Spelthorne Community Safety Partnership

Domestic Abuse Related Death Review

Overview Report

Lena

Date of Death: December 2023

Independent Chair and Author: Michelle Hulse

4th April 2025

Lena

Lena's sister described the distress she and her mother were experiencing following Lena's death and how she was missed very much.

Lena was a spiritual person and it is believed that her religion, Sikhism, was important to her.

She was university educated and qualified as an Engineer, but unable to work due to the debilitating ulcerative colitis which she experienced.

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) in her mid-twenties. Lena and Kumar regularly travelled to India to visit family.

Lena's husband Kumar was born in the (UK) and is British Indian. He had lived in the UK for a substantial period. It is believed that Lena had entered the UK on a Spousal Visa. Lena reported to Surrey Police that Kumar was helping her to obtain British citizenship as she had been in the UK for a continuous period of five years.

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 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 including the USA, Dubai and to Dharamsala in India where she sought treatment under Tibetan medication experts for many months. They had also travelled to India to pray with the Dalai Lama.

It is believed that Lena had returned to Bangalore, India from January to June 2023 as her father was unwell. She returned to UK after this, and her father passed away. Lena had a close relationship with her father and struggled with his loss.

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.

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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 Introduction

1.1 This report of a Domestic Abuse Related Death Review (DARDR) examines agency responses and support given to Lena[1], a 41-year-old resident of Surrey, prior to her death in December 2023.

1.2 Lena died whilst admitted at St Peters Hospital where she was detained under Section 2 of the Mental Health Act[2]. Prior to Lena's death, she had been discussed at the Multi-Agency Risk Assessment Conference (MARAC[3]) 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 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.

1.3 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.

1.4 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] All names have been replaced by pseudonyms assigned by the DARDR panel.
[2] https://www.legislation.gov.uk/ukpga/1983/20/section/2
[3] Multi-Agency Risk Assessment Conference (MARAC) is a meeting where representatives from various agencies share information about high-risk domestic abuse cases.

1.5 This DARDR has been conducted in accordance with the principles contained within the current Home Office Statutory Guidance[4]. The updated Statutory Guidance is due to be launched, however as this has not formally been adopted at the point of this review, the above Guidance is followed.

It is however considered that although the new draft Statutory Guidance has not yet been launched, the review is using the name DARDR rather than Domestic Homicide Review (DHR) as it better fits Lena's experience.

1.6 The intention of this review is to ensure agencies are responding appropriately to victims of domestic abuse by offering and putting in place appropriate support mechanisms, procedures, resources, and interventions, with the aim of avoiding future incidents of domestic homicide, violence, and abuse. Reviews should assess whether agencies have sufficient and robust procedures and protocols in place, and that they are understood and adhered to by their employees.

1.7 **Note:**
It is not the purpose of this DARDR to enquire into how Lena died: that is a matter that has already been noted in her death certificate.

2 Timescales

2.1 This review began on 6th September 2024 and was concluded on 4th April 2025. More detailed information on timescales and decision-making is shown at paragraph 4.2.

3 Confidentiality

3.1 The findings of each review are confidential until publication. Information is available only to participating officers, professionals, their line managers and the family (including any advocacy support), during the review process. Pseudonyms were agreed by the panel to protect the identity of all involved.

4 Terms of Reference

4.1 '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

[4] https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

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)

4.2 Timeframe Under Review

The DARDR covers the period from 1st 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.

4.3 Case Specific Terms

Subjects of the DARDR

Lena, aged 41 years

Kumar, aged 45 years (Lena's husband)

Specific Terms

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?

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?

5 Methodology

5.1 On 20th February 2024, Surrey Police notified Spelthorne Community Safety Partnership of Lena's death.

5.2 On 23rd 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][5]. The Home Office was informed of the decision on 19th July 2024.

5.3 The first meeting of the DARDR panel took place on 6th 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 14th March 2025, after which, amendments were made to the overview report that were agreed by the panel.

5.4 Prior to publication, the review chair attempted contact with Lena's sister to share the report. This is detailed below.

6 Involvement of Family and Friends

6.1 Family

6.1.1 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)[6] 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

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[5] 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.

[6] Advocacy After Fatal Domestic Abuse (AAFDA) www.aafda.org.uk

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.

6.2 The Alleged Perpetrator

6.2.1 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.

6.3 Friends

6.3.1 Lena reported to police that she had three close friends. Lena was described as a person who kept her personal information private and therefore, she did not share any information on who these friends were. Therefore, contact could not be attempted to any of Lena's friends. The circumstances of being unable to identify information on Lena's friendship group are considered within this review.

6.3.2 The review panel understood the benefits of those closest to Lena contributing to the review, however felt that all safe options had been exhausted.

6.4 Place of Worship

6.4.1 The review panel understood how Sikhism was important to Lena and therefore assumed that she would have attended a religious temple. The benefits of inviting contribution to this review from the religious temple was understood, however the review panel held no information on which religious temple Lena may have attended and therefore contact could not be attempted.

7 Contributors to the Review / Agencies Submitting IMRs[7]

7.1

Agency	Contribution
Surrey Police	IMR
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

7.2 These agencies were asked to provide details of their interaction with the subjects of the review by means of an IMR and a chronology, including what decisions were made and what actions were taken. The IMRs considered the specific Terms of Reference (TOR) in full, whether internal procedures had been followed, and whether, on reflection, they had been adequate. The IMR authors were asked to

[7] Individual Management Reviews (IMRs) are detailed written reports from agencies on their involvement with the subjects of the review.

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 the subjects of the review, nor had any involvement in the provision of services to them.

7.3 The IMRs included a comprehensive chronology of involvement of the agency with Lena and Kumar over the period set out in the Terms of Reference for the review. They summarised: the events that occurred; intelligence and information known to the agency; the decisions reached; the services offered and provided to the DARDR subjects; and any other action taken. They also provided: an analysis of events that occurred; the decisions made; and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened, but why.

7.4 The IMRs focussed on the issues facing Lena and Kumar. Further elaboration by IMR authors during panel meetings was invaluable. They were quality assured by the original author, the respective agency, and by the panel chair. Where challenges were made, they were responded to in a spirit of openness and co-operation.

7.5 Information About Agencies Contributing to the Review

7.5.1 Surrey Police

Surrey Police Force are responsible for policing across Surrey.

7.5.2 Surrey County Council Adult Social Care

Adult Social Care is about supporting those with presenting social care needs, to live the best life that they can, independently and for as long as possible, and utilising the strengths within their community to support their health and wellbeing. Adult Social Care services also undertake safeguarding duties and provides care and support services to people who are eligible and where this is required.

7.5.3 North Surrey Domestic Abuse Service (NSDAS)

NSDAS provide practical and emotional advice to anyone affected by domestic abuse and their children living in North Surrey.

7.5.4 Datchet Health Centre, Primary Care

Datchet Health Centre is a general medical practice offering primary care services in the Royal Borough of Windsor and Maidenhead. The practice sits on the boarder of the Royal Borough of Windsor and Maidenhead and Surrey.

7.5.5 Surrey and Borders Partnership (SABP)

SABP is the leading NHS provider of mental health, wellbeing and drug and alcohol services across Surrey and north east Hampshire. It is also the main provider of learning and neurodevelopment disability services.

7.5.6 Ashford and St Peters Hospital (ASPH)

ASPH is a medium sized district general hospital working across two sights in Surrey, St Peters Hospital in Chertsey and Ashford Hospital. Services provided include a wide range of acute hospital services including medical and mainly day surgical services and outpatient services.

7.5.7 South East Coast Ambulance Service (SECAmb)

SECAmb is the NHS ambulance service trust covering South Eastern England.

7.5.8 Berkshire Healthcare NHS Foundation Trust (BHFT)

Berkshire Healthcare NHS Foundation Trust provide a wide range of services for people of all ages living in Berkshire offering mental health and other community-based health services.

7.5.9 The Princess Margaret Hospital (Circle Health Group)

The Circle Health Group are a private hospital in Windsor offering private treatment and private surgery across a wide range of medical specialisms.

7.5.10 Guys and St Thomas' NHS Foundation Trust

Guys and St Thomas' NHS Foundation Trust is a large Central London Acute Hospital and Community Trust providing services to the residents of the London Boroughs of Lambeth and Southwark and other national specialist services.

There are 5 main hospitals within the Trust: Guys Hospital, St Thomas' Hospital, Evelina London Children's Hospital, Royal Brompton Hospital, Harefield Hospital.

They also delivery community specialist care for a full range of lifelong, general and specialist care.

7.5.11 Get A Drip

Get A Drip are a private company and are the UKs leading intravenous (IV) drip provider providing vitamin drips to its customers.

7.5.12 **Sikh Women's Aid**

Sikh Women's Aid were invited to share their expertise on the DARDR Panel to allow the review panel a deeper understanding of Lena in the context of her religion.

Sikh Women's Aid deliver a range of culturally sensitive strands of service delivery and support aimed at reducing the extent of harm and violence to vulnerable people, with greater emphasis on women and children with language barriers who are Sikh and Panjabi.

8 The Review Panel Members

8.1

Michelle Hulse	Independent Chair and Author
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

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

9 Author and Chair of the Overview Report

9.1 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.

9.2 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.

10 Parallel Reviews

10.1 Consideration was made as to whether the criteria for a Safeguarding Adults Review was met. This was considered by Spelthorne Safeguarding Adults Board on 13th May 2024 who agreed that the criteria was not met.

10.2 On 16th June 2022 Kumar was arrested by Surrey Police in response to concern raised by professionals in relation to coercive and controlling behaviour. Surrey Police interviewed Kumar and both he and Lena denied domestic abuse. No evidence could be found and therefore Kumar was released with no further action. Police conducted no other review in relation to Lena's death.

10.3 The documentary inquest was held and concluded by the coroner on 13th September 2024.

10.4 No agency has undertaken any form of internal review separate to the DARDR process.

10.5 A DARDR should not form part of any disciplinary inquiry or process. Where information emerges during the course of a DARDR that indicates disciplinary action may be initiated by a partnership agency, the agency's own disciplinary procedures will be utilised: they should remain separate to the DARDR process. There has been no indication from any agency involved in the review that the circumstances of the case have engaged their disciplinary processes.

11 Equality and Diversity

11.1 The nine protected characteristics[8] under the Equality Act 2010 were explored where relevant to the review, including barriers to accessing services and wider consideration as to whether service delivery was impacted. Further detail is included in the analysis of terms of reference section of the report.

11.2 Age

Lena was 41 years old at the time that she died. Local police data recorded between 01/01/2023 and 31/12/2023 shows that the highest proportion of victims of coercive and controlling behaviour within a domestic abuse context were aged between 18 to 44. Lena sits within this age bracket; however, it is important that practitioners are aware of increased risk of domestic abuse as a whole to facilitate their identification of domestic abuse victims.

Kumar was age 45 at the time that Lena died. Although Kumar was 4 years Lena's senior, this is not considered as a significant age gap which would suggest an imbalance in power dynamic within the relationship due to his age.

11.3 Sex

Domestic homicide and domestic abuse predominantly affects women, with women by far making up the majority of victims, and by far the vast majority of perpetrators being male. A detailed breakdown of homicides reveals substantial gender differences. Female victims tend to be killed by partners or ex-partners. For

[8] age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation.

example, in 2023, the Office of National Statistics[9] Domestic Homicide data revealed that 70% of victims of domestic homicide were women.

It is recognised that although the case is not classified as a domestic abuse related homicide, it is considered within the context of this DARDR as being a domestic abuse related concern which could have led to the deterioration of Lena's physical and mental health which contributed to her death and therefore the data remains relevant in Lena's experience of a female victim of coercive control perpetrated by a male. Women are more likely to be victims of coercive and controlling behaviour than men (ONS, 2023; Myhill, 2015; Barlow et al., 2018).

11.4 Race and Ethnicity

Lena and Kumar were Indian and lived in an area of Surrey that was predominantly white British demographic. Lena's GP record notes her ethnicity as being Indian and Indian British. The panel considered whether this would have created barriers in accessing support. This is explored within Term 10 of the Analysis section.

Both Lena and Kumar spoke English, Lena consented to one of her Mental Health Act Assessments being completed in English, however later she stated that she would have preferred for it to be facilitated in Hindi, as such an interpreter service was utilised. Hindi speaking doctors were also utilised to engage with Lena. When Lena became very unwell, she reverted to speaking in her mother tongue.

The DARDR panel considered how for people who have English as a second language, although they may be able to fluently speak, read and write in English, they could still experience communication challenges when navigating formal support services and topics, particularly during times of crisis. As such the panel recognised the need to ensure professional interpreters are offered to service users whose first language is not English.

11.5 Religion or Belief

Lena and Kumar practiced Sikhism. Their religion was important to them. Sikh Women's Aid (2024[10]) conducted research on 675 Sikh Panjabi women and found that 61.48% of respondents reported experiencing domestic abuse, with emotional and controlling behaviour as the most common forms. The research found systemic barriers, highlighting that there is limited access to specialist and culturally specific

[9] https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2023#:~:text=Adult%20victims&text=stranger%20(19%25).-,There%20were%20100%20domestic%20homicides%20in%20the%20year%20ending%20March,further%20homicide%20suspects%20are%20charged.

[10] https://www.sikhwomensaid.org.uk/images/documents/Publications/Gender%20Power%20and%20Abuse%20by%20Sikh%20Womens%20Aid%202024_compressed.pdf

resources and services, therefore highlighting a barrier for Sikh women to accessing services to keep them safe. This creates long term negative impacts for Sikh women. Sikh Women's Aid call for community policing to understand the needs of Sikh Women and also for a joined-up community response to victims of domestic abuse.

At the hospital, it is believed that Kumar would allege his behaviour was interlinked with his religious values, however when a Sikh medical practitioner became involved, he refused to engage. The hospital welcomed the knowledge of the Sikh doctor to identify whether Kumar's behaviour may have been influenced by his religion, however it is reported that the doctor frowned upon Kumar's behaviour and confirmed that Sikhism was not influencing Kumar's behaviours.

Surrey does not have a large Sikh population, it is overwhelmingly a white community, and the Police Force demographics represent this, however there is a large concentration of Sikh communities in West London. The review panel agreed that representation on the panel by a specialist service supporting Sikh communities would strengthen the learning and therefore would be important for this review. Sikh Women's Aid were therefore invited to sit on the DARDR Panel and provided valuable input, ensuring the review panel was both culturally informed and culturally represented.

No police officer responding to Lena or staff member had any experience within the Sikh religion at the time. The expert of the panel considered whether having a professional from the same faith would have supported those being concerned about Lena, allowing a strengthened and more culturally informed approach. The NSDAS review panel representative did share how Surrey has a Minority Ethnic Forum which professionals can access.

11.6 Disability

Physical Disability

Lena had numerous medical conditions logged on her patient record. These were:

- Ulcerative Colitis (inflammation of the lower end of the digestive system)
- Osteoporosis (bone disease)
- Aortic regurgitation (leaking of the aortic valve in the heart)
- Vitamin D deficiency
- Polyps on Colon (abnormal growth of tissue)

Datchet Health Centre did not issue any medical prescriptions, but did supply prescriptions for iron, reflux and vitamin D.

