



# Spelthorne Community Safety Partnership

## Domestic Abuse Related Death Review

### Executive Summary

Lena

Date of Death: December 2023

Independent Chair and Author: Michelle Hulse

4<sup>th</sup> April 2025

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The review panel wish to record their sadness that Lena's life should have ended this way, and our sympathies go to Lena's family and all who knew her.

## **1 The Review Process**

This summary outlines the process undertaken by Spelthorne Community Safety Partnership's Domestic Abuse Related Death Review (DARDR) panel in reviewing the death of Lena<sup>1</sup>, a 41-year-old resident of Surrey, prior to her death in December 2023.

- 1.1 Lena grew up in Nagpur, India. Her primary language was Hindi. Lena had met Kumar, her husband, via an online matrimonial site 14 years previous and entered the United Kingdom (UK) on a Spousal Visa in her mid-twenties.  
  
Lena and Kumar were Sikh, and it is believed that Sikhism was important to Lena.
- 1.2 Lena experienced various health challenges, and her Body Mass Index (BMI) was always low and around 17 to 18 from being a teenager. Lena was diagnosed with Colitis and the medical treatment over the years had not been successful. Lena was very vocal about not liking Western medicine and how her and Kumar preferred a holistic approach to her medical treatment and as such had travelled to other countries to access medical treatments.  
  
Lena was university educated and qualified as an Engineer. She reported that she had not worked for many years due to ulcerative colitis, and that this had been very debilitating. Lena's father had also passed away in 2023, she had a close relationship with her father and struggled with his loss.
- 1.3 Lena consistently described her marriage to Kumar as loving and spiritual and voiced how she felt that Kumar had done nothing but care for her, leaving his career and obtaining private health care.
- 1.4 Lena died whilst admitted at St Peters Hospital where she was detained under Section 2 of the Mental Health Act<sup>2</sup>. Prior to Lena's death, she had been discussed at the Multi-Agency Risk Assessment Conference (MARAC<sup>3</sup>) following a partner agency referral from Get A Drip expressing concern that Lena was severely underweight, and Kumar was behaving very intimidating, controlling, and aggressive towards staff. They were concerned that Lena's malnutrition was due to mental health issues caused by coercive control. It appears that much of the medical treatment obtained by Lena was privately arranged and controlled by Kumar. Several professionals' meetings had considered how to contact Lena

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<sup>1</sup> All names have been replaced by pseudonyms assigned by the DARDR panel.

<sup>2</sup> <https://www.legislation.gov.uk/ukpga/1983/20/section/2>

<sup>3</sup> Multi-Agency Risk Assessment Conference (MARAC) is a meeting where representatives from various agencies share information about high-risk domestic abuse cases.

without having to go through Kumar. Lena only engaged superficially, and concerns of professionals were rejected by Lena, and interventions implemented to support Lena were cancelled by her and/or Kumar.

- 1.5 Police had opened an investigation into coercive and controlling behaviour and subsequently arrested Kumar, however the evidence thresholds could not be met, and no further action could be taken.
- 1.6 Lena's cause of death was a cardiac event and as this was a medical related death, there was no police investigation. However, Spelthorne Community Safety Partnership (CSP) recognised that Lena's physical and mental health deterioration could have been contributed to by domestic abuse, in particular coercive control, perpetrated by Kumar and therefore the recommendation was accepted to conduct a DARDR.

Although it is unproven that Lena's death was linked to domestic abuse the review panel felt it would be beneficial to conduct a multi-agency review to consider any learning.

- 1.7 On 20<sup>th</sup> February 2024, Surrey Police notified Spelthorne Community Safety Partnership of Lena's death. On 23<sup>rd</sup> May 2024, Spelthorne Community Safety Partnership held a meeting to consider multi-agency information held in relation to Lena and Kumar. They agreed that the circumstances of the case met the criteria for a Domestic Homicide Review [paragraph 13 Statutory Home Office Guidance]<sup>4</sup>. The Home Office was informed of the decision on 19<sup>th</sup> July 2024.
- 1.8 The first meeting of the DARDR panel took place on 6<sup>th</sup> September 2024, via Microsoft Teams video conferencing. Subsequent meetings also took place using Microsoft Teams. The panel met four times. Outside of meetings, issues were resolved by email and the exchange of documents. The final panel meeting took place on 14<sup>th</sup> March 2025, after which, amendments were made to the overview report that were agreed by the panel. This review was concluded on 4<sup>th</sup> April 2025.

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<sup>4</sup> Under section 9(1) of the 2004 Act, "domestic homicide review" means 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) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or  
(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death. Where the definition set out in this paragraph has been met, then a Domestic Homicide Review should be undertaken.

1.9 The review chair attempted to contact Lena’s sister, inviting her to contribute to the review. A text message was also sent in the event that Lena’s sister did not wish to answer a phone call from an unknown number. This text message included a link to the Advocacy After Fatal Domestic Abuse (AAFDA)<sup>5</sup> leaflet. Following the text message, the chair was able to establish contact by phone. The DARDR process was explained along with further information on support provided by AAFDA. Following her taking some time to digest this information within the text message, Lena’s sister informed that she had discussed the DARDR with her and Lena’s mother. She explained that they both missed Lena very much and were distressed by losing Lena. Her sister stated that both she and her mother felt unable to contribute to the review due to the emotional impact that losing Lena’s life had on them. Lena’s sister agreed to consider the information further and agreed to make further contact should she wish to contribute to the review. When discussing the publication of the review, Lena’s sister did voice that she would like to have access to the DARDR before publication. It was agreed to make contact at this point if she had not felt able to contribute earlier. Further contact was attempted with Lena’s sister with the additional offer of support through Sikh Women’s Aid, however no response was received.

Prior to publication, the review chair attempted contact with Lena’s sister sharing the details of where the report would be published and offering to meet to discuss the report. This contact also shared the offer of support to read the report along with a link to the AAFDA leaflet. No response was received.

1.10 The DARDR Panel considered whether to contact Kumar to inform him of the DARDR. It was not possible to effectively assess risks associated with approaches to Kumar, and the panel felt that in the circumstances, it could create risk to Lena’s family. Information from a range of panel organisations indicated intimidating behaviour by Kumar and considered that if Kumar was to be made aware of the review, there is a possibility that he may pursue Lena’s sister and family for information, and this could create further risk to them. As Lena’s sister and mother felt unable to contribute to the review, the review panel concluded that contact would not be made to inform him of the DARDR.

## 2 Contributors to the Review

2.1

Agency	Contribution
Surrey Police	IMR

<sup>5</sup> Advocacy After Fatal Domestic Abuse (AAFDA) [www.aafda.org.uk](http://www.aafda.org.uk)

North Surrey Domestic Abuse Service	IMR
Surrey County Council Adult Social Care	IMR
Datchet Health Centre	IMR
Surrey and Borders Partnership (SABP)	IMR
Get A Drip	IMR
Ashford and St Peters Hospital (ASPH)	Short report
South East Coast Ambulance Service (SECamb)	Short report
Berkshire Healthcare NHS Foundation Trust (BHFT)	Short report
The Princess Margaret Hospital (Circle Health Group)	IMR
Guys and St Thomas' NHS Foundation Trust	Short Report
Sikh Women's Aid	Expertise provided to the DARDR Panel

2.2 In addition to the IMRs, each agency provided a chronology of interaction with Lena and Kumar, including what decisions were made and what actions were taken. The IMRs considered the terms of reference (TOR) and whether internal procedures had been followed and whether, on reflection, they had been adequate. The IMR authors were asked to arrive at a conclusion about what had happened from their own agency's perspective and to make recommendations where appropriate. Each IMR author had no previous knowledge of Lena and Kumar, nor had involvement in the provision of services to them.

