www.gov.uk/data-protection>

#### 4.2

1. Communication and information-sharing between services regarding domestic abuse
2. Community understanding of domestic abuse, awareness of how to identify domestic abuse, and routes for reporting domestic abuse: Could more be done to highlight the opportunities of reporting abuse for the older generation.
3. Whether family or friends of either the victim or the perpetrator were aware of any abusive behaviour prior to the death from the alleged perpetrator towards the victim.
4. Whether the work undertaken by services in this case was consistent with each organisation's:
  - a. Professional standards
  - b. Domestic abuse policy, procedures, and protocols
  - c. Safeguarding adult's policy, procedures, and protocols
5. The response of the relevant agencies to any referrals relating to the victim and the perpetrator concerning domestic abuse, mental health, or other significant harm. In particular, the following areas will be explored:
  - a. Whether there were any barriers experienced by the victim or her family/ friends/ in reporting any abuse including whether the victim knew how to report domestic abuse should she have wanted to.
  - b. Whether there were any warning signs and whether opportunities for triggered or routine enquiry relating to domestic abuse and therefore early identification of domestic abuse were missed.
  - c. Identification of the key opportunities for assessment, decision-making and effective intervention from the point of any first contact onwards
  - d. Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective
  - e. Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made
  - f. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and in a timely manner.
6. Whether the impact of any organisational change over the period covered by the review had been communicated well enough between partners and whether that impacted in any way on partnership agencies' ability to respond effectively.
7. Whether practices by all agencies were sensitive to the gender, age, disability, ethnic, cultural, linguistic, and religious identity of the respective family members. In particular the age of the victim as an older person. It has been identified that the family have links to the traveller community and this culture should also be considered.

8. Were agencies aware of the adverse childhood experiences experienced by the perpetrator. If so, did this influence decision making? Did agencies have a trauma informed approach?
9. Did the agency have policies and procedures for Domestic Abuse, Stalking and Honour Based Violence (DASH or DARA) risk assessment and risk management for domestic violence and abuse victims or perpetrators, and were those assessments correctly used in the case of this victim/perpetrator? Did the agency have policies and procedures in place for dealing with concerns about domestic violence and abuse? Were these assessment tools, procedures and policies professionally accepted as being effective?
10. Were there missed opportunities or positive intervention for support for the victim or the family for onward referral / Vulnerable Adult Risk Management (VARM) considerations (now referred to as Complex Adult Risk Management (CARM)).
11. Did the agency have awareness of child parent abuse? Are there any protocols or policies that refer specifically to child parent abuse? Has any training been delivered around child parent abuse?
12. Was anything known about the perpetrator? It is known that a restraining order was in place. What was agencies awareness of this and their response to the ongoing breaches. It is known that a Domestic Violence Protection Order was in place for 28 days in January. What was agencies awareness of this and any plans for when the order expired.
13. Did agencies consider the family holistically, consider what else is going on in people's lives and the intersectionality, in particular an older person in the household and community, the family links with the traveller community and the impact of substance abuse on both the user and those residing with him.
14. What areas of good practice have agencies identified during this review.

## **5 Methodology**

- 5.1 The initial panel meeting was held in February 2024 when the Terms of Reference were agreed. The Individual Management Reviews (IMR's) were completed by agencies and a second panel meeting was held in June 2024. The third panel meeting was in October and a fourth scheduled for November 2024.
- 5.2 The panel considered information held by agencies between January 2017 and February 2020. If any agency identified information prior to that date that was relevant, then it could be summarised or included in the Individual Management Reviews (IMR). The reviews included both documentation and in person interviews.

## 6 Family Engagement

6.1 The Chair has met with family members who agreed to engage with the wider family. There was an open offer to meet individually with any family member who wished more personal engagement. They were provided with literature in relation to advocacy through AAFDA<sup>4</sup> and explaining the process of the review. The family were also provided with the terms of reference and given an opportunity to ask for any changes or additional areas to be considered. There was no request for any amendments.

## 7 Contributors to the Review

### 7.1

	Independent Chair and Author
IMR	Surrey Police
Report	Surrey and Borders Partnership Access (drug & Alcohol support service)
IMR	Probation Spelthorne Locality Team
IMR	Surrey and Heartlands ICB(GP)
IMR	North Surrey Domestic Abuse Service (NSDAS)
IMR	A2 Dominion Housing Association
IMR	Surrey County Council Adult Social Care
Information	Director of Disabilities Surrey Council
	Community Safety Partnership
Information	Multi Agency Risk Assessment Conference (MARAC) Surrey Safer Communities
	Domestic Homicide Review Co-ordinator
	Admin Support

7.2 All the authors of the information management review, and the information reports, were independent of the case i.e. they were not involved in the case and had no direct management responsibility for any of the professionals involved. All agencies included any relevant information about Lilly, Andrew and Angela. The GP only provided information about Lilly in line with their information management disclosure policy. They would not disclose information about either Andrew or Angela without written consent. Andrew has not engaged in the process. Angela did engage to the extent of being interviewed in person. She did not provide written consent for her medical records to be accessed.

## 8 The Review Panel members

Julie Mackay	Independent Chair and Author
Andrew Pope	Surrey Police
Claudine Cox	Surrey and Borders Partnership Access (drug & Alcohol support service)
Kelly Masters	Probation

<sup>4</sup> <https://aafda.org.uk/>

Rebecca Eells	Surrey and Heartlands ICB(GP)
Sarah Macleod	North Surrey Domestic Abuse Service (NSDAS)
Wendy Charles	A2 Dominion Housing Association
Asmine Bessey	Surrey County Council Adult Social Care
Will Jack	Community Safety Partnership
Sonia Knight	Multi Agency Risk Assessment Conference (MARAC)
Georgia Thame	Domestic Homicide Review Co-ordinator
Joanna Sanders	Admin Support

8.1 All panel members were independent and held strategic roles within the agencies that they represented. They reviewed the IMR's and contributed to all panel meetings. The panel met on a total of four occasions.

8.2 The Chair invited Parental Education Growth Support (PEGS) to the second panel meeting to provide agencies with an insight into child to parent (and grandparent) abuse. Many agencies have not received any training or input into child/parent abuse.

## 9 Author of the Overview Report

9.1 The independent Chair and Author, Julie Mackay, was a Senior Officer in policing in Avon and Somerset, Wiltshire and Gloucestershire Constabularies. Her responsibilities included the investigation of domestic abuse, safeguarding victims and a PiP 3 and PiP 4 Senior Investigating Officer involved in homicides and unexplained deaths. She has undertaken the accredited training and the updated training (2024) which is delivered by AAFDA. She is trained as a review officer (in policing) and has substantial experience chairing multi agency panels and boards, preparing comprehensive reports and analysing substantial volumes of information.

The Chair has not worked in the Surrey area and is independent of all individuals and agencies involved in this review.

## 10 Parallel Reviews

10.1 There were no other parallel reviews. The Inquest into the death of Lilly was delayed by HM Coroner in order for this review to take place.

## 11 Equality and Diversity

11.1 Protected characteristics that have been identified are age for Lilly as an older person. As a female Lilly is more likely to be a victim of domestic abuse than a male making it a gender enabled crime. The presence of child to parent abuse has been identified as a contributory factor. The Crime Survey for England and Wales year ending March 2023 identified approximately 3.2% of individuals aged 60 to 74 and 1.4% aged over 74 reported experiencing domestic abuse.

11.2 Lilly had a background in the travelling community where she grew up. This protected characteristic was identified in the review. She had moved away from

this lifestyle when she married but retained several of the values and traditions that stemmed from her heritage.

