Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

August 2022

Contents

Current Reviews – Review Stage

8 Live Reviews

SAR Person L
LLR Person H
DHR Adult S
DHR Adult T
DHR Adult V
SIR Adult 7
SIR Adult 7a
SIR Adult 10

Since the last update:

- 5 SARs progressed to action plan stage
- 1 DHR commenced
- 1 SIR commenced and 2 SIRs progressed to action plan stage

SAR Person L - Young man with mental health issues who recently transitioned from children's to adults services and seriously self harmed whilst on a mental health ward. Male also moved cross region from Hull to Sheffield during transition.

LLR Person H - A young woman who moved between Rotherham and Sheffield who had suffered multiple trauma. Review being undertaken with Rotherham.

SIR Adult 7a - Adult family violence, the perpetrator had a history of domestic violence and mental health issue.

SIR Adult 7 - Woman in her 20's who was seriously physically and sexually assaulted by ex-partner whilst daughter was present. He was convicted and imprisoned.

SIR Adult 10 – Woman in her 50s stabbed by her father (they were sharing a home) - there was a history of domestic abuse exacerbated by the father's dementia

DHR Adult S - Female died by suicide. Perpetrator on a DVPN and had been a LAC. Themes of mental health & suicide, coercive and controlling behaviour, substance misuse, accountability, service engagement and violent resistance.

DHR Adult T - Case of adult family violence (fratricide). Both victim and perpetrator had a lengthy history of criminal behaviour from a young age.

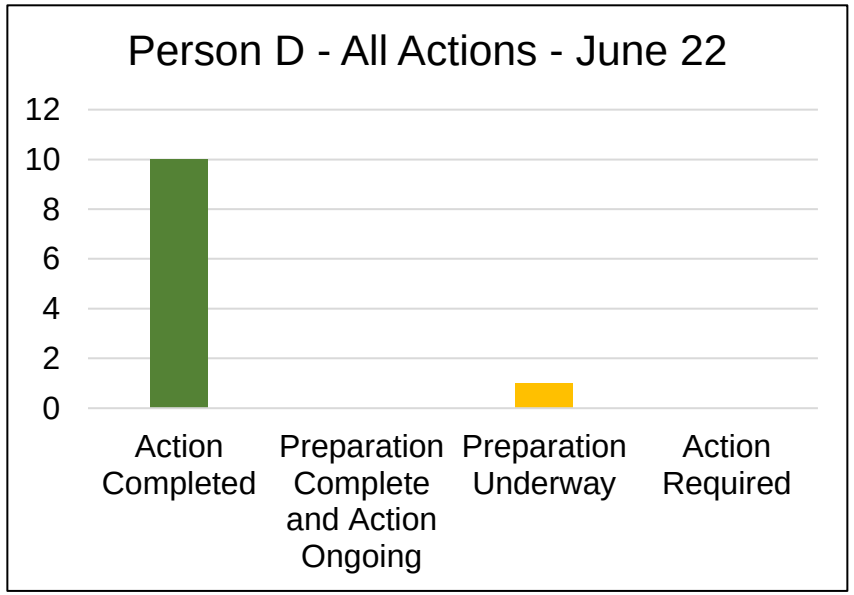
DHR Adult V – Was a woman in her 30s who died on 25th October 2021 after a drug overdose of prescription medication. At the time of her death her estranged partner was being investigated for breach of restraining order and malicious communications. There were 11 reports of domestic abuse incidents in the 14 months before she died.