2.3 The IMRs in this case focussed on the issues facing Lena. They were quality assured by the original author, the respective agency, and by the review chair. Where challenges were made, they were responded to promptly and in the spirit of openness and co-operation.

### 3 Members of the Domestic Abuse Related Death Review Panel Members

3.1 Michelle Hulse	Independent Chair and Author
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Georgia Tame (panel 1) Fran Richiusa (remaining panel meetings)	Domestic Abuse Related Death Review Coordinator, Surrey County Council
Will Jack	Community Safety Manager, Spelthorne Community Safety Partnership
Andy Pope	Statutory Reviews Lead, Surrey Police
Sharon Ballantyne	Named Lead Domestic Abuse and Exploitation, NHS Frimley ICB
Ekpen Akenzua	Senior Manager Mental Health, Surrey County Council Adult Social Care
Name removed for confidentiality	NSDAS Team Lead IDVA
Claudine Cox	Safeguarding Adults & Domestic Abuse Lead, Surrey and Borders Partnership
Jane Mitchell	Professional Head of Safeguarding, Ashford and St Peters Hospital
Emma Ray	Specialist Safeguarding Practitioner, South East Coast Ambulance Service
Sue Carrington	Specialist Practitioner Domestic Abuse  Berkshire Healthcare NHS Foundation Trust
Helen Brasier	Director of Clinical Services; Safeguarding Lead, The Princess Margaret Hospital (Circle Health Group)
Michael Fullerton	Safeguarding Adults Lead Nurse  Guys and St Thomas' NHS Foundation Trust
Sahdaish Pall	CEO of Sikh Women's Aid

3.2 The DARDR chair was satisfied that the members were independent and did not have any operational or management involvement with the events under scrutiny.

#### **4 Author and Chair of the Overview Report**

4.1 Sections 36 to 39 of the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews December 2016 sets out the requirements

for review Chairs and Authors. In this case, the Chair and Author were the same person.

- 4.2 Michelle Hulse was chosen as the independent Chair and Author of the review. Alongside her full-time career as a domestic abuse and violence against women and girls lead within a core city Local Authority (not Surrey), Michelle is also an independent practitioner who consults within the area of domestic abuse. Before this, Michelle has 13 years' experience managing a range of commissioned domestic abuse services. She has a Masters in Professional Development: Dynamics of Domestic Abuse and is also a trained MARAC Chair. She has completed the Level 3 accredited training for DARDR chairs, provided by AAFDA, and has coordinated 18 DARDRs and chaired and written an internal partnership review based on a DARDR along with several domestic abuse strategies.

## **5 Terms of Reference**

### **5.1 'The purpose of a DARDR is to:**

Establish what lessons are to be learned from the domestic abuse related death regarding the way in which local professionals and organisations work individually and together to safeguard victims;

Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;

Apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;

Prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

Contribute to a better understanding of the nature of domestic violence and abuse; and

Highlight good practice'.

(Multi-Agency Statutory guidance for the conduct of Domestic Homicide Reviews 2016 section 2 paragraph 7)

## 5.2 **Timeframe Under Review**

The DARDR covers the period from 1<sup>st</sup> December 2021 to December 2023. The reason for this timeframe was that background information highlighted an escalation in concern in relation to Lena from December 2021.

## 5.3 **Case Specific Terms**

### **Subjects of the DARDR**

Lena, aged 41 years

Kumar, aged 45 years (Lena's husband)

### **Specific Terms**

The terms of reference (TOR) were agreed by the DARDR panel at the inaugural meeting on 6<sup>th</sup> September 2024. This took into consideration the guidance<sup>6</sup> issued by the Home Office with particular reference to paragraph 5.11 and paragraph 5.13.

1. What indicators of domestic abuse, including coercive and controlling behaviour, did your agency identify for Lena? Were identified risks of coercive and controlling behaviour considered in their contacts with Lena. Were attempts made to support Lena to understand the types of abuse which she may have been experiencing, including abuse which may have been less obvious to her?
2. Was Lena a person who was in need of care and support, be this in need of community care services by reason of mental health or other disability, age or illness; and who is or may be unable to take care of herself, or unable to seek protection or protect herself against significant harm or exploitation? Was mental capacity appropriately assessed at the right time? Did professionals consider executive functioning around decision making?
3. What avenues were explored to address safeguarding concerns? Were there any missed opportunities to make referrals into both statutory and non-statutory services?
4. What barriers existed that may have prevented Lena from seeking help and support in relation to coercive and controlling behaviour? Were barriers to disclosure considered?

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<sup>6</sup> Multi Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Home Office, 2016)

5. How did your organisation assess the risk faced by Lena from the perpetrator, and which risk assessment model did you use? If risk assessment models, such as DASH, were not used, what was the reason for this and what alternative action was taken to understand risk?
6. How effective was inter-agency information sharing and co-ordination in response to Lena and Kumar, and was information shared with those organisations who needed it? Was sufficient information shared across organisations involved in Lena's care to evaluate the risk properly?
7. Was there sufficient focus on the impact of Kumar's abusive behaviour towards Lena, by applying an appropriate mix of sanctions (arrest / charge) and treatment interventions? Did this include consideration of disruption techniques for Kumar?
8. Was appropriate action taken by the police to gather evidence in line with expected standards in relation to coercive and controlling behaviour? Is there evidence that the police and/or CPS took the circumstances of Lena's death and the impact of coercive and controlling behaviour into account?
9. How well does risk evaluation between Adult Social Care, Health, the Police and MARAC processes work?
10. How does your organisation overcome language and cultural challenges to assess whether cases may involve domestic abuse or other culturally specific abuse when completing assessments?
11. Were opportunities taken by professionals to explore domestic abuse with Lena in order that multi-agency protective action could be considered?
12. What learning did your organisation identify in this case? Were there any examples of good practice?

## **6 Summary Chronology**

### **6.1 Relevant History Prior To 1<sup>st</sup> December 2021**

- 6.1.1 Lena attended medical appointments in various settings prior to the timescale of the review due to her Ulcerative Colitis, which she was diagnosed with in 2010. This included appointments at Guys and St Thomas' Hospital, her GP practice and Princess Margaret Hospital via Circle Health Group. Due to the Covid 19 pandemic, some appointments which would usually be conducted on a face-to-face basis were moved to video call. Kumar was present for these.

## 6.2 **Events within the Timeframe of Review (1<sup>st</sup> December 2021 to the end of December 2023)**

6.2.1 Between December 2021 and January 2022 Lena attended the Get A Drip clinic with Kumar. The clinic noted that Lena was very underweight and frail.