- 11.3 As a female Angela was more likely to be a victim of domestic abuse than if she were a male. The protected characteristic of sex is identified and recognised for both Lilly and Angela. The office for national statistics report for March 2023 showed approximately 93% of victims were women whilst 7% were men.<sup>5</sup>
- 11.4 The comprehension of domestic abuse suffered by older generations has not been well understood historically. Until recently older people were invisible in official statistics – until 2021, [following a successful campaign by Age UK](#), people aged 75 and older weren't asked about their experiences of domestic abuse in the survey from which the official statistics are derived.
- 11.5 Current data shows that one in twenty people aged 60-74 and one in thirty people aged 75 and over experienced domestic abuse in the past year, equivalent to 700,000 older people. And these statistics are also likely to be an underestimation of the issue. This is because older people might not always recognise what is happening as domestic abuse, they might feel shame, or they might find it difficult to speak out after years of abuse.<sup>6</sup>
- 11.6 Victims aged 61+ years are much more likely to experience abuse from an adult family member than those aged 60 and under 44% compared to 6% This is higher than the perpetrator being a current partner ( 40%)  
Adult familial abuse also presents challenges as “there seems to be a number of adult children who are experiencing some type of mental health issue including problematic alcohol and/or substance use, however, unless they are a risk to the community, services are not likely to intervene”.
- 11.7 Recognising the barriers faced by older victims of abuse can support disclosure. IDVAs who work consistently with older victims and survivors have identified that it may take several attempts at engagement or professional curiosity , in particular by GP services where there is an increased likelihood of interaction , before there will be any disclosure. Illness may mask the causation, in particular depression and low mood which can easily be considered to be linked with other physical conditions. Comprehending the home dynamics is a key factor to helping to identify abuse , particularly when adult children/grandchildren are perpetrators.
- 11.8 The barriers that Lilly may have encountered through her cultural heritage in the traveller community were more likely to have been masked. This is due to a

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<sup>5</sup><https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/bulletins/domesticabuseinenglandandwalesoverview/november2023>

<sup>6</sup> <https://www.ageuk.org.uk/discover/2025/december/shining-a-spotlight-on-domestic-abuse-in-older-people/>

lack of awareness or understanding by some agencies of her heritage. Her current lifestyle was not one of the “travelling” community, in that she was established living in her own home within a community. She had lived there for many years, which again may have hidden cultural background. However, for those who knew and recognised her traveller roots the pride and feelings of commitment to family, along with well documented approaches to being able to deal with matters internally could see that she maintained those values.

11.9 As research and understanding of domestic abuse within the traveller community and barriers to accessing help and support improve, awareness needs to be broadened to include older members of the community and those who may still retain the links but reside within other communities thus potentially making their culture and beliefs hidden. Professional curiosity and inquisition into an individual’s life and history can identify this. This was evidence through the interactions that adult social care had when conducting an assessment.

11.10 The traveller movement is an organisation that has been established to support victims of domestic abuse from this community, understanding the challenges and barriers faced, in particular internal pressure from families along with feelings of shame or bringing shame upon themselves and their families. The article breaking the silence highlights these by a survivor.<sup>7</sup>

## **12 Dissemination**

12.1 The report will be shared with all panel members and their respective agencies. It will also be shared with HM Coroner and the Police and Crime Commissioner for Surrey and the Crown Prosecution Service. The report will be shared with the Domestic Abuse Crime Commissioner.

12.2 The report was shared in draft format with family members. Family members had time to consider the terms of reference, time to read and digest the report and to provide any feedback. The limited feedback provided was acted upon.

## **13 The Facts**

13.1 Lilly died in April 2020, the cause of death has been recorded as traumatic head injury and pneumonia. She had been admitted to hospital in February 2020 from her home address. There had been an incident which involved her grandson, Andrew, who was living at the house with her and her daughter, his mother Angela. When ambulance crews attended Andrew reportedly stated that “It was just a domestic”. There was very little detail ever provided by any individual to police regarding what had occurred.

13.2 It was established that during the incident Lilly had fallen and sustained a head injury. She provided accounts that she had been hit on the head with an ashtray by Andrew and a differing account that she had fallen. Andrew was arrested by Police but not charged with any criminal offence in relation to this

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<sup>7</sup> <https://travellermovement.org.uk/news/october-2024-breaking-the-silence>

incident at that time. He was charged with breaching a restraining order that was in place.

- 13.3 HM Coroner opened an Inquest which has been adjourned to allow for the Police investigation to be completed and then for this review to be carried out.
- 13.4 Lilly was born into the travelling community, and her family have described that she retained her values from this throughout her life. She married a man who was not from the travelling community, and they lived in the Southeast of England for all their lives, moving to Surrey where they settled. Together they had seven children. Lilly's husband died approximately 30 years earlier. Lilly worked for 55 years selling flowers in the local market, a job she loved and was sorry to have to retire from.
- 13.5 Family have described Lilly as the Matriarch of the family; she had a strong personality and was unmoving in her approach or views. Growing up her daughters were expected to stay at home and do the household chores whilst the boys were expected to take part in more traditional roles, involving manual labour. This traditional approach of favouring the male members of the family extended to her grandson.
- 13.6 Angela was Lilly's youngest daughter. She had three children who were all the subject of care placements due to her drug addiction. Two children were put into foster care and the youngest Andrew went to live with Lilly, he was 7 years old at the time.
- 13.7 Angela subsequently went to live with Lilly and Andrew after successful treatment for her drug addiction.
- 13.8 Different family members describe Lilly doting on Andrew since he was born. Angela believes this is because Lilly felt protective towards him as she, Angela, was unable to care effectively for him. She states that throughout Lilly spoilt him rotten. Other family members describe Lilly as idolising him. From a young age Andrew received money from Lilly. She received the child benefit and social security from Angela and this in turn went straight to Andrew.
- 13.9 It is believed that Andrew first began to smoke cannabis at around the age of 12 years. He later went on to regularly take cocaine, this is believed to have been around eight years ago, when he was in his early 20's. The drug that caused the most extreme behaviours from him was alcohol. Family have described his violent moods would usually come when he had been drinking.
- 13.10 Andrew is described as very manipulative, he would cry and apologise after behaving badly towards Lilly and say he was sorry, and it wouldn't happen again. Everything Lilly had she gave to him: When doing the food shop Lilly would forgo a piece of fish that was £5 as it was too expensive, but buy anything that Andrew wanted, no matter the cost.
- 13.11 Andrew would reportedly kick off every morning demanding money which Lilly would give him. "I just give it to him as it gets him out of my sight for the day" she

told her family. In later years Lilly said, "I'm ready to go, to not be tortured every day of my life". On occasion Andrew had moved out, but even then, Lilly still cooked for him every day and did his washing.

13.12 The family stated that Andrew was very possessive over his things. He would get angry if anyone even moved his trainers or went to pick up a glass he was drinking from. He would not let Lilly wash any other items with his clothes. It was known that he locked the doors so that Lilly and Angela could not leave the house.

13.13 Family members did go to the house and try to intervene. They would challenge Andrew and his behaviours and speak with Lilly, but she would ask them to leave, saying "He will calm down when you have gone".

13.14 When asked what it was like living in the house with Andrew, Angela replied, "It was like living in a mental asylum". "He was regularly violent when he had been drinking alcohol, he would fall out with other people and get beaten up by them but often give us (Lilly and I) a slap, spit in our faces or pull our hair. I couldn't leave as Mum wasn't safe there with him "

13.15 Angela described an occasion when Andrew was particularly violent, she believes that he had consumed a bottle of gin that was hidden in the house and states that his eyes had a vacant look. She said he had tortured them all night, they couldn't sleep and weren't allowed to move, having to remain seated in the chair(s). He had smashed up lots of items but wouldn't allow any of it to be cleared up in case the sound of the hoover alerted the neighbours. It was the following day when someone called Lilly on the phone that she was able to ask for help.

13.16 Angela had tried to seek help. When the Police attended, she was prepared to provide a statement, but as she sat in the living room explaining to the officers what had happened, she was smoking. A senior officer attended and said that his staff should not be exposed to the smoky atmosphere, and her statement was not completed. Angela said she was traumatised by the events and needed to smoke, there was no alternative considered, such as being outside. Angela cites this as a reason for her disengaging with the police. This is in the context of previous occasions where a prosecution has not reached the evidential threshold test. Additionally, Angela has experienced conflict with law enforcement when she had been drug dependent. Police did re-visit both Angela and Lilly in an effort to gain co-operation but the barriers at the time were insurmountable.

13.17 Neighbours were aware of the violence in the household but would not intervene. It is unclear whether they were afraid or if they just did not want to be involved in any way. Angela described an occasion when Andrew was hitting her head on the concrete outside the front of the house, the neighbour saw what was happening but did not intervene. On another occasion Lilly had called out for help but was ignored.

13.18 The abuse was never discussed in the household, either with Andrew or between Lilly and Angela. Angela thinks this is because Lilly felt ashamed and

embarrassed, and she did not feel empowered to do anything about it. This was echoed by other family members, who also stated that they did not feel able to raise concerns or to intervene.