Mental Health

Psychological assessment identified that Lena was very rigid in her thinking and questioned Autistic Spectrum Disorder. They did however recognise that the rigidity in Lena's thinking could also be as a result of her extremely low Body Mass Index.

Lena and Kumar reported that Lena had a diagnosis of Anorexia Nervosa which had been diagnosed within her adolescent years prior to her arrival in the United Kingdom.

11.7 Marriage

The panel considered that Lena and Kumar's marriage was arranged before Lena entered the UK with Kumar. They had met through a matrimonial website. There was no evidence that Lena experienced Harmful Practices.

11.8 This review predominantly considers domestic abuse, and the circumstances of Lena's death meet the criteria of the definition within the Domestic Abuse Act 2021[11].

11.9 Intersectionality

The review panel considered any intersecting factors that Lena could have faced which could have increased her vulnerabilities and therefore creating cumulative risk.

The information considered that Lena was a Sikh woman aged 41 with medical needs and therefore whether she was at increased risk of coercive and controlling behaviour in the context of domestic abuse; particularly understanding how reliant Lena was on Kumar, especially in the weeks leading to her life being lost where Lena was bed bound and therefore further reliant upon Kumar for her care and support.

The review panel found no evidence that Lena was disadvantaged in relation to her access to services or support offered by professionals in relation to her protected characteristics.

12 Dissemination

12.1 Home Office
Spelthorne Community Safety Partnership
Surrey Police and Crime Commissioner
Domestic Abuse Commissioner
Surrey Coroner's Office

[11] https://www.legislation.gov.uk/ukpga/2021/17/section/1/enacted

All agencies contributing to this review.

13 Background, Overview and Chronology

This section of the report combines the Background, Overview and Chronology sections of the Home Office DARDR Guidance overview report template. This was done to avoid duplication of information. The information is drawn from documents provided by agencies.

The information is presented in this section without comment. Analysis appears at section 14 of the report.

13.1 Relevant History Prior To 1st December 2021

13.1.1 Lena attended medical appointments 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; however, treatment here did not progress as there was no further contact by Lena despite several attempts to contact without success.

Lena was last seen in person by her GP at Datchet Health Centre in December 2019, Kumar attended this appointment, and he would not agree to the GP changing Lena onto a new drug and as such the GP did not prescribe the drug initially requested by Kumar.

Lena also attended private self-funded medical settings such as Princess Margaret Hospital via Circle Health Group in 2021, however due to the Covid 19 pandemic, appointments which would usually be conducted on a face-to-face basis were moved to video call. Kumar was present for these. Lena was seen on a face-to-face basis one two occasions, one for a short 5-minute Covid-19 vaccine and the other when she was admitted as a day case admission for an endoscopy procedure. Due to Covid 19 restrictions, she attended alone but was collected by Kumar in the reception area.

13.2 Events within the Timeframe of Review (1st December 2021 to the end of December 2023)

The following paragraphs summarise issues affecting Lena within the timeframe of review, which the panel felt were most relevant.

<u>2021</u>

13.2.1 On 21st December 2021 Lena attended the Get A Drip clinic with Kumar. It was noted that Lena was very underweight and frail. Lena presented with symptoms of dehydration and fatigue.

Kumar spoke on Lena's behalf during the appointment, and it was noted that 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 asked the staff member to check her temperature on her wrist instead of her forehead.
The medical staff member began to mix the IV drip after the cannula insertion and whilst mixing, it was noticed that one of the empty vials for the vitamins was missing. Whilst looking for the vial, the member of staff checked with Lena whether she had seen the vial, in which she responded no. Upon returning to the clinical area, the member of staff found the vial on the table. It was believed that Kumar had removed the vial before replacing it once the medical staff identified it as missing.

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.

13.2.2 On 27th December 2021, Lena returned to the Get A Drip clinic and the administration of the drip proceeded without incident.

Kumar was present at the beginning of the appointment but left during the administration. No concerns were noted regarding Kumar's behaviour.

2022

13.2.3 On 7th January 2022, Lena attended the Get A Drip Clinic for her third appointment. She attended with Kumar. The medical professional observed that Lena appeared to be very lean.

During the appointment 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.

13.2.4 On 22nd 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.

13.2.5 On 24th January 2022, Lena attended the Get A Drip with Kumar, who took the lead in discussions about her treatment. Kumar selected the drip on Lena's behalf, and she 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 27th January 2022.

13.2.6 On 31st January 2022 Adult Social Care started the Section 42 Safeguarding process following the concern raised by Get A Drip. Contact was made with Get A Drip, Lena's GP, Surrey Police and MARAC.

13.2.7 On 10th February 2022, Lena and Kumar became known to Surrey Police. A Niche Occurrence was created to record the referral into police from 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. On the same day 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 16th February 2022 which included the referral for Lena.

13.2.8 On 10th February 2022 Lena's invitation to receive the Covid vaccine was declined.

13.2.9 On 14th February 2022 Surrey Police created a Police Niche Occurrence to record Lena's MARAC referral for the meeting on 16th February 2022.

Recording states that Lena was not known to any services and was registered with a GP in Datchet, Royal Borough of Windsor and Maidenhead. Mental Health services would be delivered by neighbouring trusts.

13.2.10 On 16th 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.

13.2.11 On 16th February 2022 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.

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

13.2.13 On 22nd 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.

13.2.14 On 22nd 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 being rude.

13.2.15 On 23rd 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.

13.2.16 On 24th 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.

13.2.17 On 1st 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.

The GP updated the outcome of the meeting along with the MARAC outcome to the file. A plan was agreed for a Section 9 assessment[12] which was considered as a way to make contact and offer support. The next Professionals Meeting was arranged for 23rd March 2022.

13.2.18 On 2nd 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.

[12] 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.

13.2.19 On 3rd 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.

13.2.20 On 9th 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.

13.2.21 On 16th March 2022 Adult Social Care met with the head of safeguarding to request advice and guidance on the case.

13.2.22 On 22nd 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.

13.2.23 On 23rd 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.

13.2.24 On 31st 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.

13.2.25 On 1st April 2022 the MARAC referral states that a call was made to Lena from Adult Social Care regarding a Section 9 and Section 10[13] 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 in order to get certain treatment. He said they believed in positive energy and chakras. He said reiterating heath 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.

13.2.26 The MARAC referral form recorded that on 7th April 2022 a further call was made to Lena by Adult Social Care which was again answered by Kumar. According to Kumar

[13] 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.

Lena was out. Kumar asked for email details and stated Lena would contact them on her return.

13.2.27 On 8th 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 13th 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.

13.2.28 On 11th 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 1st April 2022. Kumar stated that he felt as though the contact with professionals since Get A Drip had been harassment, and they felt harassed.

13.2.29 On 13th 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.

13.2.30 On 20th April 2022 Adult Social Care sent an email to the safeguarding lead within Adult Social Care requesting further discussion.

13.2.31 On 29th 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 22nd June 2022.

13.2.32 On 3rd 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.

13.2.33 Lena was offered a cervical smear test to be completed on 5th 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.

13.2.34 On 9th 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.

13.2.35 On 17th 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.

13.2.36 On 1st 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.

13.2.37 On 7th 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.

13.2.38 On 10th June 2022 an emergency MARAC was facilitated. The MARAC referral was dated 13th 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.

13.2.39 On 14th June 2022 Surrey Police created a Police Niche Occurrence to record the decision to arrest Kumar and document the subsequent investigation and on 16th 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.

13.2.40 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.

13.2.41 On 20th 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 21st 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.

13.2.42 On 22nd 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.

13.2.43 On 23rd June 2022, The NSDAS IDVA attempted to contact Lena 3 times. These were unsuccessful.

13.2.44 On 12th 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.

13.2.45 On 15th July 2022 Adult Social Care completed a Section 9 Care Act Assessment without Lena's input as per Section 11 (2)(b)[14].

13.2.46 On 21st July 2022 the Section 42 enquiry was closed, and the case closed to Adult Social Care.

[14] 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.

13.2.47 On 8th September 2022 Lena re-registered with her previous GP practice with an address that was within the catchment area. Lena was requested to prove her address, which she did. Lena was registered on 6th October 2022.

13.2.48 On 3rd October 2022 Kumar booked an appointment with the GP practice requesting Methylprednisolone and a steroid enema for Lena.

13.2.49 On 19th 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

13.2.50 On 27th 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 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.

13.2.51 On 29th November 2023 South East Coast Ambulance Service (SECAmb) received a call via 999 at 20:00 requesting an ambulance in relation to a deterioration in Lena's medical condition. During the 999 call, Lena was said to have a bed sore to the right of her bottom and a blister on her right foot and was unable to get up. A further call was received at 21:07 reporting worsening symptoms and that Lena was experiencing chest pain. The call came through as a category 3, requiring a 2-hour response. SECAmb were experiencing significant delays on this day, however Lena's family were advised of this delay via text message.

The Ambulance Crew arrived at 21:54 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.

The ambulance crew requested backup to help with extraction as Lena had severe pain when sitting due to the pressure sore. A second crew were requested to try to keep Lena as comfortable as possible, noting that she was extremely vulnerable. As such the Fire Service were sent to assist with extraction. Lena was taken to St Peters Hospital under emergency conditions.

13.2.52 On 2nd December 2023, the consultant psychiatrist from the Psychiatric Liaison Service from Surrey and Borders Partnership NHS Foundation Trust (SABP) had their first involvement with Lena. She had been referred to the service by the gastroenterology service who raised concerns about Lena's low weight and capacity. Lena objected to being weighed until 3rd 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.

13.2.53 Lena was seen by a nurse from SABP on 3rd December 2023 for an initial assessment and the consultant psychiatrist met Lena on 4th December 2023 along with a Foundation Year 1 colleague. Present were also Kumar and Lena's sister. 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. It was agreed that Lena would meet with another consultant psychologist. This was completed on 5th and 6th December 2023, and the consultant psychiatrist planned to review again at the end of that week.

13.2.54 On 6th December 2023 the consultant psychiatrist met with gastroenterology dietitians and discussed their concern 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. The medical recommendation was discussed, however Lena had declined this stating that she had previously been advised to have a valve replacement by cardiologists and may otherwise die, yet she had survived, so was dismissing the concerns over her death. There was discussion that there may have been potential impairment of her weighing up different information. Lena was declining an IV vitamin combination and antibiotics as well as ward care. There was discussion in relation to the process of a required formal capacity assessment and the process of the Mental Capacity Act working on the acute ward.

Later in the day on 6th December 2023, the consultant psychiatrist was informed of the concerns that Kumar was remaining on the ward 24 hours a day. It was

discussed that Lena was a patient in a female bay, so it was inappropriate for other patients, but the ward felt he had been speaking on her behalf and making it difficult to engage with her. There was discussion that the ward manager and matrons would need to enforce the visitor policy. 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 spoke to the head of safeguarding at St Peters Hospital with regards to the concerns for Lena. The head of safeguarding confirmed that the concerns had already been raised with the local authority from the admission. The head of safeguarding raised the concerns over Kumar remaining on the ward with the matrons. There was also discussion with the consultant gastroenterologist and the concerns were shared during this discussion along with discussion that the consultant psychiatrist had not elicited clear evidence of a major psychiatric disorder and also 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 7th December 2023 with the consultant gastroenterologist and the dietitians.

13.2.55 On 7th December 2023 Adult Social Care received a request for a Mental Health Act Assessment to Surrey AMPH Service at Surrey and Borders Partnership. Information was provided in relation to Lena's admission. It was also shared that Lena would require surgery due to a hole in her bowel and antibiotics to treat an abscess in her bowel. Lena was initially accepting the antibiotics by intravenous, but was later changed to oral at her request, but she later declined being of the opinion that she did not require any intervention and that she would be fine at home with a specialist diet and support from her GP. Lena had also removed her cannula. The medical opinion was that she would die without medical intervention.

Lena was placed on a Section 5(2)[15] 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.

[15] Section 5(2) Mental Health Act 1983 allows doctors to detail patients in a hospital for up to 72 hours, during which time as assessment should be conducted that decides if further detention under the Mental Health Act is necessary.

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.

13.2.56 On 8th December 2023 the consultant psychiatrist from SABP reviewed Lena alongside the consultant psychologist, consultant gastroenterologist, head of safeguarding and the ward manager. Lena continued to object the recommended medical treatment plan, had refused nursing observations overnight and declined to be weighed. It was collectively agreed that Lena had no insight into the risk of death.

A Mental Health Act Assessment was undertaken, and Lena was detained under Section 2[16]. It was of concern that the risk of death was high in the community and Lena likely had an underlying psychiatric disorder that required further assessment in hospital.

The consultant psychiatrist advised that 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.

13.2.57 On 9th December 2023 Lena was reviewed by the psychiatric liaison nurse (PLN) from SaBP who raised concern over the late presentation following weight loss and stage 4 pressure ulcer, it was explained as having a rapid onset. The PLN explained Lena's rights of appeal under Section 132 of the Mental Health Act.

13.2.58 On 10th December 2023 Lena and Kumar were seen again by the PLN who provided them with the application to appeal against her Section 2. Lena was using mindfulness and distraction techniques to manage, but it was noted that she appeared more stressed.

13.2.59 On 11th December 2023 Lena was seen by the consultant clinical psychologist with Kumar present. Lena did not wish to engage in psychological intervention but raised her frustrations. She also 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.

[16] 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 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).

Later that day Lena was seen alongside Kumar by a speciality doctor in the Liaison Psychiatry Service. They communicated that they did not wish to appeal her Section but wanted to be more involved in decision making. They felt that being in hospital prevented her from taking bone broth and homecooked meals. Kumar had also been bringing in distilled water and Lena requested to amend her elemental diet to a powdered version that could then be taken with her distilled water.

Lena was surprised 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.

13.2.60 On 12th December 2023 Adult Social Care received a request from Surrey and Borders Partnership for a Social Circumstances Report.

13.2.61 On 13th December 2023 Adult Social Care completed a visit to Lena to gather information for a Social Circumstances Report. A telephone interpreter service was used.

13.2.62 A Best Interests Meeting was held on 15th 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. When this was presented to Lena and Kumar on 16th 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 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. 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 18th December 2023.

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.

13.2.63 On 18th December 2023 Adult Social Care attended a Mental Health Act Tribunal. However, this was postponed.

Adult Social Care received the SCARF from Surrey Police dated 16th December 2023. It informed that Lena and Kumar did not believe in the treatment that the hospital were giving to Lena, and a court order had been sought by the hospital trust that had been approved for immediate effect for supplying her with antibiotics to treat the sepsis. The circumstances with Kumar were shared, informing that police had to force open the door before escorting Kumar out of the hospital advising him not to return to the hospital for 12 hours.

13.2.64 On 19th 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.

13.2.65 On 20th December 2023 Berkshire Healthcare received an urgent referral to The Gateway[17] 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. The Court had authorised the treatment of sepsis under Section 63 of the Mental Health Act. Lena died before she received any treatment or had any contact with BEDS.