Kumar would speak on Lena's behalf and was very directive of treatment given to Lena, such as when the staff member went to check Lena's vital signs, Kumar had put a divider around Lena. Lena was asked whether she was ok, in which Lena nodded. Kumar also asked the staff member to check her temperature on her wrist instead of her forehead.

During the first visit to the clinic the medical staff member noticed that one of the empty vials for the vitamins was missing. The member of staff checked with Lena whether she had seen the vial, in which she responded no, however upon returning to the clinical area, the vial had been found on the table. It was believed that Kumar had removed the vial before replacing it once the medical staff identified it as missing. As such two alerts were recorded in Lena's electronic medical record profile about Kumar. It was advised to exercise caution with the vitamin ampoules, following the attempt to conceal an empty vial. Furthermore, it was recorded that Kumar was particularly meticulous regarding the cannulation and mixing procedures, and it was recommended to utilise a disposable tourniquet.

The second visit to the clinic proceeded without incident and at one point Kumar left during the administration of the vitamin drip and during the third visit Kumar expressed significant concern regarding the products used and the quality of service provided, due to Lena's chronic condition. Kumar was particularly meticulous about ensuring that all aspects of the treatment were suitable for her specific health needs. Despite Kumar's detailed inquiries and concerns, no safeguarding issues were observed during the appointment. Lena consented to her treatment and appeared to be sound of mind.

### 2022

6.2.2 On 22<sup>nd</sup> January 2022 a letter was sent from the GP practice to Lena stating that as she had moved out of area, it would be expected that she would need to find a new local practice.

6.2.3 On 24<sup>th</sup> January 2022, Lena attended the Get A Drip with Kumar for her fourth appointment. Kumar took the lead in discussions about her treatment and selected the drip on Lena's behalf, Lena was not actively involved in these discussions. The medical staff provided Lena with a consent form and advised review of the form

before signing. During the process, Kumar closely monitored the interaction, which restricted direct communication between the medical staff and Lena.

The medical staff noted that Lena was underweight and raised concerns about a potential underlying illness that had not been disclosed. Lena attributed her weight loss to food allergies; however, no allergies were recorded in the medical questionnaire. The medical staff consulted with the medical team regarding the administration of the drip due to Lena's malnourished state. The medical staff expressed concern about the risk of Refeeding Syndrome and recommended conducting blood tests before proceeding with treatment. Kumar responded defensively, citing previous drips received without concern for her weight.

The medical staff requested documentation from Lena's GP to support Kumar's claim that the GP recommended regular drips.

Whilst consent procedures were followed by medical staff, the dynamics of the interaction raised concerns about patient autonomy and safety and a safeguarding referral was subsequently completed due to safety concerns. The referral cited:

- 1) Lack of involvement from Lena in treatment decisions.
- 2) Potential risks due to Lena's malnourished state and lack of documented allergies.
- 3) Communication barriers caused by Kumar's dominating presence.
- 4) The need for appropriate medical documentation to support treatment decisions.

The referral was initially reported to Hammersmith and Fulham County Council due to the location of Get A Drip but then forwarded to Surrey County Council (SCC) who received the referral on 27<sup>th</sup> January 2022. Following this referral Adult Social Care commenced a Section 42 Safeguarding process. Contact was made with Get A Drip, Lena's GP, Surrey Police and MARAC.

6.2.4 On 10<sup>th</sup> February 2022, Lena and Kumar became known to Surrey Police whereby a referral into police was made by Spelthorne Mental Health Locality Team in Surrey County Council, raising concerns regarding Lena and whether she was a victim of coercive and controlling behaviour by Kumar. This was as a result of the referral made by Get A Drip.

The case was reviewed by the Surrey Police Domestic Abuse Caseworker and a supervisory review was undertaken by the Domestic Abuse Team. The decision was made for no immediate action to be taken as this could put Lena at risk based on the referral which suggested contacting Lena could potentially escalate risk. This

was deferred to MARAC for 16<sup>th</sup> February 2022 which included the referral for Lena. Recording states that Lena was not known to any services and was registered with a GP in Datchet, Royal Borough of Windsor and Maidenhead and as such mental health services would be delivered by neighbouring trusts.

6.2.5 On 16<sup>th</sup> February 2022, North Surrey Domestic Abuse Service (NSDAS) received a referral from police in relation to concerns raised by Get A Drip. NSDAS attempted to engage with Lena via telephone, however, were unsuccessful in making direct contact with her.

On the same day Lena was heard at MARAC. Actions agreed were:

- Surrey police to conduct a Street of the Week visit by the PCSO.
- Police Domestic Abuse Caseworker to try to contact Lena.
- Surrey County Council to facilitate a meeting between the GP and Lena so she could be seen on her own.

An entry on the MARAC referral recorded the background, information gathering and confirmation that no other services were found to be involved with Lena and Kumar.

6.2.6 On 17<sup>th</sup> February 2022 a safeguarding concern alert was placed on Lena's GP record and stated to 'discuss care with patient individually'.

6.2.7 On 22<sup>nd</sup> February 2022, Section 42 information was shared in relation to Lena's address and confirmation that there were no children. Information was shared that Kumar attended all medical appointments with Lena and that Kumar was always present and expressed to see specific doctors. Further information was shared that there were no concerns with regards to any injuries of domestic abuse but noted that little had been seen of Lena.

The GP discussed the case and the safeguarding with their supervisor. The GP informed that they were awaiting the safeguarding conference date and added a plan to the patient notes and booked in with the supervisor to review the following week. The GP received a request to attend the professionals meeting, however due to clinic commitments, the GP was unable to attend, however the GP had been communicating with the Local Authority.

6.2.8 On 22<sup>nd</sup> February 2022 a telephone call was made to Lena by the Surrey Police MARAC coordinator, which was an action agreed in MARAC. The call was answered by Kumar who claimed that he was the next of kin. The MARAC coordinator explained that the call was in relation to a professionals meeting to discuss Lena. A request was made to speak to Lena who was not available. Kumar was requested to ask Lena to call her back. Kumar was described as rude.

- 6.2.9 On 23<sup>rd</sup> February 2022 a further call to Lena was attempted by the Surrey Police MARAC Worker. This was not answered. Adult Social Care also had contact with Domestic Abuse Outreach at Surrey Police.
- 6.2.10 On 24<sup>th</sup> February 2022 a telephone call was attempted to Lena by Surrey Police. This was answered by Kumar. After muting the call for around 30 to 45 seconds Lena came on the phone. The caller did not feel it was safe to discuss welfare with Lena as they believed the phone was on loudspeaker. Lena requested a name and identification number of the caller as she wanted to make a complaint about the police calling.
- 6.2.11 On 1<sup>st</sup> March 2022 a Professionals Meeting was convened. This was attended by NSDAS, Surrey Police, Get A Drip and Adult Social Care. The meeting looked at options to try and secure a meeting with Lena on her own. A plan was agreed for a Section 9 assessment<sup>7</sup> which was considered as a way to make contact and offer support. The next Professionals Meeting was arranged for 23<sup>rd</sup> March 2022.
- 6.2.12 On 2<sup>nd</sup> March 2022 Kumar attended an appointment at the GP practice with the Nurse. The appointment was to take bloods. He stated that Lena was not present as she had another appointment. No information was shared with Kumar due to patient confidentiality.
- 6.2.13 On 3<sup>rd</sup> March 2022 the GP sent an email to Adult Social Care to request the outcome of the safeguarding concern and the professionals meeting. A response was received containing the notes from the Section 42 meeting. The Mental Health team were actioned to contact the GP to find out about the potential opportunities to see Lena privately and alone, the suggestion of a cervical smear or a mammogram test were made. The GP confirmed to the Mental Health team that the practice would ask for a smear test to be conducted. The patient notes record that the GP would use this in supervision to discuss the case further.