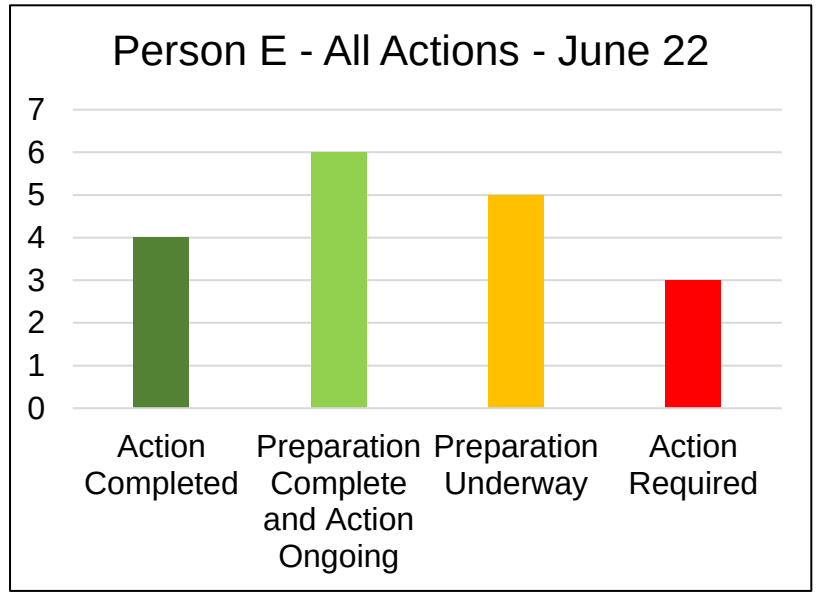
Reviews commenced since last update

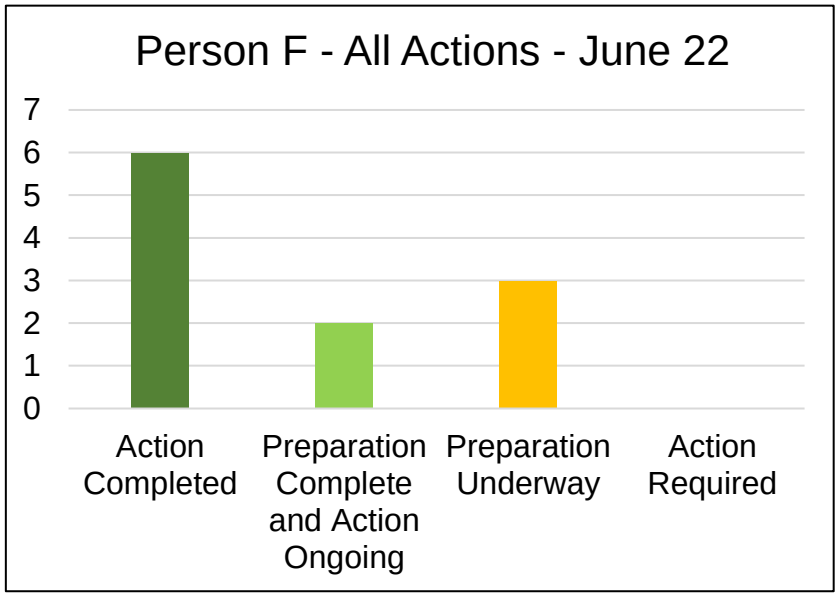
Current Reviews – Ongoing Action Plans (SARs)

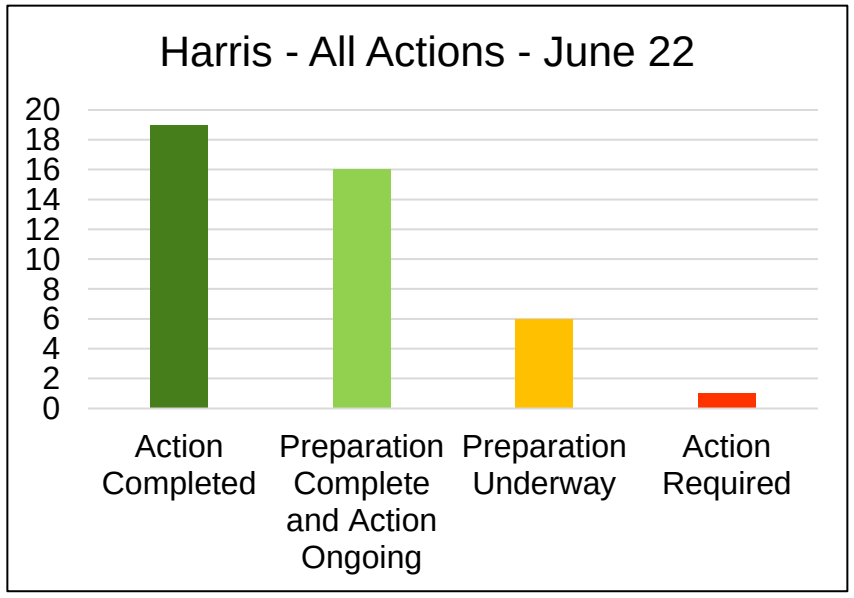
Status of actions from individual agency action plans. 54 actions have been completed in total across all 5 SARs.