13.2.66 On 21st 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 4th January 2024. The doctor was of the

[17] Formally known as The Common Point of Entry. This is where all referrals for mental health services are received.

view that Lena would require further treatment under Section 3. Lena had a tribunal for an appeal against her Section 2 on 28th December 2023.

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

13.2.68 On a date in December 2023, Lena died.

13.3 **Events Following the Timeframe of Review**

13.3.1 On 12th 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 were open with police. Police advised the social worker either submit a Freedom of Information request or to contact 101 to report concerns.

13.3.2 On 4th 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 18th December 2023. Following the death of Lena this would be closed.

13.3.3 On 5th 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.

14 ANALYSIS

14.1 **<u>Term 1</u>**

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?

14.1.1 Get A Drip, who identified and raised the concern in relation to safeguarding of Lena demonstrated exemplary practice which led to a positive response to safeguarding between agencies, multi-agency information sharing and action planning and the consideration of risk of domestic abuse.

Once the referral from Get A Drip was received by Adult Social Care, a Safeguarding Adults Section 42 meeting was conducted.

Despite there being no information or evidence held by agencies that Lena was experiencing domestic abuse, including coercive and controlling behaviour, there was strong evidence of a process of careful consideration of risk following the referral and good information sharing and creative action planning to attempt to speak to Lena alone to determine what her views were and to establish whether she was experiencing domestic abuse without putting her at risk. Adult Social Care, Surrey Police, NSDAS, Lena's GP, the Psychiatric Liaison Service (PLS) and St Peters Hospital worked together, along with gaining further information from Get A Drip, to carefully address and mitigate the risk to Lena and shared relevant information for the Section 42 enquiry to protect Lena's best interests. Risk factors were identified such as Lena and Kumar being registered at four different addresses in the last two years and all communication being dominated by Kumar, in addition to Kumar's challenging behaviour towards professionals.

Professionals faced barriers in relation to establishing direct conversation with Lena regarding whether she was experiencing domestic abuse, including coercive and controlling behaviour. For the majority of occasions where contact was established with Lena, Kumar was present and/or listening and therefore professionals made the right decision that it was not safe to explore risk in relation to domestic abuse, attempts to see Lena alone were also unsuccessful as planned contacts, such as the offer of cervical screening and the Section 9 Care Act Assessment where this could have been discussed and explored in a face-to-face contact, were cancelled. When it was deemed safe to broach such conversations with Lena, such as when Kumar was in custody, she made no disclosures. A DASH risk checklist was completed, and she answered 'no' to all questions.

14.1.2 Get A Drip clinical staff observed that Kumar often spoke on Lena's behalf, specifically detailing the treatment she received. The review panel identified a pattern of behaviour displayed by Kumar in relation to Lena's medical treatment and this was a consistent behaviour pattern across a number of health settings, such as Surrey and Borders Partnership and St Peters Hospital, whereby Kumar would be very particular or directive of how and when treatment should be provided. Examples included Kumar controlling where the blood pressure cuff would be placed on Lena's arm, resulting in challenges to take accurate readings; or placing restrictions on where body temperature readings would be taken. Kumar would place many barriers on the treatment of Lena and where treatment was agreed, he would constantly shift the goalposts, demanding different forms of treatment to what he had previously agreed.

Kumar's behaviour would become very undermining of medical professionals, often in St Peters Hospital targeting junior members of staff, with what is believed to

have been the aim of coercing them to treat Lena in ways which he directed. The extent of this was apparent within his behaviour towards a very experienced ward manager, whereby Kumar's behaviour resulted in them questioning their ability in their role. This has had a long-term impact on this member of staff. The review panel considered how this evidenced the extent of Kumar's behaviours. This pattern of moving the goalposts led professionals to be concerned in relation to his control of Lena, whereby his behaviour shifted from being that of a concerned spouse, to a controlling husband who took away Lena's voice.

Alternatively, some of the review panel felt that there was need to consider that Lena had ability to share her views and speak and therefore had her own agency in stating what treatments she did not want to receive, for example Adult Social Care identified that Lena could be very vocal at times about not liking western medicine. However, other review panel members felt that Lena did articulate her views often, but questioned whether these were actually her views, or they were in the context of Kumar's perceived controlling and coercive behaviour. The review panel shared how in isolation Kumar's behaviours presented as a doting husband, however when the information came together from all agencies involved in the review, his role in shaping Lena's decisions were observed.

The review panel also considered how some of the behaviours presented by Kumar had some similarities with fabricated or induced illness and identified the benefit of seeking further information from Kumar's medical records to identify whether this was a pattern in his own experience also, however Kumar's GP noted that he had not accessed the GP practice since 2017. The panel found it of interest that Kumar had reported to Adult Social Care that his career had been that of a mitochondrial specialist and life coach. This consideration was presented with the examples of using a range of different health settings, requesting a range of different treatments, and constantly shifting and moving the goalposts in relation to the treatment of Lena. Lena and Kumar presented that Lena had a diagnosis of Anorexia Nervosa; her medical records have no recording of this diagnosis. Lena informed that she had been diagnosed during her adolescent years, so it is thought that this could have been diagnosed when she lived in India, however it cannot be discounted that she may not have a diagnosis. During initial assessment with the psychiatrist from Surrey and Borders Partnership, there was no clear evidence of an eating disorder, however later on there was a working diagnosis of atypical eating disorder.

The medical personnel at the Get A Drip clinic, as with the other health setting are trained nurses and medical staff who are registered with the National Medical Council (NMC). Although the nurses tried to communicate directly with Lena,

Kumar frequently answered the questions for her, this was a consistent pattern of behaviour within some GP appointments and contact with other health professionals. When Lena did respond, she typically nodded in agreement. This was consistent when Surrey Police attempted to see Lena under the guise of Street of the Week; Kumar spoke on Lena's behalf despite officers asking direct questions to Lena.

During the time that Lena was admitted into St Peters Hospital, Kumar would often record interactions with professionals. Although not uncommon practice, the context of Kumar's challenging presentation to medical staff led to this making them feel uncomfortable.

At the point where the Court Order was implemented, the review panel considered Kumar's behaviour of stating he would be starting divorce proceedings and withdrawing from the hospital staff. The panel considered how unwell Lena was at that point and how his previous claims to care for Lena did not link to this behaviour. Kumar's intentions were unknown, however the review panel considered whether this was an attempt to escalate abusive behaviour as a form of control over Lena following possible feeling of loss of one form of control due to the Court Order. Although this was a consideration and not evidenced, the review panel agreed that it appeared he had little consideration of the impact on Lena or the potential to cause further distress and suffering. In addition, the expert on Sikhism shared how from a Sikh community perspective, there is no provision for divorce, and this would be frowned upon by the community, thus placing additional pressure on Lena. The review Panel considered how this threat of divorce could have been a cause of 'shame' for Lena and how this could have prompted a specific assessment relating to 'Honour'-Based Abuse which could have highlighted any concerns, however the panel equally understood how unwell Lena was at this point.

The expertise of the panel representative from Sikh Women's Aid was valuable in identifying whether any of Kumar's behaviour could link with expectations of the Sikh religion. It was confirmed that Kumar's requests, including the demands he made for specific dietary requirements or treatments had no link to the requirements of Sikhism. However, the representative on the panel did consider that similar requests may have been directed by some Sikh leaders and questioned whether any other person had visited Lena on the ward at St Peters Hospital during the 3.5 weeks leading to her death. It was confirmed that only Kumar and Lena's sister visited.

The expert also inputted information on the power dynamics of Sikh relationships. Sikh faith is clear that men and women are equal, however culture, rather than religion, can play a differing patriarchal dynamic and therefore it is possible that this could have played out in this relationship.

The Surrey and Borders Partnership delivered the Psychiatric Liaison Service (PLS) and commented upon Lena's rigid thinking pattern, which was identified from early on in their contact with Lena. It was recognised how this could have been a result of coercive and controlling behaviour placed on Lena by Kumar but also considered other options such as Autistic Spectrum Disorder and also Lena's level of malnutrition which can impact thinking patterns. It was recognised by Surrey and Borders Partnership that gaining further MARAC information could have supported them to form a view of any patterns to link to the concerns that they were seeing in Lena and Kumar. The risk posed by Kumar's behaviours was recognised, however maybe not always in the context of domestic abuse. This was an area of strengthening identified by the SaBP IMR Author.

Lena was asked by professionals about domestic abuse, including from Surrey Police and NSDAS. The review panel recognised that although Lena's first language was Hindi, she spoke, read, wrote and understood English well. Despite this, and Lena consenting to a Mental Health Act Assessment being in English, she later reflected that she would have preferred this to be in Hindi. The review panel recognised that sometimes communities, where English is not their first language, may struggle to understand professional language, particularly in the context of domestic abuse where there is often no direct translation. Therefore, if Lena would have been asked if she was a victim of domestic abuse or coercive control, this may have been challenging for Lena to identify and therefore professionals need to speak to service users using community language which they can understand. The language used in the DASH risk assessment does reflect this and the representative from NSDAS shared their expertise whereby being 'culturally sensitive' when attempting to identify or recognise domestic abuse is to not use the term domestic abuse or coercive and controlling behaviour at all, but professionals should alternatively seek to describe the behaviours, for example using questions such as; *are you able to shop for and choose your own food; is there a preference that you can have as to what you wear; if you receive a phone call, are you able to answer it without consequence?* The review panel recognised that this approach could support professionals to identify domestic abuse and therefore is a learning point for this review. The DASH risk assessment was used which described all of the behaviours of domestic abuse so Lena could have understood what it meant through this interaction.

14.1.3 On 10th February 2022, Surrey Police first became aware of Lena and Kumar and were made aware of the possibility that Lena was the victim of coercive and controlling behaviour following the referral to MARAC from Adult Social Care. The event happened on 24th January 2022, and the referral was initially sent to MASH in Hammersmith and Fulham, and then on to Surrey County Council on 31st January 2022. The MARAC referral was reviewed by the Surrey Police Domestic Abuse Case Worker and then reviewed by a police supervisor from the Domestic Abuse Team. The decision at that time was that no immediate action would be taken as it was felt that this could put Lena at risk based on the referral, which indicated any contact could potentially escalate the risk. A MARAC was scheduled for 16th February 2022, where other agencies would be present, and an appropriate plan could be put in place. This is considered a sensible and appropriate approach based on this being a third-party report, with no information known about Lena and Kumar by the police, and the importance of knowing what other information was known by other agencies before taking any action. The MARAC meeting was held on 16th February 2022.

One of the actions from the MARAC was for the local Police Community Support Officer (PCSO) to call at the address as part of Street of the Week, a local safeguarding initiative. Although the date of the visit by the PCSO had not been documented, it was recorded within an updated MARAC referral dated 13th April 2022, that it did take place. 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 for the PCSO to assess her physical condition. Upon leaving the PCSO conducted some enquiries with other households, but the occupants did not know the couple or raise any concerns.

Another action from the MARAC was for the Police Domestic Abuse Case Worker to contact Lena. Attempts were made between 22nd and 24th February 2022 and eventually contact was established with Lena, but it was not a productive conversation, and the case worker believed the phone may have been on loudspeaker and therefore the case worker was careful about what was said. Lena did not engage and asked for the identification number of the case worker because she wanted to make a complaint about police calling.

On 16th June 2022, following a further MARAC meeting, Kumar was arrested for coercive and controlling behaviour. This followed a number of unsuccessful attempts by Adult Social Care to meet with Lena, the catalyst being when Lena cancelled a meeting on 13th April 2022. The communication was sent by email

purportedly from Lena and stipulated that all future communication to be via email. Apart from the PCSO visit, no other agency had met Lena in person in response to the concern of domestic abuse.

Kumar was arrested at the home address and at the time Lena was very distressed and initially sought to prevent his arrest. Kumar was taken away allowing police and an outreach worker the opportunity to speak alone with Lena. The officer who spoke to Lena was the same officer who interviewed Kumar. The officer described Lena as being initially distressed and maintained that Kumar was her soul mate and that he would never hurt her. Between the police and the outreach worker they did try to build a rapport. During their time there, Lena phoned her sister and was described as 'ranting' down the phone about the police intervention.

In terms of identifying indicators of domestic abuse the officers completed a DASH risk assessment to which Lena answered 'no' to all the questions. The officers in attendance were aware of the concern regarding coercive and controlling behaviour and this was at the forefront of their minds at the time. Lena was offered support options but did not want any support from anyone and just wanted to move on from this "*traumatic incident"*. She did agree to maintain contact with the outreach worker and also visit her GP, which the outreach worker agreed to assist with.

It is recorded on the DASH that Lena reported having a good relationship with her sister. It is also recorded on the DASH that '*both families told him [Kumar] to put her in a nursing home when she was ill. She said he stood by her and built their own world'*. This is an area which the review panel would have liked to have explored with Lena's sister should she have felt able to contribute to the review.

In relation to her sister police did not speak to her independently. Lena also disclosed she had three close friends who lived locally but again, the police did not explore this further and seek their details.

The officer stated during the interview of Kumar that he corroborated much of what Lena told the officers. Kumar came across as caring and wanted the best for his wife but did not welcome the third-party involvement. As a result of the investigation no further action was taken and Kumar was released, the circumstances being that the officer was not in a position to re-visit Lena, which in the majority of other cases the offer states they would do where an investigation was ongoing. The officer updated Lena prior to his release, and she was very grateful for the update and welcomed the news that Kumar would be returning home.

The officer was spoken to as part of the IMR process for this review and having had the opportunity of reviewing the details had some recollection of the events. Lena came across as protective and defensive of Kumar, this did appear to be genuine. The officer did not speak to her sister which on reflection they now feel they should have done to at least try and get independent information about the relationship. Likewise, no enquiries were made to obtain the details of the three friends Lena referred to. Acknowledging the comments from the officer, and the fact that they did not speak to Lena's sister or friends, Lena did nevertheless provide background to the relationship, and although the initial enquiries were not made that does not necessarily mean the outcome would have been any different.

On 16th December 2023, Surrey Police attended St Peters Hospital as a result of Kumar barricading himself into the room denying staff access to Lena. There was a brief stand-off between police and Kumar who came out without incident and was arrested to prevent a Breach of the Peace.

It is recorded on the initial summary of information request completed by Surrey and Borders Partnership NHS Trust that Kumar told staff he knew martial arts and showed his Kirpan Knife which led to his arrest. There are differing accounts whereby police stated that the arrest was to prevent a Breach of the Peace and not linked to the Kirpan.

Police officers spent an hour with Kumar at the hospital because they wanted to better understand the nature of the Court of Protection Order that Kumar was claiming he had appealed via his solicitor and therefore the Order was not enforceable. This was a complex issue regarding the legality of the Order and officers were able to satisfy themselves by speaking to the director of nursing, who had been dealing with the matter during the course of the previous day, that no appeal had been lodged and the Order stood. Kumar was advised of this fact and although he was not preventing the treatment, he was disagreeing with the method of treatment.