On the same day, it was identified that Lena required a review of her colitis, and this involved being seen at the specialist clinic at St Marks Hospital. The GP asked the consultant at St Marks for advice and guidance on how they should proceed. This supported the decision not to prescribe medication when the severity of the condition was not known at this time.

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<sup>7</sup> A Section 9 assessment is a needs assessment for people who may need care and support, as outlined in Section 9 of the Care Act 2014.

6.2.14 On 9<sup>th</sup> March 2022 the GP had a telephone consultation whereby Lena was on speaker phone with Kumar present asking for 3 monthly Vitamin D injections. The GP advised that bloods had not been taken and will be needed to gauge iron and Vitamin D levels. The GP explained that they needed a gastroenterology review to identify what was required. Lena then took the phone and stated that she would rather go privately. Kumar stated that he had it all under control and asked to see a different GP, who he had dealt with in the past. The GP felt that Kumar was aggressive when the requests were not permitted, and the call then broke down. The GP would not prescribe Methylprednisolone until Lena had been reviewed by a specialist. The GP discussed this with the other GP involved and an update was emailed to Adult Social Care and on 16<sup>th</sup> March 2022 Adult Social Care met with the head of safeguarding to request advice and guidance on the case.

6.2.15 On 22<sup>nd</sup> March 2022, a meeting was organised and facilitated by Adult Social Care with attendance from NSDAS, Lena's GP, Police and Get A Drip to discuss safeguarding concerns in relation to Lena. This would also consider whether a Strategy Meeting should be arranged.

The adult social worker had been trying to contact the PCSO for an update following the Street of the Week visit. Records state that the PCSO has been to visit Lena as part of Street of the Week and had planned to re-visit. It had not been possible to update the social worker within the timeframe and no further update was recorded on the police Niche Occurrence following this enquiry.

The GP shared information on non-attendance to appointments, telephone contact and trying to organise a cervical smear. The practice also shared concerns about the level of impact from Kumar and that private medical intervention had been difficult to monitor.

The IDVA questioned whether a change of GP could be forced by the practice as Lena now lived out of area, with the aim of requiring Lena to attend and register with a new GP, however it was felt that it would be more beneficial for the current GP practice to remain involved.

NSDAS continued to engage with other professionals involved with Lena, including North Surrey Mental Health Services, police, primary healthcare. All of whom reported trying to establish engagement with Lena.

6.2.16 On 23<sup>rd</sup> March 2022 Lena requested Vitamin D from the GP practice via phone. During the phone call the GP checked who was with Lena and Lena gave consent for

Kumar to hear the phone call. The GP requested blood tests before agreeing to this request.

- 6.2.17 On 31<sup>st</sup> March 2022 Adult Social Care contacted the GP practice to see if there were any new concerns that would prevent Adult Social Care from conducting a Section 9 based on self-neglect. No concerns were highlighted.
- 6.2.18 On 1<sup>st</sup> April 2022 the MARAC referral states that a call was made to Lena from Adult Social Care regarding a Section 9 and Section 10<sup>8</sup> Care Act Assessment. The purpose of the call was explained, and it was left that Lena would make contact to arrange an appointment. The entry states that Kumar initially answered, and the phone was then passed to Lena. Kumar stated that they had worked very hard over the last decade about Lena's health and had lived in India for three years to get certain treatment. He said they believed in positive energy and chakras. He said reiterating health conditions would be a negative and they tried to live life positively. He said they had previously spoken with their GP who had completed home visits and said they also paid £3,000 for a specialist nutritionist to prepare meals, and they had trained with a top chef. There did not appear to be any concerns noted during this call.
- 6.2.19 The MARAC referral form recorded that on 7<sup>th</sup> April 2022 a further call was made to Lena by Adult Social Care which was again answered by Kumar. According to Kumar Lena was out. Kumar asked for email details and stated Lena would contact them on her return.
- 6.2.20 On 8<sup>th</sup> April 2022, the MARAC referral stated that a further call was made to Lena, from the Adult Social Care social worker. The phone was answered by Kumar and then passed to Lena. Lena expressed her frustration at the repeated contact and that everything was fine. Lena said she had been to Get A Drip previous times with no issues raised and so questioned why this had been flagged and criticised the nurse who treated her on that occasion. Lena explained that since the Covid-19 pandemic she had not received the support she used to receive hence attending the drip clinics to get the vitamin nutrients she required. Lena agreed to meet with the social worker and handed the phone to Kumar to make the arrangements. Kumar agreed that he and Lena would go to the office to meet the social worker on 13<sup>th</sup> April 2022. Kumar also expressed his concerns at the intrusion into their lives from several professionals and was again critical of the nurse at the clinic.

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<sup>8</sup> A Section 10 assessment is conducted under Section 10 of the Care Act 2014 which evaluates the needs of a person acting as a carer for another adult, determining whether they require support to manage their caring role.

- 6.2.21 On 11<sup>th</sup> April 2022 a further telephone call was made to Lena by Adult Social Care. Lena expressed frustration at all the recent contact from different professionals and that she did not want to rehash her health history again as this was distressing and negative for her and did not help. She stated that she did not need help and wanted to know who referred her and if it was Get A Drip. This was confirmed. She stated she got the drips as the support she had prior to the Covid-19 pandemic from other avenues was not there and got the drips as she could have occasional allergic reactions to foods and the drips provided the vitamins she was not getting. She stated that she had previous drips with the company and there had been no difficulties, but it was a new staff member on this occasion. Lena was of the view that the reason for the refusal this time was that she had arrived wearing pyjamas as she wanted to be comfortable and on the previous occasions, she had been dressed in what she described as being a nice dress. The purpose of the contact was explained with regards to a Section 9 Care Act Assessment, and she agreed to a home visit and then requested that the social worker speak to Kumar, who repeated what he had said during the phone call on 1<sup>st</sup> April 2022. Kumar stated that he felt as though the contact with professionals since Get A Drip had been harassment, and they felt harassed.
- 6.2.22 On 13<sup>th</sup> April 2022 an email was sent from Lena cancelling the appointment with the social worker scheduled for that day due to her not feeling well. The email also reinforced how this whole episode had been stressful and traumatic for Lena and was making her symptoms worse. The email requested all future contact be via email. Following this email contact, Adult Social Care contacted MARAC to request the case to be discussed again and a referral was completed. The social worker shared concern that the only face to face contact with Lena had been a visit made by the PCSO, however even on that visit Kumar was present the whole time at the doorstep and spoke on behalf of Lena.
- 6.2.23 On 20<sup>th</sup> April 2022 Adult Social Care sent an email to the safeguarding lead within Adult Social Care requesting further discussion.
- 6.2.24 On 29<sup>th</sup> April 2022 a Surrey Police Niche Occurrence created a record for the second MARAC referral made into police based on professional judgement of the adult social worker.