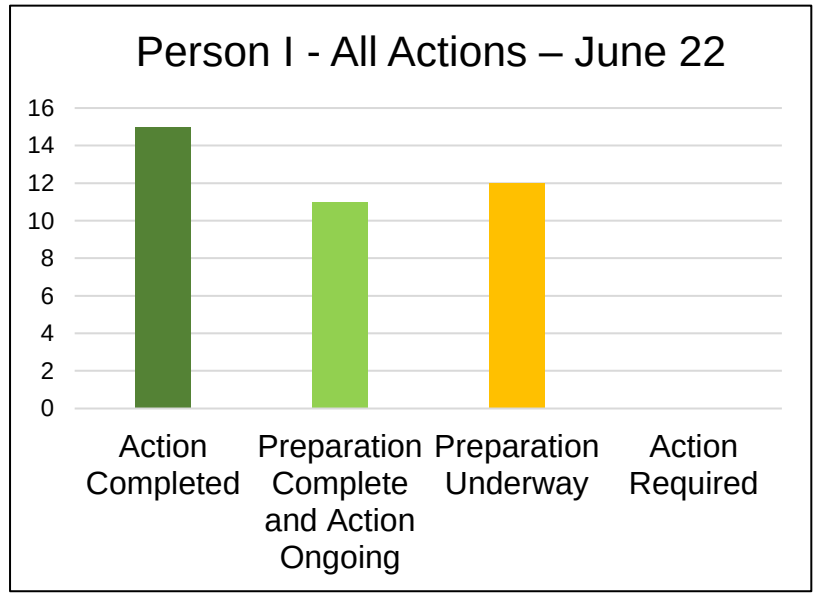
*Please note that data was not available on ASC actions for Person D, E, F and Harris or Burton St Project Actions for Person I and therefore there is some data missing from these graphs.









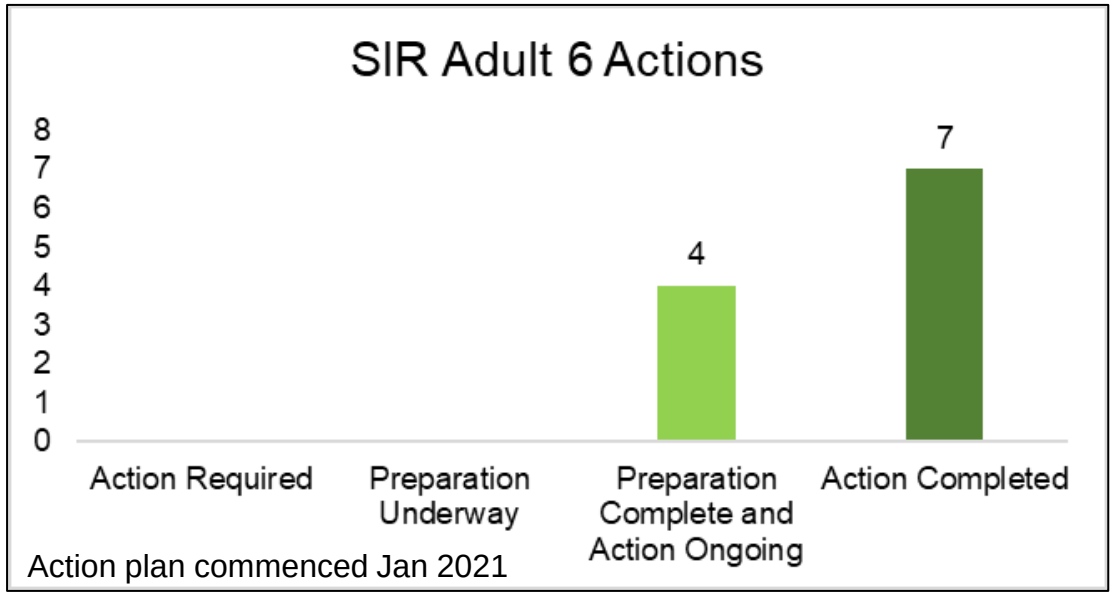


Current Reviews – Ongoing Action Plans (DHRs/SIRs)

