Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

November/December 2022

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Current Reviews – Review Stage

9 Live Reviews

SAR (Person Identifier TBC)
SAR Person L
LLR Person H
DHR Adult S
DHR Adult T
DHR Adult V
DHR Adult W
SIR Adult 7
SIR Adult 7a
SIR Adult 10

Since the last update:

- SAR Person Identifier TBC agreed
- LLR Person H Completed
- DHR Adult W commenced

SAR (Person identifier TBC) – Male who was found deceased outside the complex where he lived. There had been concerns about self-neglect, substance misuse and the individual being a victim of cuckooing.

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. Individual also moved cross regions during the transition.

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 [Looked after Child]. 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.

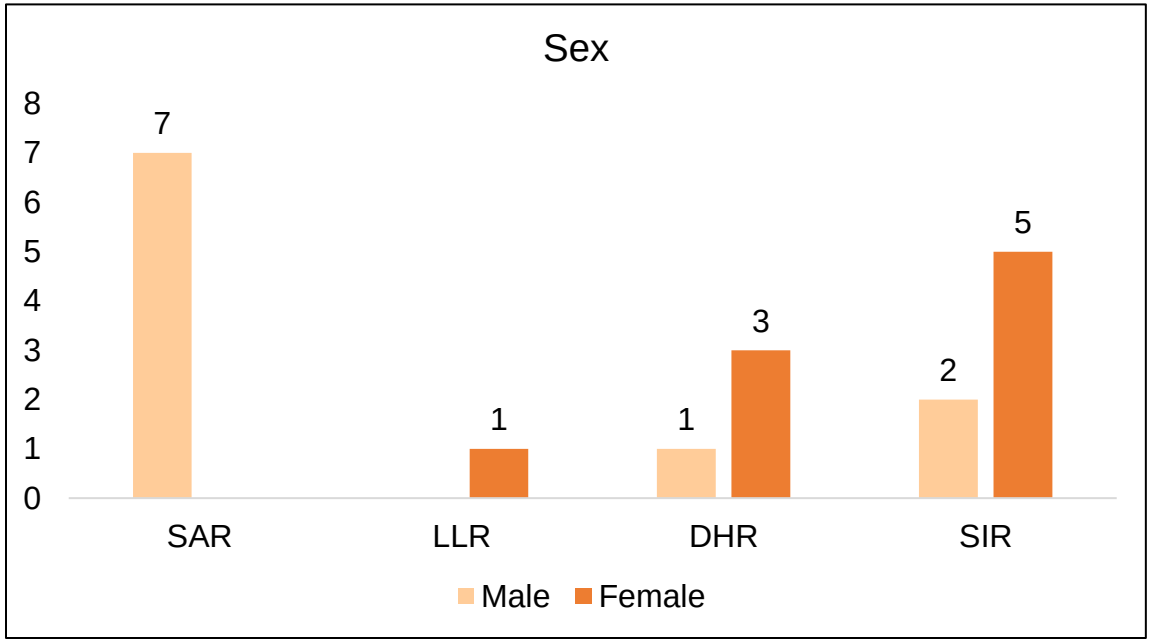
DHR Adult V – Was a woman in her 30s who died after a drug overdose of prescription medication. At the time of her death her estranged partner was being investigated for breach of restraining order and malicious communications. There were 11 reports of domestic abuse incidents in the 14 months before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

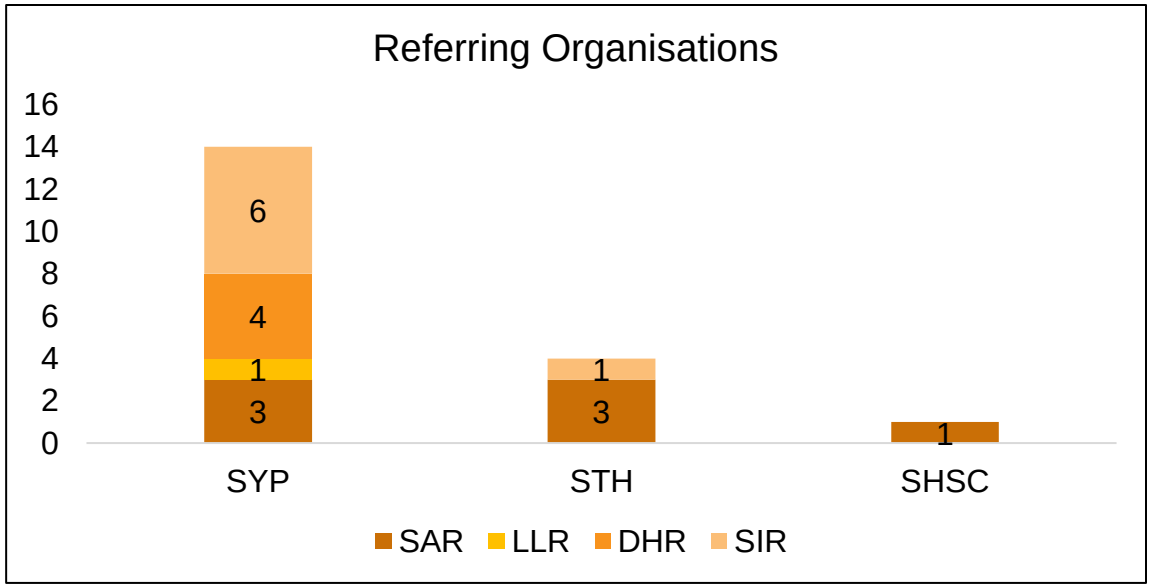
DHR Adult W – Woman in her 40s who died following being stabbed by her husband. The family had moved to the city as refugees in the 2000s. There had been several domestic abuse incidents reported to the police. The victim was receiving intensive mental health support when she was killed.