The entry detailed the concern of the social worker and that the PCSO visit had taken place although the date was not recorded on the occurrence or the ones previous to this. On attendance the door was answered by Kumar and when asked who else was in the premises Lena came to the door. When the PCSO tried to speak to Lena, Kumar intervened and provided the answers. Lena did not speak. At the

time Lena was wearing pyjamas and therefore it was difficult to determine her weight. Upon leaving the PCSO conducted some enquiries with other households, but the occupants did not know the couple or raise any concerns. There were no immediate neighbour enquiries conducted at other properties.

According to the social worker there was a 'permissions' letter signed with the GP which meant that Kumar was the one who dealt with the GP in Lena's behalf.

The police supervisor endorsed the report with no further action required by the Domestic Abuse Team and would await any subsequent tasking following the MARAC meeting, which was due on 22<sup>nd</sup> June 2022.

6.2.25 On 3<sup>rd</sup> May 2022 North Surrey Domestic Abuse Service made the decision to close the case as it was deemed not to be safe to contact Lena and all avenues has been explored with professional agencies.

6.2.26 Lena was offered a cervical smear test to be completed on 5<sup>th</sup> May 2022. This was not taken up. An alert was placed on Lena's patient record requesting that smear tests are only carried out by Datchet Medical Centre.

On the same day the GP left the practice and completed a handover of Lena to another GP. The practice discussed this at their Clinical Governance Meeting and raised an action to await the outcome of the Section 9 and noted that the appointment was still outstanding with St Marks Hospital.

6.2.27 On 9<sup>th</sup> May 2022 Adult Social Care made telephone contact with Surrey Police Domestic Abuse Team. It was shared that there would be no further action until the MARAC meeting.

6.2.28 On 17<sup>th</sup> May 2022 Adult Social Care met with the East Sussex Domestic Abuse Service (ESDAS) Service Manager, Adult Social Care outlined the information known, potential risks and Lena's reluctance to engage with the assessment. Adult Social Care raised concerns of the timeframe of the next MARAC meeting.

6.2.29 On 1<sup>st</sup> June 2022, Adult Social Care attended a professional meeting with ESDAS. In attendance was the ESDAS service manager, Chief Executive, Superintendent Detective (Domestic Abuse Lead) and the Domestic Abuse Force Advisor from Surrey Police. The safeguarding lead from Adult Social Care was invited but was unable to attend due to annual leave.

The ESDAS service manager provided a summary of the case and discussion was facilitated about options available to speak to Lena alone. The outcome was for the MARAC meeting to be arranged and to include the GP and a professional with medical knowledge of nutrition and low weight. It was agreed that police would try to build a wider picture of Kumar to increase knowledge about what options were possible.

6.2.30 On 7<sup>th</sup> June 2022 the Adult Social Care mental health social worker completed a referral to North Surrey Domestic Abuse Service (NSDAS). This was received by NSDAS the following day.

6.2.31 On 10<sup>th</sup> June 2022 an emergency MARAC was facilitated. The MARAC referral was dated 13<sup>th</sup> April 2022, just under two months following the referral.

All professionals at the MARAC agreed that Kumar should be arrested. This action was allocated to the Domestic Abuse Team from North Surrey. The MARAC action plan recorded that when Kumar is arrested, Lena will be seen jointly by NSDAS and Police.

6.2.32 On 14<sup>th</sup> June 2022 Surrey Police created a Police Niche Occurrence to record the decision to arrest Kumar and document the subsequent investigation and on 16<sup>th</sup> June 2022 Surrey Police arrested Kumar.

NSDAS attended a meeting with police and Lena. This was the first contact that NSDAS had with Lena. Lena described a loving and spiritual marriage.

Lena discussed her medical issues including Colitis and stated that she had an enlarged heart, and that stress was not good for her. Lena described how they wanted a holistic approach to her treatment. Kumar had also given up his job to care for her. Lena stated that Kumar was just taking care of her and had done nothing but help her, obtaining private health care and made her go to different Acupuncture and Osteopath clinics who she stated had become her friends and supported her through her conditions. Lena stated that they had used social media to document her journey and that all her medication was on her phone with reminders of when they should be taken.

The house appeared clean and tidy with no concerns regarding the living conditions. Because of her illness Lena and Kumar slept in separate rooms and in Kumar's room, two mobile phones were found. Lena refused to provide the PIN codes stating they were private property.

Lena was distressed that Kumar had been arrested. Lena continued to state that Kumar was only taking care of her. Lena spoke of her Sikh religious beliefs and daily religious rituals during the home visit. Lena spoke about health and said that Kumar was a good man. She stated that she had friends in the area who she can see, and she also had a good relationship with her sister who lived in another part of the UK. Lena stated that her and Kumar go to temple every week.

Lena consented to NSDAS contacting her GP and arranging an appointment. Lena also stated that she was happy to continue engagement with NSDAS. The IDVA concluded the meeting with Lena who agreed that she would like to speak with the IDVA again. However, the IDVA was still unable to make telephone contact with Lena after this initial home visit with the police.

A DASH risk assessment was completed, and Lena answered 'no' to all questions.

Prior to police leaving Lena she called and spoke to her sister, who stated she would keep an eye on Lena through the course of the day.

NSDAS followed up on making the GP appointment and stated to the GP practice that there were no immediate safeguarding concerns. NSDAS were told by the GP practice that Lena was now out of area and needed to register with a local GP. NSDAS highlighted concerns over Lena's weight and that they were unable to close the case until this was assessed.

- 6.2.33 Surrey Police interviewed Kumar on the same day. This was conducted by the same officers who had spoken to Lena. Kumar mirrored the account provided by Lena and explained her medical condition, how he has given up work to care for her, and how frustrated he was by all the attention.

Feedback was shared by NSDAS to Adult Social Care. Surrey Police also contacted Adult Social Care to advise that the case will be closed with no further action.

- 6.2.34 On 20<sup>th</sup> June 2022 the NSDAS IDVA spoke to Lena and were informed that the GP practice had said that she was no longer a patient at the practice. Lena advised that she would contact the GP practice. On 21<sup>st</sup> June 2022, the GP contacted Adult Social Care to inform that they would be de-registering Lena from the practice register. NSDAS records note that Adult Social Care had expressed concern to the GP practice that Lena was unlikely to re-register and that there would be no oversight from her GP. This was reinforced by NSDAS.