## 14 Chronology

- 14.1 Police have a significant history of responding to reports of domestic abuse and other offences involving Andrew as the Perpetrator. Between 2003 and 2016 there were 48 reports of such incidents. Given the young age of Andrew (under 16 years) not all of these are recorded as a domestic incident. These incidents involved Lilly and Angela as well as other family members. Lilly is recorded as being a victim in 15 of 23 crimes that were recorded.
- 14.2 An open-ended protection from harassment order was issued at Southeast Surrey Magistrates Court on 19th September 2013. The order was varied on 17th March 2015 and 13th October 2016 at Kingston Crown Court. The restraining order was placed on Andrew in respect of Lilly and Angela. The most recent conditions in respect of each prohibited Andrew from 1) Intimidating, harassing, pestering, or threatening Angela or instructing, encouraging or in any way suggesting that any other person should do. 2) Use or threaten violence against Angela or instruct, encourage or in any way suggest that any other person should do so. 3) Intimidating, harassing, pestering, or threatening Lilly or instructing, encouraging or in any way suggesting that any other person should do. 4) Use or threaten violence against Lilly or instruct, encourage or in any way suggest that any other person should do so.
- 14.3 In January 2017 the GP noted several interactions with Lilly who was unwilling to have medical tests. She was medicated for one issue. In February 2017 Lilly reported anxiety and panic attacks. The cause of the anxiety and panic attacks was not explored by the GP.
- 14.4 Throughout 2017 there was interaction with the GP surgery and Lilly, who was reluctant to engage with any medical diagnosis or alteration to her medication. Her family have stated that she was always very accepting of any health condition and did not want any medical intervention, approaching illness in a manner that when her time is up, she will be very accepting of that.
- 14.5 Police have history of attending the address in 2017 when reports have been made involving altercations between either Angela or Andrew and other parties not residing at the address. No interventions were taken; all incidents are recorded. It is unclear why no positive action is taken.
- 14.6 In December 2017 the GP conducted a home visit. Lilly again referred to feeling anxious, but this was attributed to physical ailments. There was no probing about the home situation, Angela was present when the GP visited, Andrew was not. The GP was unaware of MARAC referrals.
- 14.7 In August 2018 there was a MARAC meeting held following the arrest of Andrew after Police were called to an incident at the premises. Andrew had been asking for money and had threatened to smash a mirror over Lilly's head if she didn't give it. Lilly and Angela described an ongoing situation with threats of

violence or assaults. Angela stated that he had threatened to kill her and Lilly. Lilly stated that she felt that one day he would kill her or the stress of living with him would. It was identified that there had been 11 incidents in the previous 12 months. There was a protection from harassment order in place, but this was not enforced as Lilly continued to state that he was welcome at the property.

- 14.8 There were no clear actions from MARAC other than for Police to review the restraining order and a referral to Outreach (the domestic abuse support service provider at the time). A follow up states that the lack of support from the victim's Lilly and Angela is a barrier to any measures being put in place.
- 14.9 North Surrey Domestic Abuse Service, Outreach, have a record of a referral for Lilly who is the victim of domestic abuse, the perpetrator being her grandson. She did not wish to engage with the service and so there were no further interactions. It is recorded that Andrew has a complete disregard for the law and does not abide by any conditions or sanctions.
- 14.10 Angela was recorded as engaging with Outreach on occasions and subsequently Outreach have tried to assist with the housing situation.
- 14.11 Housing was contacted by an outreach worker on behalf of Angela when she was seeking alternative accommodation. There were several barriers to this, often her animals. There is no record of preventing Andrew from residing at the property. No record of subsequent MARAC in January 2020 or any actions for housing.
- 14.12 Throughout 2018 up until April 2019 Lilly had some contact with the GP surgery, usually via telephone or letter. She did not wish to engage with tests for her medical condition and did not attend scheduled appointments at hospital. Her last contact was in April 2019.
- 14.13 In October 2018 Angela called police reporting that she had been assaulted by Andrew, whereby he had pulled out a chunk of her hair. It is recorded that there was no evidence of hair missing or any pulled hair located inside the house. Andrew was arrested, and subsequently taken to hospital as he stated he had consumed crack cocaine. His behaviour towards staff at hospital and Police was violent and spitting. He underwent a mental health assessment and referred to drug and alcohol support services.
- 14.14 The assessment of Andrew recorded that he had taken cocaine with the intention of harming himself and was seen by the Psychiatric Liaison clinician at the hospital. They noted no evidence of any thought disorder although he described thoughts of hurting people. He denied experiencing any auditory or visual hallucinations. Andrew described his mental health issues as relating to anger, low motivation, and feeling sad and isolated. He connected this to an accident in 2014 which left him having to use a wheelchair for almost two years. He stated that his anger was from trauma and his drug and alcohol misuse. At this time, he disclosed that he smoked cannabis daily, used cocaine every other day and would binge drink alcohol. Andrew described wanting help with his mental health and substance misuse as he "does not like the person he becomes

– violent, angry and aggressive.” He was referred to i-Access (the alcohol and drug support agency).

14.15 It was identified that the parties involved had been heard at a Multi-Agency Risk Assessment Conference (MARAC)<sup>8</sup> on two occasions in 2016 and this incident was “noted” at MARAC. The existence of a protection from harassment order preventing Andrew residing at the address was identified and he was charged with breaching this, assault on Angela and assaulting police officers. The Crown Prosecution Service (CPS) offered no evidence in respect of the Domestic Abuse and breach of restraining order, and he was convicted for the other matters. The reason for not offering evidence is not recorded.

14.16 Adult Social Care received the referral from police, and after making efforts to engage, which were initially unsuccessful, a joint visit with police was conducted. Lilly was described as well presented, articulate and engaged during the visit. The outcomes that Lilly sought were for Angela to have her own place and for Andrew to come off drugs. She stated that she loved them both. She stated that whilst Andrew was currently in prison, Angela did not want to give evidence against him. The imprisonment had also prevented him from attending an appointment with ‘Catalyst’ a drug support agency.

14.17 Lilly was not identified as having any care or support needs, as defined by Section 42 of the Care Act 2014 <sup>9</sup>“She is independent with her personal care tasks and her daughter completes all household chores for her including the shopping, cooking and walking the dogs - grandson has 3 dogs. The house was immaculate. She walks independently indoors.” Lilly stated that her grandson does not coerce or force her into giving him money. He would not steal her money, take money from her purse or use her card. Lilly manages her own finances. She stated that her grandson usually asks her for money and nags her saying things like, 'please, why, I won't ask anymore' but never gets physical with her. Lilly stated that she gives him money when her patience is worn thin and she could not take his nagging anymore, nonetheless, she loves him to bits. She does not feel scared or in danger because of him; “he is a lovely lad”, she stated.

14.18 There was discussion about her medical conditions and medication. Lilly stated she had a large family who were supportive, there was no disclosure regarding any abuse or the situation that had led to the referral. The case was closed.

14.19 In November 2018 probation notified Police that Andrew was due for release and asked for markers to be placed on the system for the home address of Angela and his sister as he was a risk to both. No details as to why this is the case. He provided his sisters address as his home address; intelligence was

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<sup>8</sup> <https://safelives.org.uk/about-domestic-abuse/domestic-abuse-response-in-the-uk/what-is-a-marac/>

<sup>9</sup> <https://www.legislation.gov.uk/ukpga/2014/23/section/42>

received that he was back residing with his mother and grandmother in December 2018. A check at the address did not locate him there.