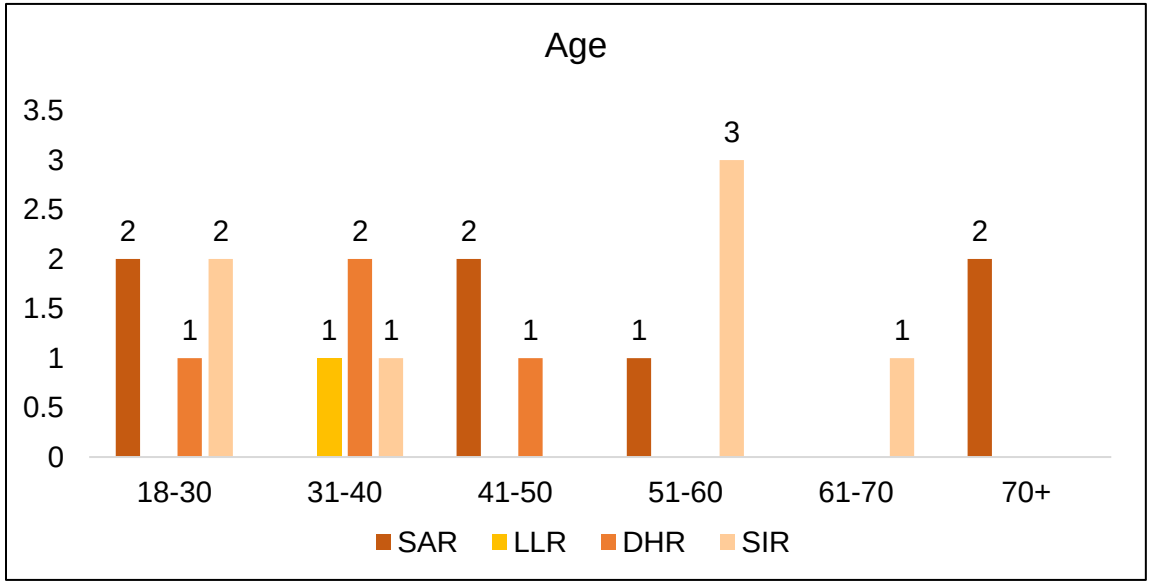
Reviews commenced since last update

Case Insights (Open/Ongoing Action Plans Only)

- In total, SYP have referred for the most reviews that are open or have ongoing action plans.
- All SARs have been Male, in the 1 LLR ongoing, the person was a Female. In DHRs and SIRs the gender split is 3 Males and 8 Females.
- The age category with the highest number of reviews is 18-30 (2 SARs, 1 DHR and 2 SIRs). 12 reviews in total have been individuals who are 50 years old or younger, in 7 reviews the person has been older than 50 years of age.







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 10 SARs/LLRs in total.

3 new themes have been identified, following the completion of LLR Person H. The following themes were identified:

- **Transition from Child to Adult Services** (in the case of LLR Person H, there was a lack of multi-agency pathway from children's to adults services or joined up after care).

- Adult had been a victim of **Child Sexual Exploitation**

- **Trauma Informed Working** (i.e. the person had experienced significant trauma and working in a trauma informed way (or lack of) was relevant to the case). Looking at previous cases, the theme of trauma informed working was also identified in SAR Person Harris and LLR Person K.