- 6.2.35 On 22<sup>nd</sup> June 2022, Lena's GP practice noted that Lena had now moved out of area and therefore Lena was asked to re-register with a practice that covered her address. The GP practice contacted Surrey Adult Social Care to inform them of this request and that no further prescriptions for vitamins or iron supplements would be issued.
- 6.2.36 On 23<sup>rd</sup> June 2022, The NSDAS IDVA attempted to contact Lena 3 times. These were unsuccessful.
- 6.2.37 On 12<sup>th</sup> July 2022 the NSDAS IDVA continued to engage with the North Surrey Mental Health Team who were still completing their own assessments with Lena and updated the deputy assistant manager that NSDAS has not been able to contact Lena. It was agreed that NSDAS would close the case as all Section 42 enquiries had been completed with Lena.

An email was sent to Adult Social Care from the Domestic Abuse Outreach Manager at NSDAS to advise that they have closed the case and added that NSDAS had contacted Lena via telephone on four occasions, but there was no response.

- 6.2.38 On 15<sup>th</sup> July 2022 Adult Social Care completed a Section 9 Care Act Assessment without Lena's input as per Section 11 (2)(b)<sup>9</sup>.
- 6.2.39 On 21<sup>st</sup> July 2022 the Section 42 enquiry was closed, and the case closed to Adult Social Care.
- 6.2.40 On 8<sup>th</sup> September 2022 Lena re-registered with her previous GP practice with an address that was within the catchment area and on 3<sup>rd</sup> October 2022 Kumar booked an appointment with the GP practice requesting a steroid medication for Lena. On 19<sup>th</sup> October 2022 Kumar requested a prescription from the GP practice. This was declined. A GP spoke to Kumar and the prescription was requested again. This was declined again. An urgent practice note request was sent by the GP after the further requests for medication to keep the other GPs updated.

## **2023**

- 6.2.41 On 27<sup>th</sup> June 2023 Lena was invited for a smear test again, however there was no response. Following this date, the only communication with the GP practice until

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<sup>9</sup> Section 11 (2)(b) of the Care Act 2014 states that where an adult refuses a needs assessment, the Local Authority must carry out a needs assessment if the adult is at risk of abuse or neglect or if the adult lacks the capacity to refuse but the authority believes it is in the adult's best interests.

Lena died was to offer appointments for a cervical smear test and the flu vaccine in an attempt to see Lena alone. These were not taken up.

6.2.42 On 29<sup>th</sup> November 2023 South East Coast Ambulance Service (SECAMB) received a call via 999 requesting an ambulance in relation to a deterioration in Lena's medical condition. On arrival the ambulance crew found that Lena was severely underweight with significant pressure sores. She was unable to mobilise due to pain and had become bedbound. The ambulance crew noted that Lena was severely anorexic. Lena was described as acutely unwell. Kumar and Lena's sister were present during the attendance. Kumar explained that he had tried to treat Lena at home as she had a phobia of hospitals and was extremely vulnerable. Kumar stated that Lena had been seen by a private nurse the previous week. No concerns were noted by SECAMB staff in relation to Kumar or Lena's sister. Lena was noted to have a severe ulcerated grade 4 pressure sore on her rectum area that was approximately 5 x 5cm and the bone was visible. She also had a large grade 2 pressure sore to her left ankle which was approximately 7x5cm and she was experiencing pain in both areas. Lena was upstairs in the property lying in bed. She was very drowsy and severely malnourished, but able to answer questions. Support was requested from a second ambulance crew and the Fire Service to assist with extraction. Lena was taken to St Peters Hospital under emergency conditions.

6.2.43 Whilst admitted to St Peters Hospital during December 2023, Lena was referred to the consultant psychiatrist from the Psychiatric Liaison Service by the gastroenterology service who raised concerns about Lena's low weight and capacity. Lena objected to being weighed until 3<sup>rd</sup> December 2023 and this identified she had a BMI of 10.6, a BMI of under 13 is categorised as the high-risk category for Medical Emergencies in Eating Disorders (MEED) guidelines. The consultant psychiatrist discussed that they could not identify how Lena had lost so much weight, as it seemed very low even with her inflammatory bowel disease, and she denied body dysmorphia.

There was communication and joint working between the consultant psychiatrists involved and the gastroenterology dietitians and concern was discussed that Lena lacked capacity to make decisions over her nutrition as well as concerns over her understanding of her infection, but there was disagreement within the ward treating team. Lena had declined medical recommendations and ward care and appeared dismissive of concerns. Lena also removed her cannula, and the medical opinion was that she would die without medical intervention. The hospital head of safeguarding was also consulted with.

Kumar was remaining on the ward 24 hours a day and ward staff felt that he had been speaking on Lena's behalf and making it difficult to engage with her and as such the ward manager and matrons were asked to enforce the visitor policy. Concerns were also raised during the period about Kumar being directive of Lena's medical care and also 'moved the goalposts' by initially agreeing to one form of medication and once provided stating that another form should be provided. The consultant psychiatrist was conscious that safeguarding concerns had already been raised as to how Lena had reached such a low BMI in the community and apparent lack of concern over her nutrition from her family. The consultant psychiatrist also discussed with the consultant gastroenterologist that they had not elicited clear evidence of a major psychiatric disorder and raised that Lena had very concrete and 'black and white' thinking which could fit with Autistic Spectrum Disorder (ASD), but her malnutrition alone would cause cognitive changes and a rigid thinking pattern. There was discussion on the need for a robust assessment of her capacity of her decision making around medical care. A joint meeting was arranged for 7<sup>th</sup> December 2023 with the consultant gastroenterologist and the dietitians.

- 6.2.44 Lena was placed on a Section 5(2)<sup>10</sup> Mental Health Act 1983 as she wanted to self-discharge. The doctor believed the risk of death was too high if she returned home. The doctor reviewed Lena with the dietitian and informed her of the consequences of returning home, however she still requested to return home. Kumar was also present and stated that the doctors were not listening to Lena and that he would seek legal advice.

The consultant psychiatrist discussed Lena with the Surrey AMHP service. The AMHP informed of the different name listed on their database for Lena's NHS number and a MARAC had been raised the previous year. This was not previously known to SABP. The head of safeguarding at St Peters Hospital was informed of this.

- 6.2.45 A Mental Health Act Assessment was undertaken, and Lena was detained under Section 2<sup>11</sup>. Lena and Kumar initially wished appeal this Section but later communicated that they no longer wished to appeal but wanted to be more involved in decision making.

Lena continued to object the recommended medical treatment plan, had refused nursing observations and declined to be weighed. It was collectively agreed that Lena had no insight into the risk of death. The consultant psychiatrist advised that

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<sup>10</sup> Section 5(2) Mental Health Act 1983 allows doctors to detain patients in a hospital for up to 72 hours, during which time an assessment should be conducted that decides if further detention under the Mental Health Act is necessary.

<sup>11</sup> Section 2 Mental Health Act 1983 allows detention in hospital for up to 28 days to assess and treat a mental disorder when someone is considered a risk to themselves or others.

the ward team would need a clear assessment of Lena's capacity over aspects of her ongoing medical care, and if felt to lack capacity, then a formal Best Interests Meeting would be needed.

During mid-December Lena enquired if she could be transferred to a hospital in another city to be closer to her sister and mother, given she felt that the hospital had a difficulty with Kumar.