- 14.20 In March 2019 Police were contacted by the support worker of Andrew's brother, who was aged under 18 years. She informed police that whilst at Lilly's address Andrew allegedly held a knife to his throat, threatened to stab him and stab his father. He was contacted but unwilling to speak with police, he was persuaded to meet away from the home. He advised police that there had been an argument between them with Andrew being rude about his friends. When Andrew was losing the argument, he then made threats to stab his father and father's girlfriend. There were no weapons involved.
- 14.21 A Single Combined Risk Assessment of Risk Form was raised with a medium risk to a child, with a high risk identified in respect of Andrew. These were shared with children services, adult social care and the school as part of operation Encompass 10 (the sharing of safeguarding information between police forces and schools).
- 14.22 In June 2019 Adult Care received a referral from the GP advising that Lilly had failed to attend any appointments. A number of telephone calls made, and letters were sent over the next six months, but no response was received.
- 14.23 In the early hours of Boxing Day 2019 a family member contacted police concerned for the safety of Lilly and Angela. When they attended police were informed by Lilly that Andrew had returned at 3am and woke her up by repeatedly punching her pillow, he was abusive towards her, smashed items within the house and damaged property. He had thrown cups of tea over her and threatened to poke her eye out and break her jaw if she talked back or called the police. This abuse continued over several hours and Lilly told officers she feared Andrew.
- 14.24 Angela reported that she too had been the subject of abuse, that they had been unable to contact the police as he had locked the door and threatened to kill them if they did. She disclosed to police having received a black eye when he punched her three weeks earlier and had sustained a cut lip where he kicked her, and she believed, a broken rib. Angela was aware of the prevention of harassment order, and that Andrew continued to breach it.
- 14.25 Angela stated she did not wish to make a report as in the past when she had, no change had happened. She stated she felt she had not been supported by police, courts or social services. Lilly felt unable to make a statement. A Domestic Abuse Stalking and Honour Based Violence (DASH)<sup>11</sup> risk assessment was completed with Lilly which scored 12, providing a medium risk assessment. Both Lilly and Angela were provided with Domestic Abuse kits. While the officers were

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<sup>10</sup> <https://www.operationencompass.org/>

<sup>11</sup> <https://safelives.org.uk/resources-library/dash-risk-checklist/>

in attendance Andrew telephoned Lilly who told him the police were looking for him to arrest him.

- 14.26 Andrew was arrested that day, Police did re-visit Lilly and Angela, but they “refused” to make statements. The case was referred to the Crown Prosecution Service who decided no further action due to evidential difficulties. There is no rationale recorded for this decision
- 14.27 A Domestic Violence Protection Notice (DVPN) 12 was served on Andrew and he was released from custody. When notified of the notice it is recorded that Lilly objected to its being served. There was no release address recorded but it is believed he went to his sister’s address. A Domestic Violence Protection Order (DVPO) 13 was obtained at court which was valid for 28 days.
- 14.28 A Single Combined Risk Assessment of Risk Form (SCARF) was submitted for Lilly and Angela, each scored 2/3 and this was shared with Adult Services. The SCARF form incorporates the DASH risk assessment and includes both adult and child referrals, where appropriate, it is a form that is bespoke to Surrey Police. Domestic Abuse Stalking and Honour Based Violence Abuse risk assessment (DASH) was also completed for both Lilly and Angela. This scored as high risk and referral to MARAC and Outreach<sup>14</sup> (Domestic Abuse support service in Surrey) was made.
- 14.29 Adult Social Care received the referral from Police, and at the beginning of January 2020 and conducted a visit to assess any care needs for Lilly. Other than bathing assistance it was established that all needs were being met by Angela.
- 14.30 The next contact at the end of January established that Andrew had returned, and Lilly was intent on caring for him. Adult Social Care were in the process of arranging a joint visit with Police when the incident on the 20th February occurred.
- 14.31 Police conducted regular checks throughout the 28 days that the DVPO was in force to ensure that Andrew had not returned to the property. Lilly maintained that she would welcome him back once the notice had expired, but he had not been staying at the property whilst the notice was in place.
- 14.32 There was a report that Andrew had been involved in an altercation with individuals with who he was staying. This was apparently in relation to his drugs

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<sup>12</sup> <https://www.gov.uk/government/publications/domestic-violence-protection-orders/domestic-violence-protection-notices-dvpns-and-domestic-violence-protection-orders-dvpos-guidance-sections-24-33-crime-and-security-act-2010>

<sup>13</sup> <https://www.gov.uk/government/publications/domestic-violence-protection-orders>

<sup>14</sup> <https://familyinformationdirectory.surreycc.gov.uk/kb5/surrey/fsd/service.page?id=lxzN9QtDbgU>

being spiked and property stolen. No action was taken by police as Andrew disengaged.

- 14.33 In January 2020 there was a complaint made by a 15-year-old girl that Andrew had been staying at her family home and had tried to sexually assault her. The victim did not wish to make a formal complaint. Andrew was interviewed and stated that the girl had tried to instigate contact when he had consumed alcohol and cocaine. Referrals were made to children's services.
- 14.34 MARAC was heard for Lilly, Angela and Andrew on the 28th January 2020. Further referrals were made to Outreach. The DVPO had expired by this time.
- 14.35 In February Andrew was the victim of an assault. He was intoxicated at the time and would not engage with Police despite several attempts.
- 14.36 In February 2020 Ambulance attended the home address of Lilly and Angela following reports of Lilly suffering a head injury. Andrew reportedly was behaving in an aggressive manner and Police attended. At the scene it was reported that Lilly had slipped on some water, there was conflicting information that she had been hit with an ashtray. Andrew was arrested to prevent a breach of the Peace. He was later charged with breaching the harassment order and Assault Police.
- 14.37 In April 2020 Andrew was charged with Grievous Bodily Harm (against Lilly) and following her death was arrested for murder. The CPS subsequently discontinued the case as it did not meet the evidential threshold test.
- 14.38 Angela was initially treated as a witness who required special measures. Forensic outcomes subsequently led to her arrest for perverting the course of justice. She was not charged with any offence.

## 15 Analysis

- 15.1 Andrew's younger years were impacted by the substance misuse of his mother which led to him being separated from his siblings and being removed from the care of his mother, Angela. To try and reduce the impact of these experiences upon him Lilly was keen from the outset to provide a secure environment for him to grow up in.
- 15.2 Childhood Experiences (ACEs)<sup>15</sup> are "highly stressful, and potentially traumatic, events or situations that occur during childhood and/or adolescence. There are several factors that can lead to these experiences; included are substance misuse by a parent and separation from a parent. Behaviours can include violence towards others or becoming a victim of violence.
- 15.3 Andrew's behavioural challenges commenced from a young age, 10 years, and he became aggressive towards others, including his own family members. The circumstances that surround child to parent abuse (CPA) are still being

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<sup>15</sup> <https://mft.nhs.uk/rmch/services/camhs/young-people/adverse-childhood-experiences-aces-and-attachment/>

understood as research evolves that helps to identify both triggers and coping strategies. In Andrews case he was born to a drug dependent mother. His formative years were in a chaotic home before he went to live with his maternal grandmother and was separated from his siblings who were placed into foster care. Comprehending the impact of these experiences as he grew up is important in relation to the behaviours, he went on to display. He later disclosed to professionals witnessing violence as a child.

15.4 Child to Parent Abuse is defined as: A pattern of behaviour which involves verbal, financial, physical and/or emotional means to practise power over a parent, such that a parent adapts their own behaviour to accommodate the child. Commonly reported abusive behaviours include name calling, threats to harm self or others, attempts at humiliation, damage to property, theft and physical violence.<sup>16</sup> (Holt, 2016:1) Lilly did not formally disclose the nature of the abuse to any agency, it is known from the time that Angela spent living in the household that it was both physical and emotional abuse.

15.5 Studies indicate varying prevalence rates, with estimates suggesting that between 5% to 10% of families experience CPA. Factors such as family structure, socioeconomic status, and cultural background can influence these rates.

Risk Factors;

- Family Dynamics: Dysfunctional family environments, including high conflict, poor communication, and a lack of parental supervision, can increase the risk of CPA.
- Mental Health Issues: Children with behavioural disorders or mental health challenges are more likely to exhibit aggressive behaviour toward parents.
- Substance Abuse: Parents struggling with substance abuse may have a higher incidence of CPA, as it can disrupt family stability and parental authority.

15.6 Impact on Parents/Grandparents; Victims of Child Parent Abuse often experience significant emotional distress, including feelings of guilt, shame, and fear. This can lead to mental health issues such as anxiety and depression. Lilly did disclose anxiety over several years and was treated by her GP. She did not disclose any one thing that was contributing to the anxiousness. Some parents may develop coping mechanisms that can inadvertently enable the abuse to continue, creating a cycle of violence.

15.7 Research shows that a female carer is more likely to be the victim of abuse than a male carer on the ratio of 8:2<sup>17</sup> (Simmons et al 2018).