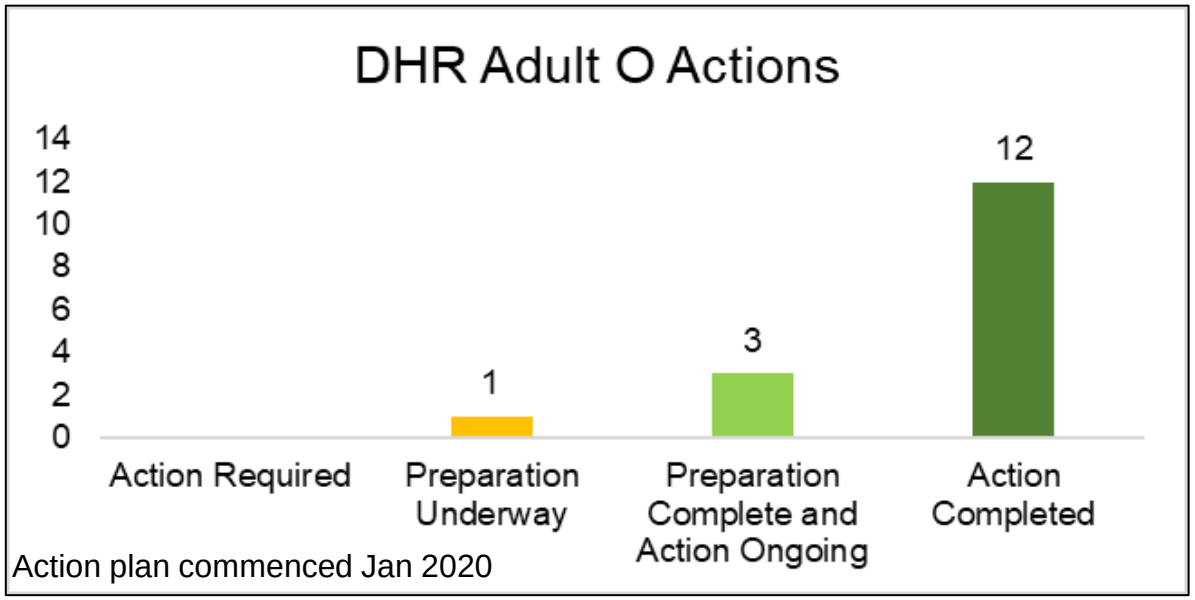
There are currently 5 DHR/SIRs with live action plans ongoing:

DHR Adult O
SIR Adult 3
SIR Adult 6
SIR Adult 8
SIR Adult 9

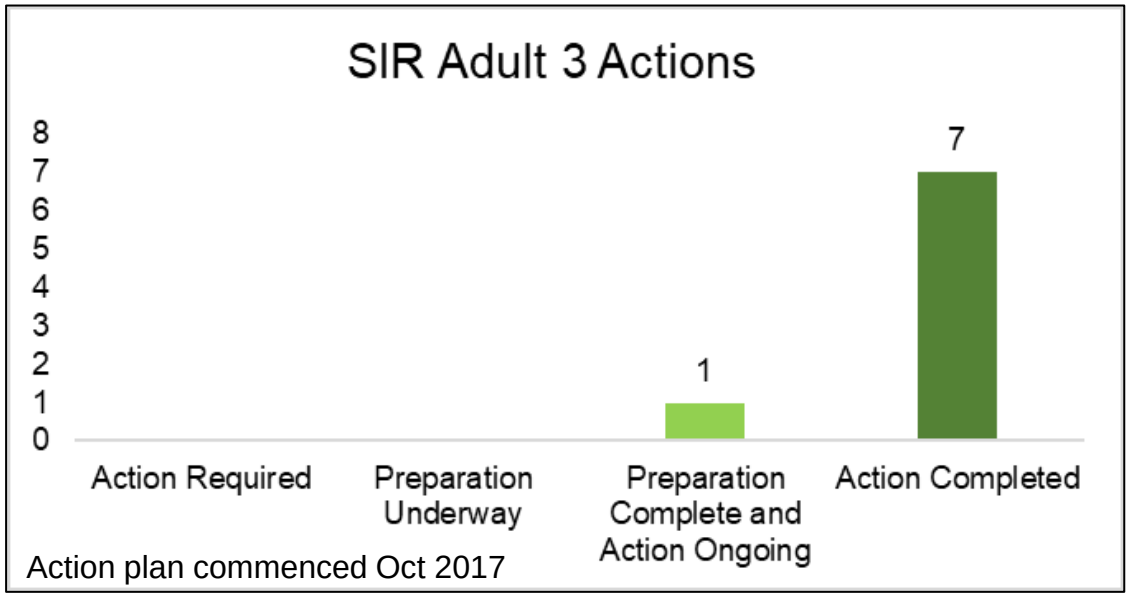
For SIR Adult 8 and 9 the reviews have concluded and actions have been agreed. However, they were not completed in time for the last strategic board when the dashboard is produced. Therefore progress will be reported next quarter.