- 6.2.46 The consultant clinical psychologist highlighted the need for a professionals meeting and given safeguarding concerns that if Lena were felt to lack capacity on aspects of her care that she may benefit from an Independent Mental Capacity Advocate (IMCA).

Lena expressed her surprise to the speciality doctor in the Liaison Psychiatry Service that staff had raised concerns over her relationship as she felt she had a strong bond with Kumar. She felt that they were misunderstood and requested in the future for assessments to be undertaken in Hindi with an interpreter. The speciality doctor in the Liaison Psychiatry Service was fluent in Hindi and able to speak in Hindi for the assessment.

Adult Social Care received a request from Surrey and Borders Partnership for a Social Circumstances Report and a visit was made to Lena to gather information. A telephone interpreter service was used for this visit.

- 6.2.47 A Best Interests Meeting was held on 15<sup>th</sup> December 2023 and determined that all proposed treatments were in Lena's best interests. There were multiple attempts to work with Lena and Kumar throughout the day, but then an emergency application was made to the Court of Protection who agreed to urgent treatment to supply antibiotics to treat sepsis. When this was presented to Lena and Kumar on 16<sup>th</sup> December 2023, Kumar became very aggressive, barricading himself into Lena's room to prevent treatment being commenced. This resulted in the police having to be called to force open the door and remove him from the hospital. Kumar was arrested to prevent Breach of the Peace and removed from the hospital. He was later released without charge and advised not to return to the hospital for 12 hours. Once Kumar was not present Lena had been compliant with treatment, as whilst she was not in agreement, she understood that it needed to happen.

The officer completed a Single Combined Assessment of Risk Form (SCARF) and classified the level of risk as Amber, providing commentary that the officers were concerned regarding Lena being left in the care of Kumar upon returning home. The SCARF was reviewed in the MASH and shared with Adult Social Care on 18<sup>th</sup>

December 2023. Adult Social Care attended the Mental Health Act Tribunal that day, however it was postponed.

Following the granting of the Order by the Court of Protection Kumar then disengaged completely from Lena's care, stating that he would be starting divorce proceedings.

6.2.48 On 19<sup>th</sup> December 2023 a Section 42 enquiry was opened by Adult Social Care. Contact was made with police and the ward manager with regards to the management of any assessed risks.

6.2.49 On 20<sup>th</sup> December 2023 Berkshire Healthcare received an urgent referral to The Gateway<sup>12</sup> for Lena by the liaison psychiatry consultant at St Peters Hospital. The referral was for Berkshire Eating Disorders Service (BEDS). This was following a previous referral to Surrey Eating Disorders Service, but due to Lena having a Berkshire GP, was not accepted, and the referral was redirected to Berkshire. There was liaison between the BEDS psychotherapist and the referring consultant including physical history, current condition and treatment. BEDS accepted the referral however would not be commencing treatment until Lena was discharged. There was a further liaison between the referring consultant and BEDS doctor about an adult safeguarding investigation in relation to adult neglect. Lena died before she received any treatment or had any contact with BEDS.

6.2.50 On 21<sup>st</sup> December 2023 Adult Social Care attended a Barring Order Hearing following Kumar's request for Lena to be discharged from the Section 2.

Adult Social Care AMPH service received telephone contact from the doctor within Surrey and Borders Partnership requesting an assessment under the Mental Health Act. Lena's Section 2 was due to expire on 4<sup>th</sup> January 2024. The doctor was of the view that Lena would require further treatment under Section 3. Lena had a tribunal for an appeal against her Section 2 on 28<sup>th</sup> December 2023.

6.2.51 On 22<sup>nd</sup> December 2023 Adult Social Care were notified that the Section 2 appeal had been withdrawn by Lena and the tribunal was subsequently cancelled.

6.2.52 On a date in December 2023, Lena died.

### 6.3 **Events Following the Timeframe of Review**

6.3.1 On 12<sup>th</sup> January 2024 the social worker contacted the Domestic Abuse Team within Surrey Police informing police of the death of Lena and asking whether any cases

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<sup>12</sup> Formally known as The Common Point of Entry. This is where all referrals for mental health services are received.

were open with police. Police advised the social worker either submit a Freedom of Information request or to contact 101 to report concerns.

6.3.2 On 4<sup>th</sup> March 2023 the social worker emailed the Police Single Point of Access PSPA (formally MASH) explaining that a Section 42 enquiry was commenced following the SCARF referral on 18<sup>th</sup> December 2023. Following the death of Lena this would be closed.

6.3.3 On 5<sup>th</sup> March 2023 the police Supervisory Review within the Adult at Risk Team determined no further police action and suggested the social worker refer this for a Safeguarding Adult Review.

## **7 CONCLUSIONS**

7.1 The review panel identified the challenges to responding to coercive control believed to be experienced by Lena from Kumar, however it is evident that there was good multi-agency creative thinking and working to ensure Lena was held at the centre of discussions.

Whilst Lena did have a low Body Mass Index, this was not identified as being of concern in isolation, in view of the plausible reason as being a result of her bowel symptoms of colitis. Although professionals raised concerns of Kumar's behaviour, in isolation this did not fully evidence the coercive and controlling nature of his behaviour, however it was not until all information came together where professionals were able to consider the extent of his behaviour in the context of domestic abuse. This provides evidence of the importance of multi-agency information sharing and collaborative working.

Towards the end of the period under review, professionals were presented with a seriously unwell person for whom urgent and definitive treatment was needed. This was difficult to achieve when it was identified that Kumar appeared to be exacerbating the situation by refusing treatments and creating barriers to delivering life-saving care. Professionals, including Ashford and St Peters Foundation Trust staff, did identify this and escalated leading to decisive action being possible to put in place, utilising the Mental Health Act, the Mental Capacity Act and seeking court intervention to deliver the necessary care. Sadly, this did not result in a positive outcome for Lena, and she died because of her multiple and complex health issues. It cannot be known whether early intervention would have made a difference to this outcome as she was very frail and had little to no

physiological reserve when she was first admitted, however, any delay in providing treatment did not allow for her to have the best chance of survival.

7.2 The panel was grateful for the input of the independent advisor from Sikh Women's Aid. They were able to provide valuable advice and context to panel members throughout discussions and were instrumental in identifying opportunities to effect change. The panel agreed it would be useful to raise awareness services available specifically to support South Asian women to understand their experiences in the context of domestic abuse in addition to raising awareness of support for women who are on Spousal Visas. The panel also highlighted opportunities to strengthen knowledge on Honour Based Abuse to ensure frontline practitioners remain curious around possible risks and also the need for cultural competency in practice.

7.3 The multi-agency collaboration was effective during point of crisis; however, it was identified that there could have been a strengthened approach to information sharing in 2022, particular with cross boarder agencies in relation to MARAC, this could have allowed a consideration of Kumar's behaviour in the context of domestic abuse at an earlier opportunity.

Supervision and multi-disciplinary discussions and meetings took place to discuss the case, and actions were agreed upon and implemented in a timely manner. Although the outcome was unfortunate, the efforts to support Lena were commendable.