Lena could be seen on the officer's Body Worn Video (BWV), she was conscious and had access to her mobile phone. When Kumar was being removed from the room and verbally protesting, she was telling him to calm down. The BWV is very helpful in terms of assessing the situation, the interactions with the hospital staff, and Kumar. There were no indicators for domestic abuse as a result of the hospital admissions, and no concerns raised regarding the physical condition of Lena as a result of domestic abuse. Based on the circumstances presented at that time, there were no grounds to arrest Kumar for coercive and controlling behaviour or any

other domestic abuse offences. He was subsequently de-arrested for the Breach of the Peace and went home.

The police officer completed a Single Combined Assessment of Risk Form (SCARF) raising a vulnerable adult risk in respect of Lena with concerns regarding her ongoing treatment upon release from hospital. This was submitted to the Police Single Point of Access (PSPA), formally the Multi Agency Safeguarding Hub (MASH) who forwarded this to Adult Social Care on 18th December 2023.

The police officer was aware of the previous incident of suspected coercive and controlling behaviour when Kumar had been arrested. However, those concerns were not present when they attended this incident. The officer did not speak to Lena due to her condition and the fact that she had been detained under the Mental Capacity Act. On reflection the police officer acknowledged that attempts could have been made to speak to Lena. This was based on the BWV which did show her to have some level of capacity, and she was able to speak, although she did look unwell. This may have been helpful, but again it is difficult to assess or comment on whether this would have added anything further.

The police officer was asked by the Surrey Police IMR Author about any weapons and although they did not initially search Kumar, he was searched under a lawful power following his arrest. The police office believed Kumar may have spoken about his Kirpan but could not be certain. The BWV did not pick this up, and likewise had the Kirpan been considered an offensive weapon Kumar would have been arrested.

Despite the limited contact police had with Lena, there was an appropriate level of supervision and management of the police response and investigation. In relation to the first MARAC referral there was sufficient multi-agency representation and oversight to seek to engage with Lena. The supervision and control of the investigation continued resulting in the arrest of Kumar in June 2022. The next event involving police contact was on 16th December 2023 and based on the circumstances there was an appropriate level of support and guidance to the officers dealing with this incident.

In both incidents the police followed the policies and procedures in place at that time. Since these events changes have been made to the risk assessment and recording and this is covered in Term 5.

14.1.4 Datchet Health Centre provided information prior to the timescale under review which was believed to be relevant. Lena last visited the surgery in person in 2019

as she was being treated for her condition by consultants at other secondary care hospitals, who prescribed medication for her Ulcerative Colitis, which was never administered by Primary Care.

The Covid-19 pandemic would have restricted face-to-face appointments, so telephone consultations became the way of communicating whenever Lena and Kumar needed to talk to a GP. As Kumar liked to be involved in her care planning, the telephone call was on speaker so both Lena and Kumar could hear and speak. The records stated that Lena's consent to talk with Kumar present on the phone was asked on each call. This is not unusual, and nothing was noted during those consultations that was concerning to the GP prior to the domestic abuse revelation in February 2022. Written consent was received from Lena to the practice allowing Kumar to be part of her care making decisions in 2015. As there were no concerns, no routine question about domestic abuse was asked. The review chair considered whether this process should be reviewed to consider situations where there are concerns about coercive control. The health representative on the panel shared that it is a patient's right to choose if an advocate is informed and involved in decisions about their health. Health professionals would assess each individual case when deciding on the suitability of an advocate request. If there were concerns regarding coercive and controlling behaviour from an existing advocate a safeguarding referral would need to be submitted, and a directive received from a Section 42 to prevent an advocate dealing with a GP on the patient's behalf.

Regular weekly supervision was conducted with the GP, particularly in relation to this case.

In March 2022, another GP had a difficult conversation with Kumar because vitamin D injections were not agreed until bloods were taken to determine the levels already in Lena's system. This GP felt that Kumar was aggressive on this call, and Lena did interject and say she would seek private medical help.

14.1.5 During Psychiatric Liaison Services (PLS) first conversation with Lena on 2nd December 2023 it is noted that she denied being at risk from anyone, but there is no detail about what the conversation involved and no evidence that domestic abuse was specifically explored. Within this same conversation Lena described a close relationship with Kumar who looked after her "*like a baby*" when ill. The SaBP notes suggest that she was seen without Kumar present as the only other person noted to have been spoken with was Lena's sister.

On 6th September 2023 the consultant psychologist saw Lena on her own and identified a safeguarding concern about neglect which was discussed with the Head of Safeguarding at St Peters Hospital.

On 7th December 2023 PLS were informed by the AMHP service that they had a different name recorded for Lena and that she had been referred to MARAC the previous year. PLS raised this with the head of safeguarding at St Peters Hospital and established that the MARAC referral had been in relation to an allegation that Lena was attending a health provider four times a week for vitamins and seemed coerced by Kumar. At this point there was no liaison with SaBP colleagues who sit within the MASH and attend all MARACs on behalf of the Trust. They could have shared more detail from the MARAC referral and actions achieved and put PLS colleagues in touch with the Adult Social Care Mental Health Team to gather more information.

There is no evidence that PLS specifically sought to see Lena without Kumar present at any point after this. There were ongoing discussions with the head of safeguarding at St Peters Hospital, as well as proactive responses to Kumar seeking to discharge her from hospital in his role as Nearest Relative. However, the term 'domestic abuse' does not appear anywhere in the notes, so it does not appear that Lena's presentation was being viewed through that lens. The SaBP IMR Author did however note that Lena's objections to the proposed treatment plan were very strong in their own right, and seeking a way to address her dangerously poor health was the focus of the involvement of PLS.

14.1.6 Lena was not known to Ashford and St Peters Foundation Trust prior to admission to the acute hospital at the end of November 2023. Kumar was present and reported that he had been trying to treat the pressure damaged areas to Lena's body at home due to her fear of hospitals. It was also reported that Lena had been seen and her wounds cleaned by a private nurse. Kumar reported having called 999 that day as Lena's condition was not improving. The review panel were unable to identify who the private nurse was. It would have been helpful for professionals to show greater curiosity when private medical professionals are used to identify who the professionals are.

Coercive controlling behaviours were not noted during Lena and Kumar's time in the Emergency Department. The focus was on stabilising Lena's condition and reducing her pain levels. Concerns were raised by Emergency Department staff regarding possible neglect in the community from the private nurse provider in regard to managing the pressure damage.

Once moved to the ward, concerns started to arise regarding both Lena and Kumar downplaying her symptoms, declining food due to her specific dietary plan and Kumar attempting to manage aspects of her environment and care. Kumar and Lena's sister initially became increasingly present on the ward and began directing care and refusing offers of nutrition. This was initially viewed as family support, with Lena being very weak and was not seen as being possibly harmful. There were several attempts made to get an accurate weight for Lena, which were deemed not to be possible by Kumar for a number of reasons which all were plausible given her physical condition, but which raised some concerns with staff.

Staff became increasingly concerned regarding Kumar creating barriers to care being delivered, such as requesting a particular food supplement, and once available, changing the request to a different type. It was very challenging for the staff to discuss concerns directly with Lena, both due to her extreme frailty and her very rarely being seen without Kumar being present.

Once concerns were escalated, staff were well supported, and the multi-disciplinary team approach provided good direction in relation to meeting Lena's care needs.

14.1.7 The Covid 19 pandemic restrictions on face-to-face contact led to there being limited face-to-face interaction with Lena and appointments, such as with the GP and Circle Health Group, were facilitated remotely. Lena did attend as a day case admission for an endoscopic procedure with Circle Health Group which lasted just over four hours. There were occasions during this admission where Lena was alone with staff.

14.2 **Term 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?

14.2.1 The review panel considered that Lena had been unwell for some time, to the extent where Lena and Kumar reported to Surrey Police that Kumar had given up his successful career in IT to care for Lena, noting that this is a different career to what Kumar stated to Adult Social Care detailed within Term 1. Panel members considered whether Lena should have been identified as having care and support needs in relation to Section 42 given that Kumar was delivering this level of care

for her. The representative from Frimley ICB shared that there was not enough evidence identified at the time by the GP that Lena had care and support needs. Lena's condition was manageable, and Kumar provided home care; no mental health concerns were observed so Mental Capacity Assessments were not deemed necessary or completed. Lena actively participated in telephone conversations, expressing her thoughts and opinions, providing consent for Kumar to be on the call. Identifying any care and support needs could have been impacted by many appointments with the GP not being face-to-face.

In the weeks leading to Lena being admitted into hospital, she became bedbound. This led to the 3.5 weeks prior to her death where she was admitted into St Peters Hospital and was extremely frail and unwell. The panel acknowledged that this would suggest care and support needs, however, Lena and Kumar did not access the same services consistently to allow identification of this. Adult Social Care did offer an assessment to Kumar; however, this was declined. The pattern of accessing different health settings was identified as a barrier to identifying this information and it was acknowledged that there is little known about the private healthcare that Lena accessed, as sharing this information with Lena's GP would have required her consent. Frimley ICB had no information on the private healthcare that Lena and Kumar accessed, especially given some of this was outside of the UK.

It was acknowledged that Lena's GP was in Berkshire and therefore this would have impacted what services Lena could access in Surrey. There was discussion of the need to ensure that the gap can be bridged between the two counties.

14.2.2 The review panel considered at the point where police attended the hospital with regards to Kumar's behaviour, whether any officer asked Lena as to whether she wanted the care being offered by the hospital or not. The police representative reflected that they should have been asked if she wanted treatment, however Lena was extremely unwell at that point and at that time she had accepted that she needed the treatment. Officers did however spend approximately an hour having discussion with hospital staff to understand the Court Order. Although Kumar was de-arrested at the hospital and taken home, it was acknowledged that it would have been useful for officers to ask Lena why she thought Kumar did not wish for her to have the treatment.

14.2.3 Lena attended the Get A Drip clinic after Kumar reported her to be dehydrated and in need of assistance with her nutrition. The medical staff explained the medical disclaimer to both Lena and Kumar, and Lena nodded before signing the document.

On two occasions prior to the safeguarding referral made by Get A Drip, both Lena and Kumar appeared calm, although Lena rarely communicated during her treatment, she would simply nod or say very few words when staff tried to engage her again.

14.2.4 During her admission to St Peters Hospital, Lena had very clear care and support needs due to her physical health and cognitive impairment. She was physically unable to provide any elements of her own care, and prior to admission, all care had been provided by her family. Lena was reported as having become bed-bound in the previous few weeks.

Lena was involved in discussion regarding her health choices, and regularly deferred decisions to Kumar, apparently choosing not to engage with staff. Whilst this was initially regarded as appropriate given how unwell Lena was, it became apparent that the decisions being made did not appear to be promoting or prioritising Lena's health needs; being driven and coordinated by Kumar and his apparent need to control all aspects of Lena's care.

PLS consistently checked that safeguarding concern referrals had been made. There was no information relating to any known mental health need prior to her admission to hospital and a full assessment of her mental health was not possible due to her very poor health and suspected impact on her cognition.

The initial referral to PLS was due to the general hospital having concerns about her mental capacity to make decisions regarding her health. On 6th December 2023 PLS identified to the Gastroenterology dieticians that a formal capacity assessment was needed. Later the same day the PLS shared with the consultant gastroenterologist that they had "*not elicited clear evidence of a major psychiatric disorder, she had denied body dysmorphic cognitions, or clear features of an eating disorder. She had denied that this was a form of deliberate self-harm and had seen no evidence of severe depression or psychosis*". PLS did have concerns about her "*very concrete and black and white thinking which could fit with Autistic Spectrum Disorder (ASD), but her level of malnutrition alone would cause cognitive changes and a rigid thinking pattern*". PLS were informed that an MRI would be arranged to rule out any organic cause. The need for an assessment of her capacity to make decisions about her treatment was again discussed.

On 7th December 2023 the PLS consultant psychiatrist was informed that the ward medical team had assessed Lena as having capacity to make relevant decisions. The PLS consultant psychiatrist raised his concern about her rigidity of thinking and

offered to support a mental capacity assessment, but medical staff would have needed to lead on that as the experts around risks and opinions.

On the same date Lena wanted to discharge herself from hospital and following a conversation with the PLS consultant psychiatrist she was detained under Section 5(2) of the Mental Health Act. Lena was assessed under the Mental Health Act on 8th December 2023 with the outcome that she was detained under Section 2 for a period of assessment and treatment. This would not have covered medical treatment unless as a direct consequence of a mental disorder and that was not clear at the time. The PLS consultant psychiatrist advised again that a Mental Capacity assessment was needed. They also discussed the issue with Paralegal at the hospital as well as peers within SaBP who agreed that the Mental Capacity Act should be explored in relation to physical health decisions.

On 12th December 2023 the PLS consultant psychiatrist agreed to undertake a Mental Capacity Assessment alongside two gastroenterologist consultants, and this was completed using an interpreter on 13th December 2023. The outcome was that Lena lacked capacity to make relevant decisions due to being unable to show that she was weighing up relevant information to make the decision.

A Best Interests Meeting was held on 15th December 2023 and determined that all proposed treatments were in Lena's best interests and divided them into those thought to be essential and urgent and those that could wait until she was more medically stabilised and may regain capacity. 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. When this was presented to Lena and Kumar on 16th December 2023 the incident requiring police attendance occurred. 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.

On 18th December 2023 Lena's solicitor informed the hospital that she was now agreeable to all proposed treatment. Her solicitor was able to explain that Lena had objected to TPN due to a bad experience in India when she experienced visual disturbance. The PLS consultant psychiatrist noted that TPN had been discussed repeatedly with her, and she had not previously raised this. Despite Lena deciding to agree with treatment, it was recognised that this did not change the assessment of her capacity and treatment was still being provided in accordance with the Order from the Court of Protection. On 21st December 2023 the PLS consultant psychiatrist received the outcome of the Court of Protection hearing on 20th

December 2023 which upheld the rulings for medical care and accepted the proposal that ongoing nutrition fell under the umbrella of Section 63[18] powers.

14.2.5 Lena attended The Circle Health Group for exploration of her colitis. Lena was identified as being of low body weight, but this was plausible in view of signs of colitis. There were no presentations or information to indicate this was due to any other reason at that time. Lena presented at her telephone and video appointments and her admission as having mental capacity for decisions around these interactions and the procedure itself.

14.2.6 Prior to the referral made by Get A Drip, Lena was not known to Adult Social Care. At that time there was no information to indicate whether Lena was in need of community care services by reason of mental health or other disability, age or illness. In addition, there was no information from the referral to indicate whether Lena was unable to take care of herself, or unable to seek protection or protect herself against significant harm or exploitation. There was an intimation that she was unable to protect herself due to staffs' subjective views of their interaction with Kumar.

However, following further contact with the referrer Adult Social Care made the decision to undertake a Section 42 Care Act[19] enquiry.

Adult Social Care also made the decision to undertake a Section 9 Care Act assessment[20] as there was reason to believe with the information available at the time that Lena had the appearance of care and support needs due to her diagnosis of an eating disorder and physical health conditions, uncreative colitis, and osteoporosis. It was also hoped that this assessment would enable Adult Social Care to enter into a discussion with Lena to establish whether she was or not experiencing domestic abuse.