Action plan commenced Jan 2021



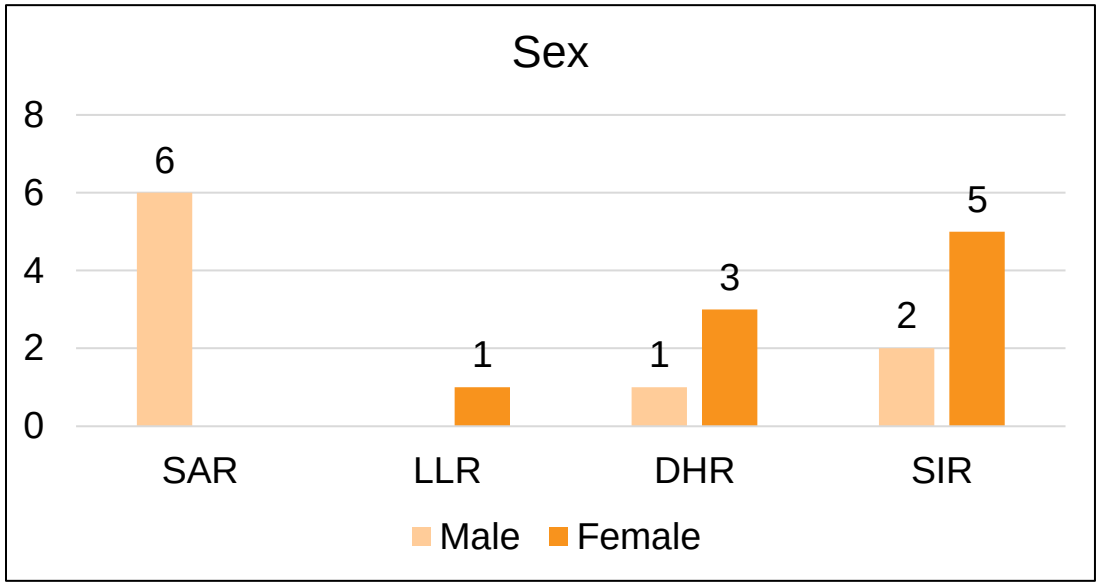
Action plan commenced Jan 2020

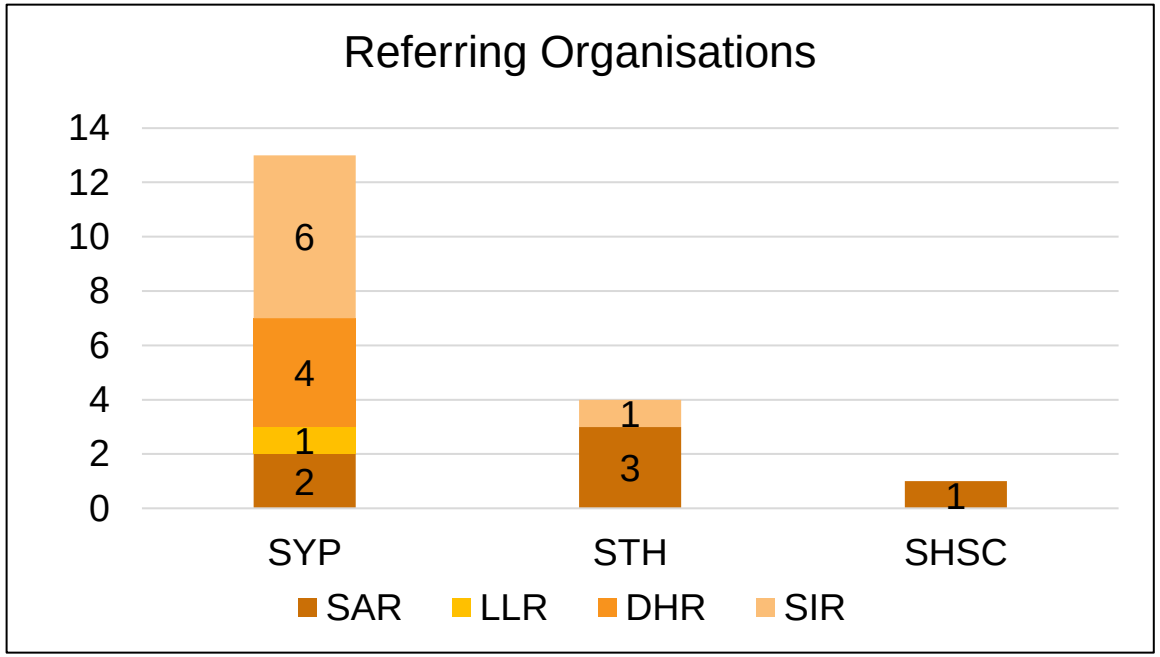


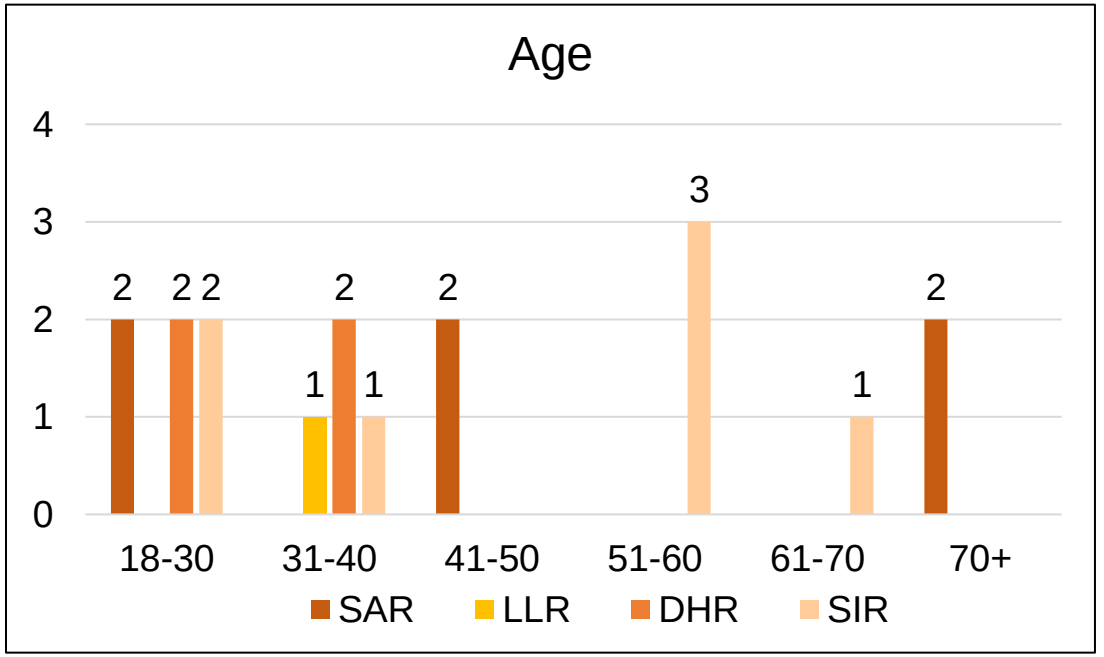
Action plan commenced Oct 2017

Case Insights (Open/Ongoing Action Plans Only)

- SYP are the agency who have referred the most reviews that are open or have ongoing action plans. However STH referred for the most SARs that are ongoing/have ongoing action plans.
- All 6 SARS ongoing/with ongoing action plans have been male. DHRs/SIRs ongoing or with ongoing action plans are mostly female.
- 6 reviews ongoing/with ongoing action plans have been in the 18-30 age category (2 SARs, 2 DHRs and 2 SIRs).







SARs / LLRs Themes and the Number of Reviews in Which They Were a Factor

The below table presents the number of SARs/LLRs which are closed or in the phase of an ongoing action plan in which the theme was present. These themes came from 9 SARs/LLRs in total.

The themes that have been highlighted in the greatest number of SARs/LLRs are:

- Mental Capacity (8)
- DA/Coercion and Control (7)
- Multi Agency Working (7)
- Professional Curiosity (6)

Themes	
Fire Risk	3
Mental Capacity	8
Self Neglect	3
Risk Assessment	2
Domestic Abuse / Coercion and Control	7
Multi Agency Working	7
Hear the Voice	3
Carers	3
Abuse or Neglect	2
Professional Curiosity	6
Substance Misuse	3
Mental Health	4
Homelessness	2
Non-Engagement with Services	3
Was Not Bought	2

SARs/LLRs Key Learning Themes

From the 9 SARs/LLRs that are closed or have action plans ongoing a number of themes have arisen. The most prevalent themes, that were an element in 6 or more SARs/LLRs were:

Mental Capacity (8)

Learning Example

Assessments of mental capacity were not routinely being recorded unless considered to be a formal assessment. Highlights importance of making sure you keep the person at the centre of decision making and where needed ensure their capacity for decisions has been considered and recorded for each decision required **[SAR Person F].**

This is inline with national analysis of SARs by Preston Shoot et al. (2019) who found The most commonly noted practice shortcoming were a failure to attend to mental capacity, noted in 60% of cases.