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<sup>16</sup> <https://hmiprobation.justiceinspectrates.gov.uk/document/child-to-parent-abuse/>

<sup>17</sup> [https://www.researchgate.net/publication/321166806\\_Sixty\\_years\\_of\\_child-to-parent\\_abuse\\_research\\_What\\_we\\_know\\_and\\_where\\_to\\_go](https://www.researchgate.net/publication/321166806_Sixty_years_of_child-to-parent_abuse_research_What_we_know_and_where_to_go)

#### 15.8 Cultural Considerations:

Cultural attitudes toward discipline and authority can influence the perception and incidence of CPA. Understanding these cultural contexts is essential for developing effective interventions. In this case the Traveller cultures that have been described would be considered to having an influence on the response to the abuse, alongside a reluctance to disclose to or engage with agencies.

#### 15.9 Recent Research Trends:

There is growing interest in the long-term effects of CPA on both parents and children, including potential cycles of violence in future relationships.

Studies are also exploring the role of technology and social media in exacerbating or mitigating CPA. In this case there was not any evidence of utilising technology to enable the control to operate or as another form of abuse.

In cases involving older victims, those aged over 60 years, 32% are living with the perpetrator and 44% experience abuse by a family member.

The reasons for inconsistent approaches to support for older victims of domestic abuse include factors such as:

- services typically being set up with younger clients in mind
- older people being less likely to call 999
- particular cultural or generational attitudes that often exist towards marriage and family life.

15.10 Abuse can often be hidden behind other physical and mental health conditions, and a lack of awareness among some professionals prevents recognition of this underlying cause.

15.11 National recommendations for MARAC involving older victims of abuse include establishing a trusted agency to act as single point of contact, and the setting up a multi-agency approach prior to MARAC with clear action planning.

### **16 Police**

16.1 There is a long-recorded history of interaction between the police Andrew, often as a perpetrator with Lilly and Angela as victims. There were previous incidents of the case being heard at MARAC in 2016 and 2018. The Police have responded to all reports of domestic abuse and have taken positive action arresting the perpetrator.

16.2 The challenges with providing sufficient evidence to CPS to ensure that the matter progressed to court resulted in an early decision by CPS that the case did not meet the full code test and therefore the perpetrator was not charged with an offence. This was in 2017. The impact of this upon Angela was a loss of confidence in the judicial process.

16.3 Angela did make further disclosures to the Police of domestic abuse, the most significant being in 2019. When she felt unable to support a prosecution through the judicial process, she states because of a lack of trauma informed approach, the Police were unable to proceed with an evidence led prosecution. The reason for this was a lack of disclosure to the police by Angela that she was in fear, this

is a criteria that is required for hearsay evidence to be considered as being admitted in the court process (R v RIAT [2012])<sup>18</sup>. It is unclear if the disclosure of fear to another agency would have been sufficient. A pathway for identifying such a disclosure could be through the MARAC process. Nationally there is more of a focus on utilising other evidence to support prosecutions where a victim is unable to engage. Establishing fear is not always a requisite for the CPS to support a charging decision.

16.4 Positive intervention was taken in respect of the Restraining Order that was in place. There was an inconsistent approach by CPS in authorising a charge in respect of a breach. In 2017 there was no charge, because of lack of victim support. Yet in April 2020, following the incident in February 2020, there was a successful prosecution for the breach of the restraining order despite neither Lilly nor Angela either being in a position to support the prosecution: In Lilly's case it was due to her ill health and subsequent sad death. In Angela's case she had withdrawn from supporting any police prosecution and was latterly arrested in relation to the incident in February 2020. No charges were ever forthcoming in respect of that matter.

16.5 At the time of the incidents attended by police the DASH risk assessment process was utilised. A review of the risk assessments has identified that it was utilised on every occasion. There was one occasion when the grading was medium and in fact it should have been high. The lack of supervisory oversight on this occasion resulted in this not being identified as an error.

16.6 Surrey Police are moving across to the Domestic Abuse Risk Assessment (DARA)<sup>19</sup> risk assessment tool, as recommended by the College of Policing. It is anticipated that the transition will be completed by 2025. This risk assessment tool is focussed upon those residing within the address. The DASH risk assessment tool is more focussed upon the intimate partner relationships. Through this change the risks associated with child/parent abuse should be identified more easily and graded appropriately. There is additional training for supervisors overseeing the domestic abuse risk assessments.

16.7 The use of a Domestic Violence Protection Notice (DVPN), followed by a Domestic Violence Protection Order (DVPO) in December 2019 was a positive intervention. This was supported by regular checks at the premises to ensure that there was not a breach.

16.8 An unforeseen consequence of the DVPO was no suitable accommodation for Andrew to be relocated to. This resulted in him becoming both a victim of crime and a perpetrator of crime (against a vulnerable victim). There is no evidence of any safety planning either for the period when he was displaced, nor for when he

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<sup>18</sup> <https://www.cps.gov.uk/legal-guidance/hearsay>

<sup>19</sup> <https://library.college.police.uk/docs/college-of-policing/Domestic-Abuse-Risk-Assessment-Rationale-2022.pdf>

returned to the property at the end of the 28 days. The MARAC hearing was not listed until after the lapse of the DVPO.

16.9 **A recommendation for consideration:** Police ensure safety planning for perpetrators who are displaced as a consequence of a DVPO and for when they return to the home address. This is being addressed through the MATAC process which has been established following a Domestic Abuse Thematic Inspection by His Majesty's Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS) in 2022.<sup>20</sup>

16.10 The aim of the MATAC process is:

- tackling the most harmful and serial Domestic Abuse perpetrators
- keeping Vulnerable families safe
- Seeking harmful perpetrators out and trying to change their behaviour and stop reoffending
- Offering programmes "like healthy relationship 7 pathways"

The office of the Police and Crime Commissioner is overseeing and supporting the funding of perpetrator focussed programme.

16.11 The MARAC process that was in place up until 2020 has been identified as not being effective. There were a lack of minutes, a lack of recorded actions and no process for ensuring that actions were completed. This process has since undergone a review, and new ways of working have been implemented

## 17 Adult Social Care

17.1 There was a lack of an appropriate response by adult social care in 2018 when a section 9 care assessment could have been carried out following the safeguarding concern that had been raised.

17.2 When a further safeguarding concern was received in early December 2019 efforts were made to contact Lilly by telephone and letter. When no response was received the case was closed. It has been identified that good practice would have been to conduct an in person visit.

17.3 Following the referral made on 26<sup>th</sup> December 2019 there was an early visit, within 7 days, where adult social care did carry out its obligation under section 42 of the Care Act 2014. This was good practice and enabled early intervention which was important as the MARAC hearing was not until nearly a month later.

17.4 The focus of the visit was on the physical care needs of Lilly and there was a lack of understanding of the emotional needs as a consequence of the ongoing abuse. Through the learning of this review and the broader and ongoing upskilling of staff in respect of domestic abuse there are now additional inquiries made around the individuals wellbeing.

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<sup>20</sup> [https://www.surrey-pcc.gov.uk/hmicfrs\\_responses/hmicfrs-report-mappa-twenty-years-on/](https://www.surrey-pcc.gov.uk/hmicfrs_responses/hmicfrs-report-mappa-twenty-years-on/)

- 17.5 There were no multi agency risk assessments recorded on the internal systems. There were opportunities to have a multi-Agency multi-discipline team (MDT) meeting involving all of those involved with Lilly and Andrew. The chronology did not show, clearly, how the different agencies viewed the risk or come together to manage the risk as a multiagency, nor did it show Lilly's view of risks or risk management, apart from not wanting to see her grandson out on the street homeless.
- 17.6 Surrey County Council has a policy for assessing and recording risk, and a new LAS tool has been developed to assist staff. Lilly's situation necessitated collaboration among various agencies to share expertise and contribute to the optimal plan for support and protection. Policies are in place to facilitate this in Adult Social Care, and Surrey County Council are taking measures to ensure that all workforce levels are aware of and confident in completing these tasks.
- 17.7 At this time there was no management oversight of the MARAC process and the tracking of actions. This was reflected in the lack of risk assessment conducted as a consequence of the MARAC in January 2020 and ensuring a timely and appropriate response was put in place. The process has improved with the change to the MARAC process.
- 17.8 Since 2020 Surrey County Council have launched their Adults Social Care Training Academy which delivers an improved training offer. Domestic abuse training is offered to all new staff and existing staff as a refresher.
- 17.9 **A recommendation from this review is** : Reflective learning session be held for Surrey County Council staff to share local learning with the North West area of Surrey and broader with the practice and development improvement team for wider county learning.