Adult Social Care were of the view that an assessment of care and support needs under Section 9 of the Care Act was appropriate with the information available at the time and arrangements were made to complete the assessment to which Lena agreed to. However, on the day of the booked assessment Lena cancelled the assessment. Kumar had previously declined a Section 10 assessment of any carers needs.

[18] Section 63 of the Mental Health Act, 1983, allows medical treatment for mental disorders without the patient's consent.
[19] https://www.legislation.gov.uk/ukpga/2014/23/section/42
[20] https://www.legislation.gov.uk/ukpga/2014/23/section/9

Adult Social Care made the decision to complete a Section 9 Care Act assessment without the involvement of Lena or Kumar exercising 2a of Section 11(1) to (4)[21] (refusal by adult of assessment).

Due to lack of engagement with the Section 9 Care Act assessment Adult Social Care were unable to complete a Capacity assessment. The principled of the Mental Capacity Act 2005 [22]were therefore followed.

During Adult Social Care involvement from 21st January 2022 to 21st July 2022 there was no evidence that Lena lacked capacity or was experiencing any executive functioning around decision making. During her admission to hospital from 8th December 2023 the psychiatrist responsible for her care and treatment formed the view that she was experiencing diminished mental capacity due to her established mental health diagnosis of anorexia nervosa and the associated low BMI on 10.7. The IMR author anticipated that the thought process of the psychiatrist at the time was that although Lena may have thought to be able to demonstrate that she was able to understand, retain and communicate decisions with regards to the care and the treatment that the decision was not capacitous because anorexic cognitions affect the ability to use and weigh the information. During this admission Lena refused to be weighed or have a heart monitor on.

14.2.7 Following the incident at St Peters Hospital where Kumar was arrested for Breach of the Peace, Surrey Police made a referral into Adult Social Care raising concern for Lena's ongoing care and support upon discharge from hospital.

14.3 **Term 3**

What avenues were explored to address safeguarding concerns? Were there any missed opportunities to make referrals into both statutory and non-statutory services?

14.3.1 PLS have recorded in their initial consultation with Lena on 3rd December 2023 that her GP record indicated there was a safeguarding concern in February 2022, which was the Section 42 raised following referral by Get A Drip. This was identified through a review of records and there is no indication that a discussion about safeguarding or a question about domestic abuse was posed to Lena herself. There is no indication that the substance of the concern from the previous year was fully explored. By 6th December 2023 it was noted by PLS that there was a safeguarding concern regarding neglect. The PLS consultant psychiatrist discussed this with the

[21] https://www.legislation.gov.uk/ukpga/2014/23/section/11

[22]https://www.legislation.gov.uk/ukpga/2005/9/section/1#:~:text=(1)The%20following%20principles%20apply,have%20been%20taken%20without%20success.

head of safeguarding a St Peters Hospital the same day and also asked that the concern about Kumar remaining on the ward with Lena was referred.

On 7th December 2023 the PLS consultant psychiatrist had a conversation with the Surrey County Council AMHPs regarding a Mental Health Act assessment and was informed by them that Lena had been discussed at MARAC the previous year. This was discussed with the head of safeguarding at St Peters Hospital. On 8th December 2023 it is noted in an MDT meeting that a safeguarding concern had been raised in relation to suspected controlling and coercive behaviour by Kumar.

There was a reliance on the general hospital making a referral to the Local Authority regarding the safeguarding concerns. However, the Care and Support Statutory Guidance states that *no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. If a professional has concerns about the adult's welfare and believes they are suffering or likely to surer abuse or neglect, then they should share the information with the Local Authority and/or, the police if they believe or suspect that a crime has been committed*.

There was no referral to domestic abuse services by PLS or the hospital, however this was driven due to Lena being critically unwell, the primary focus was improving her physical health.

14.3.2 There were no missed opportunities identified by Adult Social Care to make referrals into both statutory and non-statutory services. The following actions were taken by Adult Social Care:

- Section 42 enquiries undertaken
- Section 9 Care Act assessment
- Referral to MARAC
- Attendance at MARAC meetings
- Regular contact and follow up with Surrey Police
- Referral to ESDAS and NSDAS
- Professionals' meetings
- Consultation and guidance sought from Surrey County Council safeguarding lead
- Consultation and guidance sought from Surrey County Council mental health safeguarding advisor.

Adult Social Care's response to information and/or risk assessments were shared in accordance with agency policies and procedures including multi-agency ones.

14.3.3 The nurse at Get A Drip appropriately escalated their concerns by refraining from providing treatment based on the concerns and consulting one of the on-call doctors. The nurse also escalated the matter to the safeguarding lead and completed the referral in accordance with company policy. The company and medical team were not aware of any safeguarding alerts or referrals from other agencies.

14.3.4 Prior to Datchet Health Centre receiving notification from Adult Social Care regarding a domestic abuse referral, the practice had not witnessed or been informed of any concerning behaviour between Kumar and Lena that would have triggered a risk assessment or prompted a discussion with Lena to ask the routine enquiry question. The Circle Health Group identified no safeguarding concerns and recorded that her low body weight was a plausible physiological explanation, hence having the procedure which she did. The consultant wrote letters to Lena's GP advising of their involvement.

14.3.5 Unfortunately, although safeguarding was considered as a concern for Lena by Ashford and St Peters Foundation Trust, due to her being acutely unwell, it was not possible to pursue this fully before her death. Involvement of partners would have formed part of any support discharge process if her health had improved.

14.3.6 Surrey Police did seek to explore safeguarding concerns with Lena when they spoke with her on 16th June 2022. Lena did not disclose any concerns and articulated her reasons to officers and the outreach worker, Lena complained and felt harassed at the intervention of police, other agencies and professionals.

On two occasions when police were directly involved with Lena and Kumar, the circumstances of their involvement were shared with other agencies. In relation to the MARAC referral, the efforts made by professionals in the lead up to the arrest, and following the arrest, were shared with partners. Following the incident at the hospital, this was shared with partners in accordance with the force policy via a vulnerable adult at risk form completed on the SCARF. Based on these two incidents, and the IMR presented by Surrey Police, it is not believed any opportunities were missed.

14.4 **Term 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?

14.4.1 Whilst admitted to St Peters Hospital, staff recorded they became uneasy with Kumar's behaviour whereby he would record interactions. He would also leave

concealed devices such as mobile phones in the room on the occasions that he left Lena alone. The staff were concerned he could be using these devices to record Lena when he was not present. Although it is acceptable and common for patients to record their interactions with medical professionals, the staff involved and the review panel were concerned that Kumar's intentions when possibly recording these interactions were in relation to his control over Lena and not for the purposes encouraged by the General Medical Council (GMC). This prevented safe opportunities to hold conversations with Lena when Kumar was not present relating to possible controlling or coercive. The review panel agreed it would be beneficial for professionals to understand such barriers to why victims of domestic abuse may be unable to disclose the abuse and therefore for professionals to consider other opportunities for victims reporting rather than having to verbally discuss any disclosure.

The ward staff made attempts to engage directly with Lena on numerous occasions, however in addition to the issues outlined above, Lena was extremely unwell, making challenging conversations inappropriate to pursue.

14.4.2 Get A Drip identified the below barriers that may have prevented Lena from seeking support:

1) Kumar's presence was dominated, which often resulted in him communicating on Lena's behalf.
2) Lena rarely initiated communication with staff; she typically only responded to questions without offering additional information.

However, the review panel identified that on one occasion he left Lena alone to receive treatment.

Medical staff made continuous efforts to engage with Lena throughout her appointments but received minimal responses. Her demeanour was constantly calm. When clinic staff asked for her consent to check her vital signs, insert a cannula, and provide intravenous treatment, she would either say yes or nod in agreement. However, there were continuous concerns regarding Lena's autonomy, as decisions about her treatment were predominantly made by Kumar.

14.4.3 Lena denied domestic abuse including that of coercive and controlling behaviour including when this was addressed when she was not in the company of Kumar.

It is acknowledged that the most commonly identified cultural barriers in reporting domestic abuse and accessing support services are immigration concerns, such as fear of deportation; cultural issues, such as patriarchal social norms that facilitate abuse; monitoring and surveillance and lack of social networks; racism and cultural

sensitivity which can lead to a lack of trust in the police and public services. It is not possible to know whether these existed for Lena due to a lack of evidence and/or information from her or friends and/or family members and no police evidence. UK statistics in 2023 (Office for National Statistics, 2023[23]) for domestic abuse report almost twice as many women in the White ethnic group experienced domestic abuse in the last year (6.0%) compared with Black or Black British women (3.1%) and Asian or Asian British women (3.0%). It is however acknowledged that there may be underreporting in other ethnic groups.

It is noted that during the Mental Health Act assessment on 8th December 2023 that Kumar did agree at the professional's request to leave the room to enable the assessing team, including AMHP, to speak to Lena in private.

14.4.4 English was not Lena's first language. However, it was not until she stated to SaBP that she felt misunderstood and requested that assessments were undertaken in Hindi that this appears to have been taken into account. She was in conversation with a PLS specialist doctor who was fluent in Hindi when she stated this, and she was seen by a consultant psychiatrist who spoke fluent Hindi later in her admission. Although this enabled gathering of additional collateral information, the opportunity was not used to seek and gain an understanding of her relationship with Kumar and explore the concerns about domestic abuse. The SaBP IMR author noted that it does not appear that a translation service was routinely used for conversations with Lena following her request.

It was known by SaBP that Lena grew up in India and came to the UK to get married, but there is no evidence of any exploration of her culture and how that may have impacted on her relationship or her views on healthcare. It is clear that Lena was also vocal about her objections to proposed treatment and there were concerns about her ability to weigh up relevant information to make a decision due to her apparently very rigid thinking. This concern was borne out in the formal assessment of her capacity which was conducted with the support of a translator. These concerns, along with the immediacy of the need for medical intervention, likely impacted on clinician's decisions around how much exploration of the impact of her culture and the possible domestic abuse to undertake while she was so unwell.

Kumar was with Lena on most occasions when PLS saw her. The SaBP IMR author noted that when she was seen by a specialist doctor who was fluent in Hindi on 19th December 2023 Kumar and her sister were present and the doctor recorded

[23]ONS, 2023. At: file:///C:/Users/HulseM/Downloads/Domestic%20abuse%20victim%20characteristics,%20England%20and%20Wales%20year%20ending%20March%202023.pdf

that he asked Lena to tell him if she wanted more privacy. It would have been more helpful for the doctor to insist on speaking to Lena alone, at least for part of the conversation, to be able to ask her about domestic abuse.

14.4.5 Datchet Health Centre and the Circle Health Group determined potential barriers to disclosure as being challenging. While Covid-19 may have influenced patient-provider interactions, Lena's visits and interactions with the GPs did not necessitate routine enquiry questions. Subsequent attempts to schedule appointments for a flu jab and cervical smear tests were unsuccessful. The practice continued to offer these appointments on multiple occasions even when they had been declined. This is unfortunate as it would have provided possible opportunities for Lena to be seen alone.

14.4.6 Following Kumar's arrest on 16th June 2022, Surrey Police officers and the outreach worker were able to explore information on Lena's views of the marriage, her health and her care and treatment. In view of the responses, it was difficult to assess whether in fact there were barriers that prevented Lena seeking help.

The incident on 16th December 2023 was not a domestic abuse incident and was treated as a vulnerable adult concern by the police. Given the extent of medical intervention, the fact that Lena had been subject to assessment under the Mental Capacity Act, her release was not considered imminent, there was limited action the police could take in respect of Lena. A vulnerable adult referral form was considered an effective response to this incident in alerting Adult Social Care of the concerns post discharge. It is considered there was a sufficient level of engagement by police in both incidents.

14.4.7 Circle Health Group have signage in relation to domestic abuse present in the surgery; however, the review panel identified the need for this message to be in other accessible languages.

14.4.8 It is believed that Lena had entered the UK on a Spousal Visa. Lena reported to Surrey Police that Kumar was helping her to obtain British citizenship as she had been in the UK for a continuous period of five years. It is not understood that Lena had obtained British citizenship before her death. The Panel considered how Lena not having yet having obtained British citizenship could have presented a barrier to her disclosing abuse as her visa was dependent upon Kumar and as such the Panel agreed that this review could highlight an opportunity to share information and support options available for women with no recourse to public funds with insecure immigration status.

14.4.9 The Panel acknowledged that is would be useful to raise awareness of 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 and that awareness of these services could have possibly prompted consideration of supporting Lena to access helplines on the rare occasions she was seen alone.

14.5 **Term 5**

How did your organisation assess the risk faced by Lena from Kumar, 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?

14.5.1 During Lena's last appointment with Get A Drip, in which the safeguarding concern was raised, the medical staff noted the potential risk posed by Kumar's behaviour. The medical staff, an experienced nurse, was also alarmed by Lena's weight. After asking appropriate questions and evaluating Lena's responses, they escalated the situation to one of the doctors, who advised that further investigations were necessary before proceeding with an intravenous drip, leading to Lena being declined treatment. This response aligned with their safeguarding policy, and the appropriate staff members were notified. A safeguarding referral was completed, and communication with the Local Authority occurred after the referral.

14.5.2 Adult Social Care responded immediately from receipt of the referral from Get A Drip by making further enquiries under Section 42 of the Care Act.

It is clear from the minutes of the Section 42 Safeguarding meeting chaired by Adult Social Care that possible risks to Lena were identified, and consideration was given as how to not increase risk by further agency involvement and creative approaches to meet with Lena on her own were discussed and considered, such as offering cervical screening at her GP surgery.

In the Adult Social care AMHP report of the assessment under the Mental Health Act, 1983, on 8th December 2023 it clearly documents that Lena was assessed in private without Kumar present.

Adult Social Care did not complete a DASH as this was completed by Surrey Police with Lena when Kumar was in custody.

14.5.3 SaBP did not complete a specific risk assessment regarding domestic abuse. There is now however a tool available on SystmOne to support clinicians in exploring domestic abuse and assessing risk. This includes the DASH risk assessment, although not all staff are trained in the use of this and there are prompts

throughout the tool to contact domestic abuse services for support for the adult but also for the professionals working with them. DASH risk assessment training is being explored for SaBP staff, although support from specialist services would still be encouraged to ensure that this is done effectively. The SaBP safeguarding team are available to all clinicians for advice and guidance in relation to safeguarding adults and domestic abuse. The new tool on SystmOne contains prompts to consider a conversation with the team.

It is clear that the risk that Kumar posed to her was in the mind of PLS clinicians, as evidenced by their conversations with the head of safeguarding at St Peters Hospital and also their proactivity in relation to him being her Nearest Relative under the Mental Health Act. However, this does not appear to have translated into their direct work with her. As already stated, that may be due, at least in part, to the focus being on her immediate physical health.

14.5.4 After Datchet Health Centre received notification of the referral and Section 42 contact, it was discovered that a risk assessment had already been completed by other agencies to identify Lena's safety. The GP actively participated in a professionals meeting and implemented necessary actions.

During a telephone consultation, the GP identified Kumar's aggressive behaviour and promptly reported it to Adult Social Care, recognising its potential impact on Lena's risk level. A multi-disciplinary team meeting was convened within the practice to discuss Lena's case, ensuring information sharing among all relevant in-house professionals. Safeguarding flags and additional information were added to her patient record to enhance visibility of concerns which were assessed for all practitioners who accessed her notes. All correspondence sent to the practice with multi-agency partners was added to patient record.