DA / Coercion and Control [Individual at centre of SAR perpetrator of DA or victim] (7)

Learning Example

Person E's partner was not included in discharge planning so risks of further domestic abuse were not reviewed [Person E perpetrator of DA]. She was closed to the IDVA service having not engaged and therefore had no support from DA services despite E returning home and being a known risk to her. No safeguarding process was followed to manage the risk of either DA or self-neglect. Victims of DA who are subject to coercive control may not be able to make informed decisions about protecting themselves from further abuse, a reluctance to engage with support should not be seen as a reduction in risk **[SAR Person E].**

Multi Agency Working (7)

Learning Example

In the SAR the safeguarding enquiries did not lead to a multi-agency conversation to ensure safe decision making. This review highlights the need for a MASH or similar system to enable early and facilitated multi agency conversations for decision making **[SAR Harris].**

Professional Curiosity (6)

Learning Example

Agencies are missing subtle signs that all is not well. Lack of confidence to initiate open dialogues with clients that they don't know well, is inhibiting professional curiosity. Families not bringing their dependents to medical appointments, education and day care services, in line with plans, should be considered as indicators that abuse may be occurring, and require further exploration **[SAR Person I].**

DHRs/SIRs Themes and the Number of Reviews in Which They Were a Factor

The below table presents the number of DHRs/SIRs which are closed or in the phase of an ongoing action plan in which the theme was present. These themes came from 19 DHRs/SIRs in total.

Themes in 1-4 DHR/SIRs		Themes in 5-8 DHR/SIRs		Themes in 9 + DHR/SIRs	
Suicide	2	Post Separation Abuse	6	Risk Assessment (Victim)	11
Sexual Abuse	2	Coercion and Control	8	Professional Curiosity / Challenge	9
Risk Assessment (Perpetrator)	2	Multi-Agency Working	7	Mental Health (Perpetrator)	9
Child Contact Issues	1	Adult Family Violence	6	Asking about DA / Routine enquiry	11
No Recourse to Public Funds	1	Caring Responsibilities	5	Information Sharing	9
Accessible Services	3	Substance Misuse (Perpetrator)	7		
Focus on Incidents not Pattern of DA	3	Substance Misuse (Victim)	5		
Record Keeping	3	Mental Health (Victim)	7		
Support for Perpetrators	3	Policies & Procedures about DA	6		
Recognising Male Victms	2	Public Awareness re. DA	8		
Violent Resistence	1	Clarifying Pathways	7		
Serial Perpetrator	1	Training Needs Identified	7		
Modern Slavery	1	Whole Household Approach	5		
Forced Marriage	1	Cultural/Faith Issues	5		
Use of Interpretors	1	Did not Engage with Services	7		
Recording who Accompanies who to Appointments	1				

DHRs/SIRs Key Learning Themes

From the 19 DHRs/SIRs that are closed or have action plans ongoing a number of themes have arisen. The most prevalent themes, that were an element in 9 or more DHR/SIRs were:

Risk Assessment (Victim) E.g., Opportunities missed to risk assess (11)

Example Learning

Ensure that a DASH is not a one-off activity and treated as the only assessment which can result in misleading understanding about true risk if it is only focussed on single incidents rather than looking at markers and patterns of abuse and behaviour. It is not seen as the sole responsibility of the police to complete **(DHR O).**

An analysis of DHRs by the Home Office (2021) highlights risk assessment issues as a common theme including agencies sharing risk assessments, need for training in risk assessment, absence of risk assessment, not being carried out at the right time, and information missing.

Asking About DA/Routine Enquiry (11)

Example Learning

Discuss challenging cases with your supervisor where an assessment of domestic abuse or routine enquiry is difficult; e.g. where a mother is accompanied by her husband or family. Record clearly if you have not been able to ask the question and why **(DHR G).**

Information Sharing (9)

Example Learning

Staff need to be proactive in gathering information to inform an assessment. Gathering information from other agencies and other areas, and maintaining the momentum when seeking information from other agencies, needs to be embedded in practice **(DHR D).**

In an analysis of DHRs by the Home Office (2021) found in 38 DHRs there were 129 instances of referencing an agency and information and In 23 DHRs there was reference to the importance of improving the sharing of information between agencies.

Professional Curiosity/ Challenge (9)

Example Learning

Remember that Domestic Abuse is common. Be curious about relationships in a family; ask about issues such as a woman returning to a relationship after a long separation. Why did she leave? Why has she returned? **(DHR H).**

Mental Health (Perpetrator) (9)

Example Learning

When presented with familial abuse, agencies need to consider whether family members such as parents may be minimising the risks to themselves given their concern for their adult child and the caring role they have undertaken e.g. where the adult child has mental health issues **(SIR 3).**

In the 2021 DHR Analysis by the home office, 31% of perpetrators were affected by mental health issues, primarily depression and suicidal thoughts.