## 18 GP Practice

- 18.1 The GP practice only had Lilly as a patient and were unaware of the other family members residing at the address or the dynamics within the address. Lilly had a number of ongoing medical issues that she had declined treatment for. There was no professional curiosity or consideration that domestic abuse was present in the home. The disclosure and treatment for anxiety was considered to be related to physical health issues.
- 18.2 The GP surgery was not notified of the MARAC meetings in either 2018 or 2020. This has now changed so that notification is sent to all agencies regarding individuals who are being heard at MARAC. This enables relevant information sharing and for flags to be added to patients' records. This in turn will prompt a targeted inquiry into a patients' circumstances to enable a more holistic approach and tailored support to be implemented. This was identified as learning in a previous DHR.
- 18.3 All Surrey GP practices have an all-age safeguarding policy, which includes domestic abuse. This was first introduced within the safeguarding adult's policy in 2018, evolving into an all-age policy in 2022. Access to a safeguarding policy is a requirement of CQC inspection; the Surrey-wide model policy is updated annually

by the Surrey and Heartlands safeguarding team. The last update in June 2023 reflects the changes brought about following the Domestic Abuse Act 2021 and highlights the all-age nature of domestic abuse, and its presence within non-intimate partner relationships.

18.4 There has been a learning event webinar held in June 2024 “Learning from Surrey Domestic abuse related deaths” which was available for all staff to attend, or view at a later date. This is part of the ongoing learning and awareness for staff around domestic abuse and takes learning from reviews such as this one.

18.5 **A recommendation from this review is:** The Safe lives document “Safe Later Lives”<sup>21</sup> is shared with all Surrey GP practices both alongside and independently of the above webinar, to ensure the widest possible audience and increase awareness of the issues faced by our older patients experiencing domestic abuse.

## 19 North Surrey Domestic Abuse Service (NSDAS)

19.1 NSDAS followed all the correct practices. It would be down to the individual experiencing the abuse to provide consent for us to work productively with them. In this case consent was never provided to work with an outreach worker and Lilly did not consent to referrals or wish to engage with the service.

19.2 Angela did access support, and it is recognised that the IDVA<sup>22</sup> engaged with other agencies to try and support Angela. The conflict within the household and the complexity of the family dynamics is recognised as challenging and a potential barrier, especially for Lilly. On the back of this Andrew had no respect for the law or bail conditions or orders. That would have been a difficult barrier to overcome alongside the desire by Lilly to continue to support him as best she could.

19.3 **A recommendation from this review is:** to deliver child to parent/grandparent violence training to professionals, highlighting national domestic abuse and barriers to accessing support from victims within this community.

## 20 Housing

20.1 A2Dominion Housing were involved with Lilly and Angela. The first recorded interactions were following a MARAC hearing in 2016. Andrew had been arrested after he demanded money from Lilly and made threats against her and her property if she did not provide it. It was noted that Lilly was unwilling to support the police action, even though this was the 11<sup>th</sup> such incident in the previous 12 months. Initially Andrew was on remand but following his release he went back to

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<sup>21</sup> <https://safelives.org.uk/research-policy-library/safe-later-lives-report/>

<sup>22</sup> <https://saferfutures.org.uk/our-programmes/idva/>

the property. There is no evidence of securing alternative accommodation for Andrew at this point. A2Dominion Housing were not included on any safety plan.

20.2 A2Dominion Housing were unaware of the incident in 2018 that led to another term of imprisonment for Andrew. Probation had challenges tracking where he was living post release and there is no reference to information sharing between probation and A2Dominion housing so that suitable accommodation could be found for Andrew, thus reducing the risk he posed to others.

20.3 A2Dominion Housing does have a Domestic Abuse Policy<sup>23</sup> This Policy makes reference to “victim-survivor safety- We will create safer homes and communities where perpetrators are held to account for their behaviour” The lack of awareness of the domestic abuse occurring within the premises prevented any intervention from A2Dominion housing such as the relocation of Andrew. There were barriers to relocating Angela which centred upon being able to accommodate her dogs.

20.4 A2Dominion Housing were unaware of any further incidents as they were not invited to or notified of any further MARAC hearings. It was post the incident in 2020 that Angela reached out to them requesting a supported move as she was in fear.

20.5 The MARAC process has subsequently changed to include notifying all key partners which includes A2Dominion Housing. This is welcomed and A2Dominion are supportive of the change that has now been embedded.

## **21 Probation**

21.1 The Probation Practitioner was aware that Andrew had a traveller background and during interview they explored with Andrew some of the possible influences of his early experiences. Andrew disclosed having been exposed to violence from a young age and the Probation Practitioner recognised that this had an adverse impact on him growing up (ACE's). The Probation Practitioner also evidenced an insight into the difficulties that Lilly and Angela's individual circumstances and experiences may have had on their ability to report and address violent behaviour that had been perpetrated by Andrew.

21.2 During the review period identified for the purpose of this review Andrew was supervised by the Probation Service from the 23/11/2018 until the 22/11/2019. Andrew was subject to licence until the 27/12/2018 and thereafter probation support until the 22/11/2019. It is of note that the period under licence was short due to the length of sentence; however, upon reviewing the case the Probation Practitioner identified that additional licence conditions were required and varied the licence to add the following:

- Not to seek to approach or communicate with Lilly or Angela without the prior approval of your supervising officer

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<sup>23</sup> <https://a2dominion.co.uk/pdfs/domestic-abuse-client-policy.pdf>

- Attend Probation as reasonably required by your supervisor. To give a sample of oral fluid / urine in order to test whether you have any specified Class A or specified Class B drugs in your body, for the purpose of ensuring that you are complying with the condition of your licence requiring you to be of good behaviour
- To comply with any requirements specified by your supervising officer for the purpose of ensuring that you address your drug and offending behaviour problems at the Probation Centre

- 21.3 In reviewing the licence plan the Probation Practitioner was able to add additional licence conditions which were both necessary and proportionate to manage the risks. It is positive to note that this action was taken swiftly upon sentence and allocation of the case. Whilst there was a Restraining Order in place it is critical to ensure that these individuals are named on the licence so that it can be enforced should any concerns around increased risks to these individuals be identified.
- 21.4 Having reviewed case management records, it is evident that there were ongoing concerns around Andrew's compliance particularly whilst subject to PSS. He failed to attend numerous appointments, and his engagement appears to be somewhat superficial. Significant adjustments were made by the Probation Practitioner to accommodate Andrew including re-scheduling appointments and using professional judgement to make absences acceptable to promote compliance and engagement. Andrew had supplied the Probation Practitioner with medical evidence detailing a condition which caused significant pain / inflammation in his foot and Andrew asserted that on occasion this impeded his ability to attend appointments.
- 21.5 There was evidence of the Probation Practitioner drawing on theories of desistance and risk, needs and responsivity in management of this case. It was noted during interview that Andrew presented as someone with a very high level of needs and therefore required a lot of support. It seems that often his immediate presenting needs would take focus during supervision sessions. A key component of Probation practice is the need to use professional curiosity to enable our work with complex and challenging individuals. It is positive to note that the Probation Practitioner provided Andrew with practical support, and this also enabled them to build trust which enhanced the working relationship. However, it is clear that Andrew would often withhold key information pertaining to his risk, for example, details of where he was residing. This could have been challenged and explored in greater depth during supervision.
- 21.6 There were ongoing concerns around Andrew's accommodation situation throughout the period of supervision. The Probation Practitioner experienced difficulties in obtaining Andrew's address when he was residing with a relative. He claimed to be residing with another relative, despite their denials of this fact.
- 21.7 The dishonesty and obstructiveness exhibited by Andrew raises concerns around his compliance and engagement. It also impeded the Probation Practitioner from being able to make a fully informed assessment on the

suitability of any release address which is imperative to manage risk. The Probation Practitioner regularly consulted with their manager for oversight and input on the case. It was deemed having conducted a review of Andrew's risk assessment that he could remain living with his relative, but this would need to be closely monitored.

21.8 Probation did liaise with Police on a regular basis to obtain information and intelligence around any offending behaviour. They also requested an unplanned visit to the home address of Lilly to check compliance, which is good practice. A safeguarding referral was submitted relating to the other relatives where he was considered to be residing. These actions all demonstrate a proactive approach to managing risk.