14.5.5 Unfortunately, Ashford and St Peters Foundation Trust staff found it not possible to fully assess the risk to Lena as she was acutely unwell at the time of her admission. The initial picture on Lena's presentation to St Peters Hospital and PLS was of an attentive husband who was providing care and support to his wife; this was not challenged as there was no information available to contradict his, and all of Kumar's actions were seen through the lens of a concerned spouse. The safeguarding training provided to Trust staff supports being professionally curious which was helpful for staff identifying that Kumar's behaviour was delaying and on occasion preventing treatment being given to Lena, resulting in escalation and definitive action being taken to try and safeguard Lena from possible abuse or harm The hospital staff did have significant concerns regarding the nature of Lena and Kumar's relationship resulting in interventions such as removal from the ward and an application to the Court of Protection being made to facilitate delivery of

health care. There was concern regarding being able to document the level of risk once it had been identified, however given Lena's extreme frailty, completing a formal risk assessment was not high priority.

14.5.6 The DASH risk assessment tool was used by Surrey Police in assessing the potential risk faced by Lena from Kumar.

In July 2023, Surrey Police launched a coercive and controlling behaviour improvement plan, which was published on the Force's intranet site and has also been incorporated into the updated Force Policy on Domestic Abuse. The intention was to improve the identification and recording of coercive and controlling behaviour as crimes and as part of raising officer awareness, guidance has been issued in relation to six questions on the DASH risk assessment which help to better inform identification of coercive and controlling behaviour.

The current forms used across the Force for recording and referring domestic abuse, adult and child at risk notification is the SCARF, and within that the DASH is the risk assessment tool for domestic abuse. The SCARF is being replaced with a new form called SIGNS (no acronym) and the DASH is being replaced with a new risk assessment tool to the Force called DARA (Domestic Abuse Risk Assessment). The use of the DARA is now recommended by the College of Policing. SIGNS will still incorporate the necessary forms for vulnerable adult and children at risk as well as domestic abuse, stalking and harassment, but the way in which these forms are recorded on the current crime and information system Niche is moving away from what is known as a Niche Occurrence, to an Event. An Event will now be created and is an intuitive process that guides officers through whatever incident they are dealing with ensuring that the relevant question sets are completed. The system will not allow an officer to move on from a question without providing the necessary information. The questions are designed to be more specific around risk whereas the current assessment tools allow for free text information, which is not always answered accurately, or that informative. The Event also informs officers where the form should be sent for example, in a domestic abuse incident it will inform the officer to submit the form to Outreach Services. This will help improve the current performance around sharing information with partners. The use of the new forms is currently being piloted on one area in Surrey and the intention is that this will be rolled out across the Force in early 2025. The new SIGNS form has been developed with significant input from Adult Social Care and Children's Social Care in Surrey.

Surrey Police are also seeking to utilise an IT based performance management system called Power BI, which is intended to be able to populate the SCARF

(SIGNS) forms with previous referrals. PowerBI will enable the drawing of information from one quick search which means the PSPA will be able to share more information with partners. These new developments demonstrate the Force appetite for change to improve the service provided to victims of domestic abuse, vulnerable adults, children at risk, and partner agencies.

14.6 **Term 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?

14.6.1 The DARDR panel considered that Lena and Kumar attended different temples. This behaviour was recognised as being consistent with moving around various medical facilities both within the UK and abroad. This was further challenged by them living on the boarder of Spelthorne and also accessing cross boarder medical services. Although not unusual to attend different health settings due to each having different specialities and to access appropriate medical interventions, in this context it was considered whether this could have been an attempt to prevent authorities identifying what was happening and also had a theme similar to those identified in fabricated or induced illness, as explored in Term 1, however it is of note that this was a consideration of the panel and there was no evidence that this was the reason for the use of various medical settings.

14.6.2 There is evidence of good partnership working and information sharing by Adult Social Care with a wide variety of agencies including Surrey Police, NSDAS, Surrey and Borders Partnership Psychiatrist and Psychiatric Liaison, the GP, MARAC, Dietician and General Hospital nursing staff.

14.6.3 NSDAS were embedded into the multi-agency partnership approach, working with police and North Surrey Mental Health Team and attended a home visit on 16th June 2022 to speak to Lena. The NSDAS IDVA agreed to work alongside the police and North Surrey Mental Health Service to support Lena, however Lena's case with NSDAS was closed on 12th July 2022 and all partners were notified. The reason for closure was due to NSDAS being unable to maintain contact with Lena and all Section 42 enquiries has been completed.

14.6.4 There was good multi-agency working which focussed on Lena's health and welfare to try and prevent her death. This was emotionally challenging for all staff involved in her care and had a lasting impact on the ward nursing and nutrition teams particularly. Post incident debriefing was put in place and the ward engaged well with this which was positively received.

14.6.5 There is evidence within SaBP of good partnership working and information sharing with St Peters Hospital, including their head of safeguarding. The PLS consultant was instrumental in supporting the medical doctors at St Peters Hospital to complete their assessment which led to the application to the Court of Protection, although it is felt by SaBP that this should have happened sooner. There is also evidence of PLS consulting with the Local Authority AMHPs and the social worker allocated to complete the Social Circumstances Report for Lena's appeal against Section 2 detention. However, there is no evidence that this partnership working was used to fully understand and explore the concerns about domestic abuse. The Local Authority and SaBP clinicians based in MASH would have had more information about the safeguarding concern that was known as the first consultation to have been raised in February 2022 as well as at MARAC. The knowledge of these previous concerns, which were the same as the concerns noted in the hospital, may have triggered more in-depth exploration of this with Lena, although again, the immediacy of her physical health concerns may still have impeded this. This process is now included in safeguarding training and needs to be highlighted to teams.

It is fortunate that Surrey County Council AMHPs picked up on the fact that Lena was known by an alternative name, otherwise her MARAC history would not have been known.

14.6.6 Trying to get a good overall picture of Lena's medical care was problematic for Datchet Health Centre due to the number of other care providers involved with her. There was also a combination of the use of email and official pathways from multi-agency partners which led to a lack of continuity and ability to monitor and follow the correspondence to and from providers. Information was of a good standard and updates were sent regularly. Primary Care continued to supply the information that was asked of them and gave updates when they felt it was necessary and could contribute to safety and care needed for Lena. When concerns arose, these were proactively shared with the Adult Safeguarding Team. There were not any identified barriers to information sharing.

The Circle Health Group consultant wrote a clinic summary letter following both the consultations with Lena to her GP.

Given the very short time frame Ashford and St Peters Foundation Trust had to work with Lena and Kumar, staff worked hard to engage with partner agencies in response to the evolving situations. Taking a proactive approach to risk and care planning in relation to possible coercive and controlling factors was not possible outside of trying to meet Lena's urgent physical care needs.

As delivery of care prior to admission was quite fragmented (alternative/holistic remedies, private healthcare provision and travelling abroad for care) getting a clear picture of the level of risk was challenging.

14.6.7 The response to the first MARAC referral was positive and within five days a MARAC was held to agree multi-agency response.

The Police National Database (PND) covers all 43 Forces across the UK, and a search of this system would identify whether an individual was known in a Force area outside of Surrey as a victim, witness, suspect or offender, and any intelligence recorded. The searches on Lena and Kumar included their alias names and they were not known in any other Force area.

On 12th January 2023, a social worker contacted the Police Domestic Abuse Team and spoke to an officer to inform them of the death of Lena and asking whether there were any open reports. The officer took advice from their supervisor who advised that the social worker should either make a Freedom of Information request or dial 101 reporting the death and requesting an investigation. This advice is considered unhelpful and given the supervisor worked within a safeguarding environment, should have responded more positively to this request, and provided the necessary information.

14.6.8 Berkshire Healthcare have worked to improve referrals into specialist domestic abuse services following learning from a previous Domestic Homicide Review where the client was signposted but did not go on to engage. Rather than signposting to specialist services, BHFT gained the agreement of all the domestic abuse services to accept one referral form. This has helped reduce the barrier to referring as prior to this each service had a different referral form and referral method. The referral form has a link to the DASH risk assessment, and it is expected that this will be included in the referral.

14.6.9 All of the agencies working with Lena were in receipt of good quality, regular supervision and have safeguarding and domestic abuse policies implemented which were followed. These include NSDAS following the code of practice for victims and agencies following their range of domestic abuse policies and procedures. There was good management and senior management oversight including that of the safeguarding leads. Although not mandatory in all agencies, domestic abuse training was widely available and completed for all professionals. This included strengthening knowledge and understanding of recording practices, access to specialist local services, how to complete the DASH and how to refer to MARAC for

example. Some agencies, such as BHFT have a specialist practitioner for domestic abuse who is available to provide support and advice to professionals on concerns about domestic abuse and a further two safeguarding advice lines for child and adult safeguarding.

Agencies demonstrated that staff applied appropriate legislation when working with Lena, such as Adult Social Care applying the Care Act, 2014 (Section 9 and Section 42), the Mental Health Act, 1983, and consideration of the Mental Capacity Act, 2005. Adult Social Care staff also acknowledged their duties towards Kumar and offered a Section 10 Care Act assessment. However, 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.

14.6.10 The facts presented by Surrey Police surrounding the death of Lena relate to two incidents 18 months apart. The coercive and controlling implementation plan was put in place following Home Office data which highlighted that Surrey Police could improve their performance in this area. Kent Police were seen as the leading Force, who moved away from using the DASH risk assessment tool to using the DARA model. This approach has been adopted by Surrey and the recording of coercive and controlling behaviour and outcomes has seen some improvement with solved outcomes increasing from 4.9% in 2023 to 15.9% in 2024.

The guidance regarding coercive and controlling behaviour within the force policy also reflects the legislation and Approved Professional Practice issued to all forces by the College of Policing.

Changes to current processes are seen as good practice and shows the Force is forward thinking in seeking new ways to improve the response to victims and sharing information and joint working with partners.

14.6.11 Referrals to specialist services such as ESDAS, NSDAS, and referrals into the MARAC process were appropriately made and outside of MARAC agencies shared

information in a timely and appropriate manner and sought support and guidance from their own internal agency leads.

Get A Drip are currently in the process of including a flow chart outlining the safeguarding reporting procedures for each Local Authority where a Get A Drip clinic is operated. Additionally, while not directly related to this case, Get A Drip have implemented Safeguarding training for all patient-facing non-medical employees.

14.6.12 Spelthorne Community Safety Partnership has reviewed all previous Domestic Homicide Review and DARDR cases, including those that are both in progress and awaiting assessment by the Home Office Quality Assurance Panel. The specific learning in this review has not featured in any previous review, nor have any key features of this particular case.

14.7 **Term 7**

Was there sufficient focus on the impact of Kumar's behaviour towards Lena, by applying an appropriate mix of sanctions (arrest / charge) and treatment interventions? Did this include consideration of disruption techniques for Kumar?

14.7.1 Following completion of the IMRs, the review panel identified that very little was known about Kumar, therefore following the second panel meeting, Health representatives were tasked to identify and share any relevant information to form a picture of Kumar. However, Kumar had not been seen by his GP since 2017/2018 so it became unlikely that he accessed any other NHS services as the GP would have been notified about community and secondary care appointments and therefore no further information in relation to this was achieved.

Primary Care were unaware of and did not witness domestic abuse. Kumar was on one occasion aggressive with a GP over the phone, but not towards Lena and this incident was reported to Adult Social Care.

14.7.2 Kumar was offered a Section 10 Care Act assessment, Carers Assessment, which he declined and also declined referrals to carers support groups in his capacity as a Carer for Lena.

Adult Social Care have no recorded incidents of verbal or physical aggression to Adult Social Care staff during any of the contact with Lena. There have been no observed abusive or aggressive behaviour by Kumar towards Lena noted or recorded by professionals who came into contact with the couple. The allegation of

domestic abuse is founded on the views and experience of some professionals and their interactions with Kumar during the treatment of Lena.

14.7.3 The SaBP PLS consultant psychiatrist discussed the concerns about Kumar remaining with her on the ward with St Peters Hospital colleagues but was not in a position to respond to this directly. There was not enough done to seek to speak with Lena with a translator and without Kumar present which would have provided time to seek to explore the dynamics of the relationship and concerns about domestic abuse. The likelihood of Kumar seeking to use his power as Nearest Relative to discharge her was recognised and steps taken to plan for a timely response to seek to displace him if that happened.

14.7.4 Ashford and St Peters Foundation Trust staff who were delivering care to Lena were very aware of Kumar's behaviour and the impact that they witnessed. However, it was challenging for them to intervene as Lena was keen to have Kumar in the hospital with her, and the deteriorating relationship between staff and Kumar was minimised as staff wanted to support Lena's choices. As the coercive and controlling behaviours became more overt and were applied to staff delivering care, sanctions were implemented, this included ensuring visiting times were adhered to as Kumar had been staying 24 hours a day. Placing Lena under Section under the Mental Health Act resulted in Kumar attempting to remove her from the Section as her Nearest Relative, he did this by advising a very junior member of staff who was not aware of the significance of his actions. It is assumed that this could have been in the apparent hope that the timeframe would be missed. There was a real risk that he would have then removed Lena from the hospital against medical advice.

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

14.7.5 It is the assumption that Kumar displayed abusive behaviour towards Lena during their relationship and there is no evidence known to Surrey Police that this was the case based on two interactions Surrey Police had with Lena and Kumar. On 16th June 2022, Kumar was arrested This was a positive course of action agreed at the MARAC since Adult Social Care had not been able to see Lena on her own. The arrest was justified and necessary based on the potential concerns regarding coercive and controlling behaviour and as a disruption tactic to enable Lena to be seen alone.

Kumar spoke freely during his police interview and set out the medical history of Lena which had been exacerbated by the Covid 19 pandemic, limiting the availability of hospital appointments, leading them to seek alternative treatments through private clinics. Kumar stated that prior to the pandemic they received a lot of support from the GP at Datchet Surgery with a mixture of home and surgery visits. Lena did not drive which is why Kumar attended all appointments, but also as a means of support to Lena. Kumar stated that anyone could go to their house and mentioned that Lena's sister often visited to see Lena. He also said that Lena had her own phone and her own independence although limited because of her various medical conditions. Kumar expressed concern that his arrest was based on third-party information, and it was explained to him that the arrest was lawful and that it can be based on such information where there are reasonable grounds. It was explained that his behaviour raised the concern leading to the referral. Kumar stated that on the last visit to the IV clinic he got annoyed at the nurse claiming she did not know what she was doing or understood the specific nutrients that Lena needed and that was the issue on that occasion.

There was no evidence of coercive and controlling behaviour or other forms of domestic abuse by Kumar and to that end there was limited advice and service provision the police could offer. As a consenting adult Lena was entitled to refuse conventional medical treatment and seek alternative methods which is the route she chose. There is no evidence to Surrey Police that this was driven or directed by Kumar through coercive and controlling behaviours.