Cross Over Themes – In Focus

- **Professional Curiosity**

  Professional curiosity was highlighted as a common theme in both DHR/SIRs (9/19) and SARs/LLRs (6/9). This reflects analysis on a national level.

- An analysis of 231 SARs April 2017 - March 2019 (Preston-Shoot et al.) highlighted that *"A practitioner attribute that draws frequent comment in SARs that note its absence is professional curiosity. Often this related to practitioners' failure to probe the circumstances with which they were faced….It might relate to a failure to explore inconsistencies and mixed messages, or the impact that an individual's life experience might have on their current decisions".*

- An analysis of DHRs (Home Office) found that professional curiosity was lacked particularly in relation to knowledge and confidence to apply professional curiosity, absence of professional curiosity when it came to risk assessments, and DA not being recognised.

- **Multi Agency Working**

  Multi agency working was highlighted as a common theme in both DHRs/SIRs (7/19) and SARs/LLRs (7/9).

- This is perhaps unsurprising considering the nature of reviews and that one of the key criteria for a SAR is that "there is reasonable cause for concern about how agencies worked together to safeguard the adult".

- A key learning from SAR Person F is to **"ensure an appropriate multi-agency meeting takes place that clearly agrees responsibility for actions and monitoring. Make sure you are familiar with the new multiagency self-neglect guidance including VARM and CCM",** this policy has now been published.

There we several other themes that crossed over both DHRs/SIRs and SARs/LLRs for example non engagement with services/was not bought, mental health (perpetrator and/or victims) and coercion and control.

Achievements - SARs

Recommendation	Action
SASP - Review the Multi-agency policy and procedures for managing Self-Neglect, the VARMM process to ensure that it is up to date **[SAR Person E, F and Harris].**	Multi Agency Self Neglect Policy and Practice Guidance (including VARM and CCM) reviewed, signed off and published Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk)
SHSC - Ensure all mental health staff are aware of the risks of self-neglect when people are difficult to engage and decisions about case closure, or transfer are made after sharing information with other involved agencies, as part of the VARMM procedures **[SAR Person E].**	Staff will receive a CPD session on managing complex cases from the VARM Advanced Practitioner.
SYP - The DVPO [Domestic Violence Protection Order] specialist team to assist in raising the awareness of the criteria and benefits of DVPOs, increase the use of these orders and ease the workload of frontline officers. Training to be delivered to a number of frontline officers/staff and to remain an on-going process. Advice/guidance/Procedural information is published and accessible to all officers/staff **[SAR Harris].**	Since the introduction of the DVPN/O Unit and appropriate training, there has been an increase in the number of DVPN's issued by frontline officers and DVPO's approved at Court. SYP are also seeing an increased number of breaches being reported and dealt with via the court system. The new DVPO Team was launched and a reminder sent to officers (and information on obtaining DVPO's) by way of the Force Intranet. The forces DVPN/O Policy was updated.
Overarching Recommendation - All services providing a service for a client with learning disabilities, to ensure they have established lines of communication with the client and their family/carer. Services must, wherever possible, communicate with the client and assess their mental capacity to make decisions regarding their care provision. Whether the client is assessed to be competent or not, the service must have direct contact with the client to seek their thoughts and explore issues such as coercive control and neglect before accepting they no longer wish to attend a service **[SAR Person I].**	**Respite Home** - Cancellation policy has been amended so that where possible the respite home speak to the service user where a cancellation is made. Further, where a cancellation is made and the nights not rebooked or there are concerns over reason for cancellation and/or two consecutive stays are cancelled/postponed the relevant health /social care professional is contacted.

Published Reports and Learning Briefs

- Published SARs and Learning Briefs: Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk) [Including recently published Person E, Person F, Harris and Person I].

- Published DHRs and SIRs: Domestic Homicide Reviews and Serious Incident Reviews: Learning Briefs | Sheffield Domestic Abuse (sheffielddact.org.uk)

National Learning and Guidance

- Home Office Key Findings from Analysis of Domestic Homicide Reviews (September 2021) Domestic Homicide Reviews (publishing.service.gov.uk)
- Briefing for practitioners - Analysis of Safeguarding Adults Reviews (2019) https://www.local.gov.uk/topics/social-care-health-and-integration/adult-social-care/resources-safeguarding-adults-boards/practitioners
- The Multi Agency Self Neglect Policy and Practice Guidance (including VARM and CCM) Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk)
- SASP Safeguarding training covers professional curiosity, take a look at the courses run by SASP for more information Sheffield Adult Safeguarding Partnership - (sheffieldasp.org.uk)