21.9 The Probation Practitioner recognised the interface between Andrew's offending related needs and his risk. Significant efforts were made to engage Andrew with both mental health and substance misuse service and there is also evidence of signposting and advocacy in respect of housing and finances.

21.10 The probation service has as part of the ongoing learning and development programme for 2024/25 placed a focus upon using their professional curiosity as a key component to professional practice.

21.11 **A recommendation from this review** is that probation service should ensure that Probation Practitioners regularly access information and intelligence held within the Prison, particularly for immediate or 'time served' releases to inform release and resettlement planning and where there are concerns around risk / need.

## **22 MARAC (Multi Agency Risk Assessment Conference)**

22.1 During Lilly's lifetime the MARAC process was not managed in an effective manner. Not all agencies were either notified or invited to attend, preventing a cohesive multi-agency approach to the management and support of victims and perpetrators. The lack of minutes and tracked actions resulted in agencies not being fully sighted on the status of any outstanding matters.

22.2 In 2020 the responsibility for MARAC moved across to Surrey County Council. As part of the changes to MARAC effective administrative support was put in place to provide minutes and tracked actions.

22.3 All agencies are notified of cases being heard at MARAC which not only allows for more effective information sharing, but it also enables key flags to be added to the records of nominals.

22.4 The managing of actions and feeding back into MARAC was identified through this review as an area where information could get missed. There is generally a lead agency (usually outreach or the police) who would refer back into the process if there were further incidents or if it is considered that the risk is still high. Through this review it was identified that agencies could call a professionals meeting for those cases that may not require to be heard at

MARAC again but do require continuing oversight. This is a learning outcome that will be circulated to all.

22.5 The improvements to the MARAC process have been recognised as positive by all agencies. A consideration is that there should be a formal review of the process as part of the ongoing continuous improvement. This has been fed back into the MARAC steering group. They have agreed to seek to identify a successful and meaningful way to review the MARAC process, as a whole system – from point of referral to completion of actions and required follow up.

22.6 **A recommendation from this review is** for agencies to adopt the guidance in the safer lives MARAC for older persons, the aim of the report was to identify what's different about older victims' experiences of domestic abuse. The following were identified:

- Engagement with services
- Financial and housing issues
- Health/mental health issues

22.7 Prior to MARAC a single point of contact with a trusted professional should be established. A strategy/professionals meeting should be arranged with the right people around the table. There should be effective research and effective action planning.

## 23 Conclusions

23.1 The perpetrator, Andrew, exerted controlling and coercive behaviour towards the other occupants of the house. He consumed excessive amounts of alcohol and controlled drugs, and these contributed to extreme and violent behaviours.

23.2 He had exerted economic control and created an atmosphere of walking on eggshells which impacted on the wider family who felt helpless to intervene. Lilly was the matriarch of the family, a proud woman who did not feel able to disclose the true extent of the abuse or the impact it had upon her. Influencing factors were age and her background in the travelling community, which both created a culture of seeking to resolve issues within the family. Her desire was for him to seek and receive help and to protect him.

23.3 Angela carried guilt from her own dependencies and the impact that had on her children, in particular the perpetrator. Despite making a number of allegations to police regarding the abuse an early discontinuation caused a loss of confidence and subsequent disengagement with the judicial process. She did engage with support services and has subsequently made significant steps to be free from the abuse.

23.4 Since the sad death of Lilly there continues to be progress made both in legislation as well as policy when it comes to Domestic Abuse. The Domestic Abuse Bill 2021 has ratified in law additional offences and as part of the legislation being embedded. Agencies have undertaken a variety of mandatory learning to ensure their staff are sighted and aware of offences of coercive

control and the barriers and enablers of victims and survivors to make disclosures.

23.5 Surrey County Council has shown commitment to learning from previous Domestic Homicide Reviews and Domestic Abuse Related Death Reviews. The challenge now is to continue to build upon that in areas where there are barriers for victims still, either because of their age, or the nature of the relationship between the perpetrator and the victim. Continuing to work with third sector agencies such as hourglass who support the older generation, and PEGS who support families where there is child to parent abuse can help to remove the stigmas and ensure ongoing safeguarding of all.

23.6 This review does not draw any conclusions on culpability, that is not the purpose or the role. The panel have been engaging and willing to show reflective practice and to continue to create an environment in which to learn.

23.7 As a panel we would like to conclude by sending our condolences to the family of Lilly and thank them for their engagement and participation.

## 24. Lessons Learnt

Learning Point	Responsible Agency/Group	Description	Outcome/ Goal	Progress
Training on adolescent parent-child abuse	NSDAS	Provide targeted training to staff to address adolescent parent-child abuse cases effectively.	Enhanced staff capacity to handle specific abuse dynamics.	Ongoing
Continuous professional development on curiosity in practice	Probation	Promote CPD programs focusing on fostering curiosity in probation practices.	Improved decision-making and case management.	Embedded practice
Accessing intelligence from prisons for release/resettlement planning	Probation	Encourage better intelligence gathering from prisons to support smoother transitions.	Enhanced release and resettlement outcomes.	Embedded practice
Use of EPF 2 for custody release licence planning	Probation	Ensure the consistent use of EPF 2 forms	Improved planning and risk management	Embedded practice

		in licence planning.	for custody releases.	
Regular engagement with police and accommodation checks	Probation	Strengthen collaboration with police and verify accommodation circumstances for released individuals.	Reduced risks and better living conditions for individuals.	Embedded practice
Effective interventions for mental health, substance misuse, housing, and finances	Probation	Develop tailored interventions addressing core issues faced by clients.	Better support and reduced recidivism.	Embedded practice
Review of risk recording procedures for visibility	SABP	Revise protocols for recording risks to enhance inter-service awareness.	Improved risk management and service integration.	Embedded practice
Comprehensive system for abuse or neglect concerns	SABP	Establish an integrated system to document and manage abuse/neglect cases.	Increased efficiency in tracking and addressing concerns.	Embedded practice
Strengthening MARAC documentation	SABP	Improve records of MARAC attendance and discussions.	Enhanced accountability and information sharing.	Embedded practice
Risk information sharing improvements	SABP	Ensure effective communication of risk-related data between services.	Better-informed service responses to risks.	Embedded practice
Initial learning integration into training webinars	GP	Include lessons from domestic abuse-related deaths in GP training webinars.	Improved GP awareness and response to domestic abuse.	Embedded practice
Targeted enquiries for mental health and domestic abuse	GP	Train GPs to focus on mental health and abuse concerns,	Better detection and support for vulnerable patients.	Embedded practice

		especially for older adults.		
DASH submissions audit and policy compliance	Surrey Police	Conduct an audit of DASH submissions to ensure adherence to review policies.	Improved data quality and policy compliance.	No longer practice as evolved to more competent training for practitioners
Clarification of DASH accreditation and supervision	Surrey Police	Define and communicate the scope and impact of DASH accreditation on supervision.	Enhanced oversight and accountability .	No longer required
Timely sharing of MARAC minutes	Surrey Police	Ensure timely distribution of MARAC meeting minutes to partners while upholding confidentiality.	Improved collaboration and effective decision-making.	MARAC no longer Police responsibility  Improvement embedded.

## 25.Recommendations

- 25.1 **A recommendation for consideration:** Police ensure safety planning for perpetrators who are displaced as a consequence of a DVPO and for when they return to the home address. This is being addressed through the MATAC process which has been established following a Domestic Abuse Thematic Inspection by His Majesty’s Inspectorate of Constabulary and Fire and Rescue Service (HMICFRS) in 2022.
- 25.2 **A recommendation from this review is :** Reflective learning session be held for Surrey County Council staff to share local learning with the North West area of Surrey and broader with the practice and development improvement team for wider county learning.
- 25.3 **A recommendation from this review is:** The Safe lives document “Safe Later Lives” is shared with all Surrey GP practices both alongside and independently of the above webinar, to ensure the widest possible audience and increase awareness of the issues faced by our older patients experiencing domestic abuse.
- 25.4 **A recommendation from this review is:** to deliver child to parent/grandparent violence training to professionals, highlighting national domestic abuse and barriers to accessing support from victims within this community.