14.7.6 On 22nd 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 to be Lena's next of kin. Kumar appeared to obstruct the call and would not let the MARAC coordinator speak to Lena until he knew what the call was about. In order to circumvent his obstruction, the coordinator explained in a roundabout way that it was about a professionals meeting to discuss Lena. The coordinator had to think on her feel to find a way around Kumar's obstructive behaviour and when speaking to the Surrey Police IMR author described that she tried her best in a very awkward situation to explain the reason for her call without mentioning MARAC. This was the only route open to the coordinator at the time and the only other alternative would be not to contact Lena at all.

14.8 **Term 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?

14.8.1 Within Surrey Police Force policy there is a requirement for officers to apply a level of professional curiosity as a minimum standard of investigation and although covered in Term 1, the officers should have made attempts to try and speak to Lena's sister and her friends.

Taking the above into account, and in the context of the information already discussed, the report of coercive and controlling behaviour leading to the arrest of Kumar on 16th June 2022, was investigated and the decision to take no further action by police was the correct decision based on the available evidence. The facts of this case fell short of the evidential requirement to refer to the Crown Prosecution Service.

Surrey Police were notified of the death of Lena in January 2024, and as outlined above, they should have been provided or obtained the necessary information and at that point Lena's death should have been raised to the appropriate level within the police to embark on a proportionate investigation to establish the circumstances surrounding Lena's death.

On 1st March 2024 a social worker sent an email into the PSPA in which they referred to a Section 42 enquiry that had commenced following the SCARF referral from police on 18th December 2023, and that following the death of Lena in December 2023 that enquiry would cease. On 4th March 2024, the PSPA sent this notification to the Adult at Risk Team (ART). The ART is a newly formed police team created in October 2023. The Force had recognised that their response to adult safeguarding and investigations could be improved, and this was also identified by the HMICFRS during their inspection of the Force in 2023 leading to them identifying an Area for Improvement (AFI). The remit of this new team has developed, and the parameters of their work refined to ensure they effectively manage the demand. A supervisor reviewed the circumstances and determined it would be more suitable for the social worker to refer this for a Safeguarding Adults Review (SAR). This review was conducted without the supervisor being in possession of all the information. Having researched the Niche system this review, by the supervisor, was not sent to any other internal police department and so its purpose was therefore redundant. The Surrey Police IMR author has discussed this with their line manager to provide feedback and learning for the future because given the circumstances, this should have been raised to a more senior officer within the police to independently assess and determine what levels of investigation was required. In any event, the reviewed did not consider the criteria was met for a Safeguarding Adult Review. A further review was then completed by

the Domestic Abuse Team under the guidance of a detective inspector (DI) who has responsibility within the Domestic Abuse Team which consisted of enquiries with the Coroner's Office to determine the cause of death. In addition, the DI was provided with some additional information from the Public Protection Support Unit Lead Specialist in Surrey which included Summary of Information Reports from other agencies.

The review by the DI concluded there was no evidence of coercive and controlling behaviour or other criminal offences and therefore there was no requirement to engage with the Crown Prosecution Service.

Following discussion within Surrey Police, and given the fact that Lena had died, her death should have warranted closer scrutiny and agreement between the two departments who should take the lead. On reflection of the IMR author from Surrey Police, this was not an adult safeguarding concern and given the one previous allegation of coercive and controlling behaviour, should have been led by the Domestic Abuse Team from the outset.

In the end, some action was taken by the police to better understand the circumstances surrounding Lena's death, but this could have been made much easier had ownership been agreed from the outset at the appropriate level. This may have led to a better understanding within the PPSU and may have negated the requirement for a DARDR.

Unfortunately, the review undertaken by the DI was not recorded on the Niche Occurrence, which is where it should have been. The chronology of events was later established from speaking to the DI and another member of Surrey Police staff to help form the IMR for this review. Individual learning has been provided to the DI regarding the importance of documenting enquiries on Niche records as opposed to individual notebooks and electronic storage files.

14.8.2 Within the review panel there was discussion on why it took three months for Surrey Police to be informed of Lena's death and whether this should have been raised straight away given the history of concern that hospital staff held in relation to Kumar preventing Lena from accessing safe and timely medical treatment. The police representative shared that if the police would have been notified within 24 hours of Lena's death, they would have been afforded the opportunity to explore this further. However, it was recognised that Lena's cause of death was medical, so it may not have occurred to health professionals, particularly knowing of previous police involvement and that there was not enough evidence of criminality, to inform the police. However, it was known that Kumar was preventing access to

potentially life-saving treatment and therefore there could have been missed opportunities for this to be explored further and investigated by police would they have been informed.

14.9 **Term 9**

How well does risk evaluation between Adult Social Care, Health, the Police and MARAC processes work?

14.9.1 Get A Drip's response to safeguarding concern was prompt and urgent, and the appropriate referrals were completed. If the company had received an alert or been aware of the safeguarding issue, Lena would not have received treatment, and the same safeguarding process would have been followed. Information was shared only with the clinicians directly involved in Lena's care and the safeguarding referral. It was challenging to predict that Kumar was causing harm, as medical staff reported not seeing any visible injuries. However, Lena's weight was a concern.

14.9.2 It proved difficult for Primary Care that sits in Royal Borough of Windsor and Maidenhead to know about the process and procedures that happen across the border in Surrey. Primary Care did not receive notification that this was a MARAC case and were not asked to contribute information towards this. The review panel considered the barriers to inviting the GP to the MARAC, particularly as the GP was based in Berkshire, bringing cross-border challenges. The review panel considered how cross boarder practice could be addressed, breaking down any barriers to information sharing and a coordinated action plan to manage and reduce risk faced. It was agreed that the GP should have been invited to contribute to MARAC, whether they were within the boundary of Surrey or not. It was acknowledged that MARACs are commonly facilitated during periods which clash with clinics, however this should not prevent the GP, who are a key part of the approach and how as a minimum, if the GP is unable to attend, then there should be sharing of information into and out of MARAC to ensure that GP information is inputted to the MARAC discussion. GP involvement in MARAC has been a long-term sticking point in Surrey, however work is being delivered to get GPs more involved in MARAC as this has been identified as a gap prior to this review. It was also confirmed that GPs within Berkshire do not attend MARAC, but a letter is shared with them following the MARAC to share relevant information. The panel expert from Sikh Women's Aid noted that although Sikh women may not usually report domestic abuse, they do access their GPs and sometimes report abuse to their GP (Sikh Women's Aid, 2024) where reporting could happen and therefore it is important that GPs feed into MARAC.

14.9.3 Adult Social Care response to the information and/or risk assessments were shared in accordance with the agency's policies. Lena and Kumar reported that Lena had a diagnosed mental health disorder that being of Anorexia Nervosa, from an assessment with a psychiatrist, during her admission, who assessed her using her first language, Lena reported anorexia from her early teenage years which was prior to her meeting Kumar. The onset of Anorexia Nervosa occurring in adolescence and young adulthood. Lena reported always being underweight, but this had not raised concern as she appeared to be younger than her birth years. Lena's sister reported that Lena had always been underweight from childhood and that she had witnessed her putting food into her mouth, sucking it then spitting it out due to stomach fears.

During the Mental Health Act Assessment on 8th December 2023, Lena denied any mental health issues and stated that her mental health was fine. Adult Social Care asked her why she was not wanting to engage in the treatment plan. She said that she did not believe the treatment at the hospital was advanced enough and there was a hospital in Dubai where she wanted to have laser treatment. It was discussed with Lena the treating doctor's views that she would be at high-risk of death if she left the hospital and potentially would not survive a flight to Dubai. Lena said that she had heard this before from a cardiologist, "*and yet here I am*". Lena minimised concerns around her weight. She said she had always been slim. She said that she had trouble eating after her father had died. Lena said that she would prefer to go home and re-start her eating regime, and she said she followed a rigid diet. Lena said she did not want to die and said she did not believe she was at imminent risk of doing so. Lena was tearful when there was discussion about her father, who had died during the summer.

Adult Social Care notes record that during this admission it was reported that Lena was displaying very rigid thinking, she would sometimes report that the ward staff were neglecting her care and nutrition but then at other times would block their attempts to provide care, such as only allowing one member of staff to toast bread, or only one clinical staff in the room at a time. The treating psychiatrist informed the allocated social worker at the time that he was of the view that they were considering three possibilities for her current presentation – (1) an a-typical eating disorder; (2) an abnormal grief reaction to her father passing away; (3) Autism, due to her 'black and white' thinking, but this could be due to her brain being starved of oxygen.

Anorexia Nervosa is defined as a restriction of energy intake relative to requirements, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health (typically this would include BMI

<18.5). An intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain, even though a significantly low weight. Also, disturbance in the way of which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. At the time of her death Lena had a pervasive psychiatric illness in which she experienced a grossly distorted perception of her correct body shape.

Anorexia Nervosa has the highest mortality rate of all the psychiatric illnesses. More than 10,000 people die from anorexia every year. Its highest death rates are due to the complications of malnutrition, which can cause multiple organ failure. Lena's cause of death was that of myocardial infarction (heart attack). Due to the high rate of mortality in Anorexia Nervosa, the leading cause of hospitalisation is cardiovascular complications which occur in up to 80% of cases. Sadly, sudden death secondary to arrhythmia is often the cause of death with people with Anorexia Nervosa[24].

14.9.4 SaBP held no evidence that the full circumstances of the referral to MARAC or conversations held was known by PLS aside from noting that there was no evidence of controlling and coercive behaviour so '*closed*' to MARAC. PLS could have sought and/or been given more detail by the Local Authority when in conversation with them, or they could have sought it from SaBP colleagues who sit within the MASH and attend all MARACs. This resource is now included in Safeguarding Adults training and further guidance is being developed regarding MARAC and the responsibilities. As a process SaBP have identified that MARAC has improved significantly over the last few years, with better record keeping regarding referrals, discussions and agreed actions. Further work is needed to ensure that SaBP colleagues benefit from this improvement and know how to access this information when it is needed.

14.9.5 The information held by Surrey Police from the initial referral, and the subsequent concerns regarding Lena were shared between agencies and the risk evaluation adequately shared resulting in the decision to arrest Kumar.

The SCARF referral from the police on 16th December 2023, set out the risk evaluation as they determined it and made the appropriate referral on the SCARF form which was shared with Adult Social Care.

Surrey Police did not receive any further calls from St Peters Hospital following the incident on 16th December 2023. At the time Lena was receiving treatment in

[24] https://pmc.ncbi.nlm.nih.gov/articles/PMC8429328/

hospital from medical professionals and from a policing perspective it was not reasonable predictable that harm would come to Lena in this health care setting. The cause of death recorded is one of natural causes.

14.10 **Term 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?

14.10.1 The review panel considered Kumar's behaviour towards professionals and with the support of the panel expert from Sikh Women's Aid were able to consider whether Lena and Kumar's religion and culture could have played any part in his behaviour. The expert allowed the panel to gain an understanding that Kumar's behaviour did not link to their religion or culture. For example, at the hospital when Kumar presented his Kirpan. Sikh men carry the Kirpan as part of their faith to symbolise their duty to stand up against injustice and protect the weak. This is considered as one of the five core articles of Sikhism which is meant to be a reminder of the commitment to principles such as justice, charity, and morality, rather than solely for self-defence. The panel considered whether Kumar presenting the Kirpan linked to him representing his commitment to fighting his perceived injustice and protection for Lena; or whether he was presenting the Kirpan as a threat to hospital staff. Hospital staff believed that Kumar's behaviour was perceived as a threat, and although he did not draw the Kirpan, staff perceived his behaviour as a symbol that he could use the Kirpan if he wanted to. It is not known whether Kumar was baptised as Sikh and therefore whether or not he should be carrying the Kirpan and therefore whether there was definitely an underlying threat.

14.10.2 Staff at Get A Drip participate in mandatory annual training that includes topics on equality, diversity and the safeguarding of both adults and children. However, there is currently no specific guidance on assessing culturally specific abuse during treatment. Instead, the medical team relies on their clinical judgement when conducting treatment assessments. The service delivered by Get A Drip was accessible to Lena, who consistently attended the clinic with Kumar.

14.10.3 The clinical team in St Peters Hospital treated Lena with great respect and supported her being involved with making decisions wherever possible in line with the principles of the Mental Capacity Act.

During the Mental Health Act Assessment on 8th December 2023 an interpreter was not used, the report by the AMHP records that Lena "*said she was expecting us* (Adult Social Care) *and greeted us warmly. Her English was good*". The assessment was conducted in English in a question-and-answer format. The AMHP

had recorded that English was Lena's second language however she was able to converse in this language.

During the home visit to Lena to gather information for the Social Circumstances report a translator service was used to ensure that the information was conveyed to her in her first language of Hindi.

Lena and Kumar were Sikh, within the Sikh religion Sikh women have equal rights to men and participate in all aspects of Sikh life. According to Sikhism, men and women are two sides of the same human coin. There is a system of interrelationship and interdependence whereby man is born of woman, and women are born of man's seed. By these doctrines a man cannot feel secure and complete in his life without a woman, and a man's success is proportional to the love and support of the woman who shares her life with him, and vice versa. Lena had a strong faith and followed daily religious rituals and visited the temple every week. Lena reported to various professionals, including Adult Social Care, Police and Mental Health Services, that Kumar was a good man and that he took care of her and that he had given up his job to take care of her. Lena was very distressed when Kumar was arrested. Lena reported having a social network of friends in the area with no restrictions placed on her with regards to visiting them and also visiting her sister who lived in the UK on a regular basis whom she had a good relationship with.

Adult Social Care provide all staff with Domestic Abuse and Ritual Abuse training in addition to Safeguarding training.

14.10.4 During her admission to St Peters Hospital, Lena was seen on occasions by doctors who spoke Hindi, and translation services were used via Language Line her formal Mental Capacity assessment, it is concerning however that the use of a translator was not considered sooner or used consistently. Staff continued to try to engage positively with Kumar even when his behaviour became challenging.

Translation services are used by SaBP, and all details are easily accessible on their intranet and have recently been highlighted to teams once again. The SaBP IMR author noted that once Lena identified that a translator would be helpful this was arranged, although not used in all contact with her. It is the expectation that culture is explored and taken into account when working with someone, although it is noted that this is not well reflected in the work with Lena. However, this was likely impacted by the immediacy of her physical health at the time of SaBP involvement.

Cultural competency is included in all safeguarding training.

14.10.5 SECAmb records indicate that there were no protected characteristics recorded that would have been relevant to care from SECAmb. Lena is noted to have a good level of spoken English and so there were no identified barriers to good communication.

14.10.6 Datchet Health Centre understand that language and cultural barriers can hinder effective communication and delivery of care. To address this, they utilise professional interpreter services to facilitate clear and accurate communication between the practice and patients. This ensures patient confidentiality and privacy, as personal relationships may compromise these essential principles. Additionally, the practice adopts a patient-centred approach, actively listening to the patient and family to understand their unique needs and concerns. By tailoring the care to their cultural beliefs and preferences, aiming to provide culturally sensitive and compassionate care. The response from the practice to Lena was in line with this.