## **8 LEARNING AND RECOMMENDATIONS**

This multi-agency learning arises following debate within the DARDR panel.

### **8.1 Narrative**

Lena attended several different healthcare settings both within and outside of Surrey. Not all were aware of key safeguarding information, including MARAC information or who provided some self-reported private medical care.

#### **Learning**

Professionals should explore information on the network around a patient to build a full understanding of agency involvement to allow effective information sharing on risk and treatment.

#### **Panel recommendation 1 applies:**

Professionals must be more alert with regards to professional curiosity to ensure agencies have explored and gained a full understanding of the experiences of the victim, including when individuals are receiving treatment in healthcare settings, including private or wellness clinics.

## 8.2 **Narrative**

Lena's weight loss had a plausible explanation and coercive and controlling behaviour was not believed to be a cause of such; however, professionals should have been open to considering wider possible factors on the deterioration of such conditions. Kumar's behaviour was known to be a hindrance to her accessing medical treatment and he created barriers to safe, effective and timely care.

### **Learning**

Professionals should understand the connection between deterioration in eating disorders and domestic abuse to allow for wider thinking and consideration of risk.

### **Panel recommendation 2 applies:**

Agencies should receive guidance and training in relation to how coercive control can contribute to the deterioration of mental health and eating disorders, taking into account research indicating that Lena's weight loss could have been an indicator of trauma. This should also include awareness of coercive control and health related matters.

## 8.3 **Narrative**

Although PLS were aware of concern about domestic abuse there is no evidence that they met the National Institute for Health and Care Excellence (NICE) Quality Standards in relation to domestic abuse which states that *people presenting to frontline staff with indicators of possible domestic violence or abuse are asked about their experiences in a private discussion*. The panel however were satisfied that although there were a small number of opportunities to speak to Lena alone and also when a Hindi speaking medical staff member was present, Lena was dangerously unwell and therefore the conversations were very much focussed on her physical health risks and the need for treatment that may be lifesaving.

### **Learning**

It may be that Psychiatric Liaison Service were aware that the hospital staff had done, or were doing, this but as this is not reflected in records, the assumption is

made that it was not considered. The learning therefore relates to the need to ensure patient records are clear in relation to this guidance.

**Panel recommendation 3 applies**

Health professionals, including PLS within Surrey and Borders Partnership should receive training on the NICE Domestic Abuse Quality Standards and Guideline and ensure patient records relate to this guidance.

**8.4 Narrative**

Although Lena's cause of death was medical related, Surrey Police were not informed of Lena's death until 3 months later. Given the circumstances whereby Kumar prevented Lena's access to potentially life saving treatment, the concern raised by professionals in relation to coercive and controlling behaviour and also knowing that Lena had been heard at MARAC, would the police have been notified within 24 hours of Lena's death, they would have been afforded the opportunity to explore and investigate this further.

**Learning**

An opportunity for Surrey Police to potentially investigate the circumstances that led to Lena's deterioration was missed.

**Panel recommendation 4 applies**

Acute hospital settings, the coroner, police and the Medical Examiner Service Office should scope how police could be alerted, when relevant to do so, following the death of a person where recent domestic abuse is considered to be a possible factor in the deterioration of their medical condition that led to their death.

**8.5 Narrative**

On the rare occasions when it was made possible to see Lena alone, this could have been an opportunity for Lena to access a helpline specifically for South Asian women, for example Karma Nirvana or Sikh Women's Aid who provide services in other languages. Such an intervention may have enabled Lena to understand her experiences in the context of domestic abuse.

Lena's Spousal visa could have been a barrier to her disclosing abuse as it is possible she felt dependent upon Kumar for secure immigration status.

**Learning**

It would be useful to raise awareness services available specifically to support South Asian women such as Sikh Women's Aid and Karma Nirvana who provide services in other languages to ensure that victims are supported to understand

their experiences in the context of domestic abuse. This review should also highlight the opportunity to share information and support options available for women with no recourse to public funds with insecure immigration status.

**Panel recommendation 5 applies**

Spelthorne Community Safety Partnership should disseminate information on services available to specifically support South Asian women. This should also include information and support options for women who may be on Spousal Visas, have no recourse to public funds and/or have insecure immigration status.

**8.6 Narrative**

No evidence was found that Lena was experiencing Honour Based Abuse, however there is also no evidence that this or the barriers to disclosure for South Asian who experience the intersection of domestic abuse and mental ill health was considered.

**Learning**

The review panel considered that it would be useful to share information to frontline practitioners on the importance of culturally competent practice and curiosity around the possibility of Honour Based Abuse. It would also be an opportunity to strengthen understanding of Honour Based Abuse. This should include risk assessment tools available to support the identification of risk.

**Panel recommendation 6 applies**

Spelthorne Community Safety Partnership should consider how to strengthen understanding of the need for culturally competent practice to break down barriers to disclosure, and Honour Based Abuse to ensure that frontline practitioners are able to remain curious and identify risk. This should also include awareness raising of the Karma Nivana Honour Based Abuse Identification Tool.

**8.7 Single Agency Learning – Surrey Police**

**Recommendation 1**

Learning submission highlighting the outcomes from this review to be shared with the relevant teams identified within this review to improve police response and investigations.

**8.7 Single Agency Learning – Get A Drip**

**Recommendation 1**

Ensure all staff members feel confident in addressing and challenging intimidating behaviour from clients or their relatives.

**Recommendation 2**

Complete thorough medical documentation that explains the rationale for providing treatment based on the client's clinical condition.

**Recommendation 3**

Maintain the duty of candour and always act in the best interest of the client.

**8.8 Single Agency Recommendation – Circle Health Group**

**Recommendation 1**

Ensure there is shared learning with the team in relation to professional curiosity and asking additional questions to patients presenting as underweight.

**Recommendation 2**

Ensure there is shared learning and/or supervisory sessions with regards to ethnicity and cultural considerations with patients for holistic assessment.

**8.9 Single Agency Recommendation – Surrey Adult Social Care**

**Recommendation 1**

Due to the requirement that the individual is *interviewed in a suitable manner* all staff to clearly document why an interpreter is not used during a Mental Health Act Assessment when a person's first language is not English.

**8.10 Single Agency Recommendation - Surrey and Borders Partnership NHS Foundation Trust**

**Recommendation 1**

Ensure records relating to safeguarding concerns and risks relating to domestic abuse are robust. There is now a safeguarding Springboard on SystemOne to support clinicians in this task and the effectiveness of this should be monitored.

**Recommendation 2**

SaBP should not assume that another agency is going to refer a safeguarding concern.

**Recommendation 3**

Sufficient detail regarding past safeguarding concerns or MARAC discussion should be sought in order to inform current risk assessment and planned actions.

**Recommendation 4**

Ensure that staff have adequate training and support to respond effectively to concerns about domestic abuse. This is currently provided through Safeguarding training and access to specialist advice from the Safeguarding Team. However, the Trust would benefit from stand-alone domestic abuse training.

**Recommendation 5**

The use of translation service should be considered for all people who do not have English as a first language.

End of Executive Summary 'Lena'