25.5 **A recommendation from this review** is that probation service should ensure that local Probation Practitioners regularly access information and intelligence held within the Prison, particularly for immediate or 'time served' releases to inform release and resettlement planning and where there are concerns around risk / need. This is supported by the National guidance for probation Risk of Serious Harm guidance.

25.6 **A recommendation from this review is** for agencies to adopt the guidance in the safer lives MARAC for older persons, the aim of the report was to identify what's different about older victims' experiences of domestic abuse. The following were identified:

- Engagement with services
- Financial and housing issues
- Health/mental health issues

## 26. Action Plan

**All Actions will be tracked for progress and completion by the Spelthorne Community Safety Partnership.**

<b>Recommendation</b>	<b>Scope of recommendation i.e. local or regional</b>	<b>Action to take</b>	<b>Lead Agency</b>	<b>Key Milestone achieved</b>	<b>Target Date</b>	<b>Completion Date and Outcome</b>
<b>Safety planning around perpetrators when issuing a DVPO</b>	Local	Develop and implement safety plans focused on the perpetrator in DVPO cases.	Police	MATAC is now embedded in Surrey  Accommodation is available for disrupted perpetrator	December 2025	Reduced risk and improved safety outcomes for victims.
<b>Delivery of reflective learning from this review</b>	Local	Delivery of reflective learning from this review	Adult Social Care	Already commenced	December 2025	Integration of lessons learned into future practices.
<b>Circulation and training for Safer Later Lives</b>	Local, however the guidance is national	Share and train relevant staff on the 'Safer Later Lives' framework.	GP	Completed embedded practice		Improved understanding and implementation of Safer Later Lives principles.  November 2024
<b>Training to staff on child-parent abuse</b>	Local ( but with national learning needed)	Provide targeted training to staff on identifying and addressing child-parent abuse.	NSDAS	Delivery now ongoing	Review December 2025	Enhanced staff capacity to handle cases involving child-parent abuse.  Ongoing programme for new staff as well as current.
<b>Obtain a complete intelligence picture,</b>	Local	Gather and analyse comprehensive	Probation	Guidance in place	Review effectiveness	Better-informed probation decisions and enhanced public safety.

<p><b>particularly for 'Time served' referrals</b></p>		<p>intelligence for effective decision-making in 'time served' cases.</p>			<p>December 2025</p>	
<p><b>Delivering the Safer Lives in Older Persons approach (Single agency point of contact)</b></p>	<p>Local ( part of National guidance)</p>	<p>Establish a streamlined process with a dedicated point of contact for this approach.</p>	<p>MARAC</p>		<p>August 2025</p>	<p>Effective and cohesive service delivery for older persons.</p>
<p><b>Continuing to deliver the same level of service to agencies, including admin support</b></p>	<p>Local</p>	<p>Maintain high standards of service and administrative support for partner agencies.</p>	<p>MARAC</p>			<p>Sustained collaborative and efficient MARAC operations.</p>

**27. Good Practice**

Good Practice	Responsible Agency/Group	Description	Outcome/Goal
Consistent utilisation of DASH process	Police	Ensure consistent use of the DASH (Domestic Abuse, Stalking, and Harassment) process.	Standardised risk assessment and improved victim safety.
Conducting regular checks when DVPO is in place	Police	Perform routine checks to ensure compliance and monitor safety when a DVPO is issued.	Enhanced victim protection and perpetrator accountability.
Seeking positive intervention	Police	Proactively implement interventions to address domestic abuse cases effectively.	Improved resolution and safeguarding outcomes for affected individuals.
Development of a learning hub for Domestic Abuse training	SABP	Create a centralized hub for training, offering refreshers and onboarding programs for new staff.	Increased staff competency and consistent application of domestic abuse procedures.
Delivery of regular seminars sharing learning	GP	Conduct regular seminars to share insights and	Improved awareness and

from domestic abuse-related deaths		learning from domestic abuse-related fatalities.	practice among GPs.
Inquisitive enquiry approach embedded in practice	GP	Adopt and maintain an inquisitive enquiry approach when dealing with domestic abuse cases.	Better identification and support for victims.
Demonstrated adherence to practices and protocols while supporting Angela	NSDAS	Ensure strict adherence to organizational practices and protocols to provide effective support.	High-quality support and better engagement with clients.
Good inter-agency action around safeguarding	Probation	Collaborate effectively with other agencies, particularly when addressing non-compliance by perpetrators.	Strengthened safeguarding and accountability measures.
Significant improvements to MARAC process	MARAC	Enhance the MARAC process with wider information sharing and inclusive practices.	Better collaboration and comprehensive case handling.

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## APENNDIX A



### 7 Minute Briefing DARDR SP01

#### Background

Lilly was a white female aged in her 80's at the time of her death in 2020. She was residing with her grandson, Andrew, a white male in his 20's and her daughter, Angela, a white female in her 50's.

Lilly suffered a head injury following an incident at her home address, which Andrew stated "it's just a domestic", and passed away two months later.

Cause of death was 1.) head injury 2.) pneumonia.

No-one was ever charged in relation to her death.

Andrew was charged with breach of a restraining order.

#### Background

Angela had been drug dependent and in an abusive relationship, this resulted in her children being removed, two went into foster care, Andrew, aged 7 yrs, went to reside with his maternal grandmother.

From the age of 10 yrs Andrew displayed violence & disruptive behaviours. Over the next 13 years there were 48 reports to police of domestic incidents, Lilly was recorded as a victim on 23 occasions. Angela overcame her addictions and went to live with Lilly and Andrew  
A restraining order was in place from 2015 (Andrew Vs Lilly & Angela).  
There were 2 MARAC hearings, 2016 & 2020  
Andrew was alcohol dependent, used class A drugs and displayed coercive and controlling behaviours as well as physical assaults to both Lilly and Angela.  
Lilly was very reluctant to disclose any of this as she had an overwhelming desire to protect Andrew and just wanted him to get the help he needed.  
Andrew was never prosecuted for domestic abuse related behaviour or for breach of the restraining order.

#### Key Learning

Child to Parent Abuse is not well understood by agencies. The move to DARA as a risk assessment tool is positive as this focusses on the whole family rather than just intimate partners.  
GP to recognise that anxiety and low mood can be indicators of domestic abuse  
Failure to attend appointments may be an indicator of domestic abuse  
Follow up by adult social care should include an in person visit if no response to other communication is received.  
Sharing of risk information across all agencies  
A trauma informed approach is needed when engaging with victims of domestic abuse  
Awareness of abuse involving older adults as victims.

#### Key Learning

Response to domestic abuse should be suspect centric, including identifying any safeguarding risk when displaced through DVPO (or other factor), with housing.

<b>Signposting and follow up with other supportive agencies to address factors which influence offending behaviour</b> <b>Effective sharing of intelligence between agencies</b> <b>The use of a suspect focussed programme ( MATAC)</b>
<b>Recommendations</b>
<b>GP embedding the safer later lives framework</b> <b>NSDAS providing targeted training for child parent abuse</b> <b>Adult Social Care conducting reflective learning sessions from this review.</b> <b>Police to develop safety plans to support the issue of DVPO's</b> <b>Police/CPS to seek to improve successful outcomes through prosecutions, including evidence led ( recognising lack of documented fear is not a barrier).</b> <b>MARAC to adopt the safer older persons approach, nominating a lead agency as point of contact.</b> <b>Probation to obtain a complete intelligence picture, particularly when dealing with time served referrals.</b>
<b>Recommendations All Agencies</b>
<b>Improve understanding around older victims, child parent abuse, emotional abuse and traveller community culture and values</b> <b>Adopt a trauma informed approach when dealing with victims and perpetrators to give confidence to engage.</b> <b>Comprehending coercive control in non-intimate relationships</b>
<b>Good Practice</b>
<b>Police; Consistent use of the DASH (DARA) risk assessment tool</b> <b>Police; Conducting regular checks when a DVPO is in place</b> <b>SABP: Development of centralised training hub to improve staff competency around domestic abuse.</b> <b>GP: Learning events based on safeguarding and domestic abuse related reviews</b> <b>NSDAS: Good practice and protocols that support long term victims of abuse</b> <b>Probation: Effective collaboration with partners to address non-compliance.</b>

**MARAC: The new process is effective inclusive and provides wider safeguarding**  
**Adult Social Care: early response to referral following significant incident.**