14.10.7 As Circle Health Group had little contact with Lena, there were some barriers regarding physical access as previously explored due to Covid-19 restrictions. These are no longer in place. As part of Safeguarding Supervision in the hospital, learning is shared with regards to review of ethnicity, culture, language, age, disability and immigration status. This is discussed for wider consideration.

14.10.8 There were no apparent barriers to communication during the meeting with Lena and the police, and when dealing with Kumar. Domestic abuse was not disclosed by Lena and so it was difficult to assess whether any equality and diversity issues existed, or a lack of knowledge regarding domestic abuse services and sign posting for Lena.

14.10.9 The review panel considered 'Honour' Based Abuse and although they found no evidence of this within information available to this review it is important to understand research which informs that Sikh Panjabi women often face systemic barriers when reporting domestic abuse and mental health concerns due to the perception of stigma, shame and honour and fear (Sikh Women's Aid, 2024[25]).

There is a growing body of research highlighting that the Sikh community often face challenges when experiencing mental health concerns as this is often a taboo subject due to stigma and further compounded by the subsequent fear of bringing shame (Sikh Women's Aid, 2024). This often silences Sikh people, preventing access to support. This, intersected with barriers to disclosure regarding domestic

[25] Found at: Gender Power and Abuse by Sikh Womens Aid 2024_compressed.pdf

abuse highlights the need for culturally competent practice as Sikh Panjabi women often feel compelled culturally to either remain silent or conform to what is expected of them. It is recognised that 'by-and-for'[26] services are vital as they offer trusted expertise to local communities as they understand the intersecting barriers faced by women from marginalised groups, it is therefore important that agencies are aware of services available to support South Asian women.

Honour featured within research conducted by Sikh Women's Aid (2022[27]), however Honour Based Abuse[28] is not a term that Sikh Panjabi women and girls commonly identify with, however shame or honour underline the barriers to disclosure within he Sikh Panjabi community, and the absence of safe space to disclose contributes to further barriers to disclosure.

Surrey Police now use the Karma Nivana Honour Based Abuse Identification Tool which aims to support frontline practitioners to recognise and respond to cases of Honour Based Abuse, however this tool was not launched at the time. Completion of the DASH risk assessment was attempted on one of the rare occasions that Lena was seen alone when Kumar was in custody. This is the commonly used risk assessment used by agencies within Surrey. The DASH includes Honour Based Abuse and when an officer is dealing with a matter they believe is linked to Honour Based Abuse they complete a risk assessment with the relevant questions. This is then flagged to the police domestic abuse team who have trained Honour Based Abuse advisors who review and ensure the investigation is dealt with correctly around evidence collection and safeguarding. Although Surrey Police Force are moving from the use of the DASH to the DARA, the expectation remains the same.

The panel recognised how this assessment would have been central to understanding Lena's experiences and have been an opportunity to explore her culture and family dynamic. Lena responded 'no' to all the questions asked during the completion of the DASH and there was no further evidence available to suggest Honour Based Abuse. The review panel considered that it would be useful to share information to frontline practitioners on the importance of curiosity around the possibility of Honour Based Abuse and also strengthen understanding of Honour Based Abuse and the Karma Nivana Honour Based Abuse Identification Tool.

[26] By-and-for services are services designed and delivered by and for the communities they aim to serve.
[27] Found at: SWA-BOOKLET-EDITABLE.cdr
[28] The Crown Prosecution Service define Honour Based Abuse as: an incident or crime involving violence, threats of violence, intimidation, coercion, or abuse (including psychological, physical, sexual, financial or emotional abuse) which has or may have been committed to protect or defend the honour of an individual, family and/or community for alleged or perceived breaches of the family and/or community's code of behaviour.

14.11 **Term 11**

Were opportunities taken by professionals to explore domestic abuse with Lena in order that multi-agency protective action could be considered?

14.11.1 Get A Drip reported that Lena did not provide any private personal information or mention anything about Kumar or his behaviour. If she had disclosed such information, the medical team would have explained the process and the necessity of sharing data with the appropriate members of the multi-disciplinary team.

14.11.2 During the time that Kumar was in police custody, Lena was supported by Surrey Police and an IDVA, she denied experiencing domestic abuse, including coercive and controlling behaviour, and responded 'no' to all the questions asked on the DASH risk assessment.

A Section 42 Safeguarding professionals meeting was facilitated and chaired by Adult Social Care, this was without the presence or knowledge of Lena and Kumar. The first principle of the six core principles of adult safeguarding is that of Empowerment – People should be encouraged to make their own decisions and give informed consent. The foundation of this being 'no decision about me, without me'. The decision was taken at that time does not inform either party to enable professionals to ascertain what actions needed to be taken as part of the enquiry to establish whether Lena was or was not experiencing domestic abuse. Confidentiality is important in safeguarding, but it is not absolute. Sharing information with the right people at the right time is essential to good safeguarding practice. Information shared by Adult Social Care with the police and other agencies was shared on a need-to-know basis and was done so in the context of keeping Lena safe from harm and/or abuse.

Lena was informed of the professional's concerns that she may be experiencing domestic abuse at the time Kumar was arrested by Surrey Police, and she was interviewed. Neither the Section 42 Enquiry nor the police investigation found any evidence to confirm domestic abuse.

14.11.3 SaBP had discussion with partner agencies, but there was no evidence of direct conversations with Lena that would have enabled her to make a disclosure had she wished to. As PLS did not make any safeguarding concern referral directly they did not have a conversation with Lena about this. There is evidence of multiple conversations with Lena about concerns about her mental health and mental capacity and her rights in relation to those issues, but not in relation to safeguarding.

14.11.4 SECAmb's interaction with Lena focussed on her medical presentation, which took priority along with her safe removal to hospital. Therefore, exploration of domestic abuse was not deemed appropriate at the time.

14.11.5 Berkshire Healthcare NHS Foundation Trust attend all MARAC meetings each month across the 6 local authorities. They also attend Multi-Agency Task and Coordination (MATAC) meetings and the Domestic Abuse Perpetrator Panels (DAPPs). BHFT are also represented on the Domestic Abuse Boards across Berkshire.

14.11.6 Lena was not seen alone by Datchet Health Centre following the concerns of coercive control, however the offer for her to consider having her flu vaccination and cervical smear test suggested at the professionals meeting would have been an opportunity to explore any concerns and if it was felt that she was in danger, the practice would have referred to MARAC if not already done so or directly to the police for further investigation. Lena did not take up many of the offers made to her.

14.11.7 Opportunities were taken by Ashford and St Peters Foundation Trust to discuss possible domestic abuse with Lena, she was not open to these discussions and opportunities were limited. Following the Trust taking court action to enable treatment to be delivered, Kumar withdrew from the hospital and had Lena survived, there is a chance that protective action and planning could have been taken.

14.11.8 Agencies involved in this review worked hard to seek opportunities to see Lena alone. Sikh Women's Aid (2022)[29] highlight how enabling safe spaces for discussion and disclosure is critical for this community. On those rare occasions when it was made possible so see Lena alone, this could have been an opportunity for Lena to access a helpline specifically for South Asian women who provide services in other languages and therefore possibly enable Lena to understand her experiences in the context of domestic abuse.

14.12 **Term 12**

What learning did your organisation identify in this case? Were there any examples of good practice?

14.12.1 The Get A Drip nurse who raised the safeguarding concern demonstrated good practice by responding to the concern they identified for Lena. The nurse voiced her concerns to the medical team and escalated the situation appropriately, following the safeguarding policy. They also explained to both Lena and Kumar

[29] Found at SWA-BOOKLET-EDITABLE.cdr

that it was not safe to provide the treatment as advised by the doctor. Throughout Lena's appointments, the staff made consistent efforts to communicate with her, aiming to make her feel comfortable and clarifying all aspects of her treatment.

There were no identified gaps in Adult Social Care current provision, including skills, knowledge, and ability of staff to respond effectively to the needs of Lena. There is evidence of good practice by Adult Social Care staff with their immediate response to the referral from Get A Drip, consistently following up with other agencies such as ESDAS, NSDAS, the GP surgery and Surrey Police. Adult Social Care highlighted to MARAC that Lena had another name that she preferred to use which enabled cross referencing.

Adult Social Care staff demonstrated a clear understanding of the Care Act and undertook a Section 9 assessment under Section 11(2b) of the Care Act. Consideration was given with regards to the most appropriate legislation, such as the Mental Health Act or Mental Capacity Act during the hospital admission and the rationale for the use of the Mental Health Act was clearly documented.

Adult Social Care expressed concern to the GP that Lena was unlikely to re-register with the surgery and expressed their concern that as a result there would be no oversight from healthcare professionals.

There was clear oversight of the Adult Social Care input at the time by the assistant manager of the team and advice and guidance was sought by the team from the Safeguarding Lead of Adult Social Care and the Mental Health Safeguarding Advisor.

Adult Social Care identified two key learning opportunities detailed in section 16 of this report.

14.12.2 SaBP had some good practice evident in relation to multi-agency working with St Peters Hospital, the consideration and challenge in relation to mental capacity and the application to the Court of Protection.

There is learning in relation to SaBP's response to concerns about domestic abuse, the recording of risk and the lack of seeking involvement from a domestic abuse service. There is further learning in relation to their work with people whose first language is not English. There was a lack of full exploration and recording of Lena's cultural needs, but there is the question of whether this was due more to the immediacy of her physical health needs and her cognitive impairment at the time rather than an indication of a lack of awareness of the importance of this.

14.12.3 SECAmb treated Lena according to clinical and professional standards. Lena was treated as would be expected in line with clinical guidance and service policy and procedure.

14.12.4 Berkshire Healthcare NHS Foundation Trust are currently working on embedding the DASH risk assessment into their electric patient record system. This is to make it more accessible to practitioners and also be able to collect data on how many DASH risk assessments are being completed by BHFT.

BHFT is covered by 2 Integrated Care Boards (ICBs). Both ICBs have set up Domestic Abuse Health Groups. These have several roles and responsibilities including disseminating learning from DARDRs, work on a consistent approach to domestic abuse and share legislative changes and latest research. These groups are relatively new and were established to support the domestic abuse agenda across health.

14.12.5 No learning was identified for Datchet Health Centre. The below good practice was identified:

- Written consent was gained from Lena to discuss her medical care in the presence of Kumar.
- The GP was not prepared to offer prescriptions until further information was known about Lena's condition.
- Safeguarding flags were placed on Lena's record to alert all practitioners.
- Supervision was sought regarding this case on a weekly basis.
- Information sharing with Adult Social Care to support the Section 42 enquiry resulting in positive multi-agency working.
- Follow up appointments with St Marks Hospital and supporting the decision not to prescribe medication until further checks were carried out on Lena to determine her suitability.
- Supporting actions agreed at the professionals meeting to try to see Lena alone by offering appointments for immunisations and tests.

14.12.6 Although initially, for Ashford and St Peters Foundation Trust staff, it was difficult to separate the real concerns of a husband in relation to a very sick wife from the subtle markers of Kumar's perceived coercive and controlling behaviours. However, the cycle of care being offered, agreed and then declined due to further changes being needed; for example, fluids were agreed, then declined as they requested warmed fluids that were not necessary, the fortisip being agreed, provided and then declined as a different flavour was requested; was soon noted as being a pattern of behaviours. When this occurred, Kumar became increasingly overt in his

demands, refusing to engage with more senior nursing staff, who were able to advocate for themselves and Lena and refusing to speak to some of the female medical staff. Staff were tenacious in their management, creative in their approaches and articulated and escalated their concerns. The Trust response was a great demonstration in multi-disciplinary working with the Liaison Psychiatry Team fully engaged in supporting Lena alongside the medical teams.

The ward team have been significantly affected by this case and continue to struggle with many aspects of Lena's admission and death. The Trust had undertaken restorative supervision sessions with staff affected by this case and continues to support staff. There was no specific additional learning identified for the Trust and no single agency actions have been identified.

14.12.7 The learning from this review identified by Surrey Police is around the apparent disconnect between the Adult Review Team, Domestic Abuse Team, and the Public Protection Support Unit, and the importance of clearly documenting enquiries and decisions, and communicating those to relevant departments and other agencies. This has been detailed within Term 8.

The local initiatives employed by the police are considered good practice namely, 'Street of the Week' initiatives which enable police to be 'overt to be covert'. What is meant here, is that through such initiatives it allows the police to be creative when making enquiries with potential victims of domestic abuse and where it is safe to do so, to then seek to engage with them further.

The implementation of the Adult at Risk Team is also seen as good practice in terms of improving the policing response and investigations regarding vulnerable adults at risk.

14.12.8 It was appropriate that the initial referral from Get A Drip was assessed by Surrey Police, and action taken. However, following the police investigation there was lack of evidence to support the fact that Lena was in an abusive relationship and that Kumar was a perpetrator of domestic abuse. There have been some assumptions made that Lena was the victim of domestic abuse but there is a lack of evidence to support the fact according to Surrey Police information.

It would appear the deterioration in Lena's health was exacerbated following the loss of her father in August 2023 when she became depressed, followed by a fall resulting in her being bed-ridden, as stated in the hospital doctor's Referral of Death to the Surrey Coroner.

The decision by Lena to choose alternative treatment for her conditions was not based on any cultural or religious beliefs; it was an independent decision and one of her choice. Given the history of Lena's health and based on the evidence, it appears her decision regarding treatment was made at a time when she did have capacity and there is no evidence that this choice was influenced by Kumar through coercive and controlling behaviour.

It would have been helpful had police sought to speak to Lena's sister and close friends because this may have given a greater insight into the relationship and Lena's decision regarding her health care. Although there is a helpful summary of Lena's history in this review, this will no doubt be explored with the family by the Independent Chair for this review.

The contact with police on 12th January 2024 should have resulted in a proportionate level of investigation to establish the facts, which eventually took place, but time was lost. Has this been done sooner, and recorded on the appropriate Niche Occurrence, there may not have been the requirement for a DARDR according to Surrey Police.

Surrey Police identified the below Learning:

Learning Outcome 1

Where there are previous reports of domestic abuse and separate concerns regarding adult safeguarding primacy should be agreed at the right management level to determine the most appropriate team to progress the investigation.

Learning Outcome 2

Where an investigation is reviewed this must be recorded on the approved Force crime and information system Niche to properly articulate the nature of the investigation, decision making and rationale.

Learning Outcome 3

Officers and staff within Domestic Abuse Teams to be reminded of the information sharing arrangements in place allowing police to share information with partner agencies.

Learning Outcome 4

Where officers work within specialist teams it should not be taken for granted that their knowledge levels and skill set are at the required standard and their continuous professional development, training, support and supervision should be a continuous process.

These learning outcomes will be translated into a learning submission and shared with the specialist investigation teams prominent in this review.

15 CONCLUSIONS

15.1 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.

15.2 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.

15.3 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.

16 LEARNING AND RECOMMENDATIONS

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

16.1 Narrative

Lena attended a number of 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.

16.2 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.

16.3 **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.

16.4 **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.

16.5 **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.

16.6 **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.

16.7 **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.

16.8 **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.

16.9 **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.

16.10 **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.

16.11 **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 SystmOne 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 Overview Report Lena