The theme Adult Family Violence is looked at in further detail this quarter. Following discussions it has been identified as a theme for 2 SARs (Person D and Person I)

Themes	
Fire Risk	3
Mental Capacity	8
Self Neglect	3
Risk Assessment	2
Domestic Abuse / Coercion and Control	8
Multi Agency Working	8
Hear the Voice	3
Carers	3
Abuse or Neglect (excl Self Neglect)	3
Professional Curiosity	6
Substance Misuse	4
Mental Health	5
Homelessness	2
Non-Engagement with Services	4
Was Not Bought	2
Trauma Informed Working	3
Transition from Child to Adult Services	1
Child Sexual Exploitation	1
Adult Family Violence	2

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				

In Focus

Two themes have been identified for “In Focus” for this quarter:

Adult Family Violence (AFV)

- There have been **6 published DHRs/SIRs** where AFV has been a factor. It is also a factor in a number of reviews that are currently at review stage. It was a theme in **2 SARs.**

Non-Engagement and Was Not Bought

- There have been **7 Published DHRs/SIRs** where Non-Engagement was identified as a theme and **6 SARs/LLRs** where Non-Engagement/Was Not Bought was identified as a theme.

Adult Family Violence – In Focus

Follow the link to the full research paper by clicking the underlined sentences

Adult Family Violence (AFV) is a form of Domestic Abuse where the perpetrator has a familial relationship to the victim. The definition includes wider family members e.g. cousins and step relations. This form of violence often presents different dynamics and motivations to intimate partner violence.

Research

- **A study looking at Domestic Homicides during the Covid-19 Pandemic 20/21 found in cases of Adult Family Homicide (AFH):**
- 43% of victims were aged 65+, reflecting a pattern of parent and grandparent victims. Suspects were found to be overwhelmingly male.
- Suspects nearly 2x more likely to have mental health recorded as a risk factor than suspects of intimate partner homicide. *Suspects and/or victims were often known to mental health services highlighting the importance of effective multi-agency working and processes (e.g. MARAC) in domestic abuse cases.*
- In a home office analysis of DHRs (2021), For 27% of the victims there was a family relationship between the victim and perpetrator.

Examples of Published Reviews in Sheffield

DHR C: Mother killed by her adult son in an apparent "one off incident" following a period of [the son's] deteriorating mental health.

DHR F: Daughter with severe depressive illness, caring for her 93 year old mother, admitted manslaughter on grounds of diminished responsibility.

SIR 3: Life changing injuries were inflicted on a father by his son who had moved home to live with his parents following a relationship breakdown and loss of his job. He had long term, deteriorating mental health issues.

SAR Person D: Elderly male, being cared for by his son who experienced neglect. He was living in a cluttered environment, with no heating, inability to independently exit the property and poor diet resulting in weight loss

SIR 8: Mother seriously injured in a violent incident perpetrated by her adult son, who was experiencing a psychotic episode.

SAR Person I: Young male with a learning disability and autism, neglected by his mother and step-father. He was consequently admitted to Intensive Care severely malnourished and in a neglected state.

Learning Examples

- **If a carer is depressed, make sure you ask them about risks to self and others and take appropriate action to address it.**
- **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.**
- **The need to enquire about / assess domestic abuse within the wider family where individuals are presenting with alcohol misuse and mental health issues.**

Risk Factors for AFV

Mental Health Issues /Substance Misuse	Caring Responsibilities	Social Isolation and Instability	Previous History of Perpetrator	Sense of Entitlement
Commonly in perpetrators	E.g., parent caring for adult son/daughter with support needs or vice versa	of victim/perpetrator, and unable to sustain employment and relationships	violence against women, previous criminality, antisocial behaviour	E.g. to financial resources

Non – Engagement and Was Not Bought

Follow the link to the full research paper by clicking the underlined sentences

Reasons a person may not engage with services are personal. Engagement can also fluctuate. Some reasons that a person may not engage include:

- Experience of trauma
- Lack of trust in professionals
- Difficulty accepting help is needed
- Mental health problems
- Cultural or religious reasons
- Social isolation
- Homelessness
- Cognitive impairments

Coercion and Control
An individual may be prevented from engaging with services or feel unable to engage due to fear over own safety and what might happen if they do.

Was Not Bought
Non-attendance at appointments may be an indicator of coercion and control and/or neglect. Where a person is reliant on another person to bring/accompany them to appointments or support them with their care, they may be at risk of abuse and neglect, as they are unable to attend without this support.

Research has found reluctance to engage a common theme in SARs e.g.,

Absence of strategies to address non-engagement e.g. insufficient persistence, taking refusal at face value.
Need for practitioners to be proactive when faced with consistent lack of engagement, factoring in communication needs, possible barriers such as disorganisation of lifestyle, involving specialist agencies and using significant events (e.g., hospital discharge) as opportunities to effect change and persist.

Learning from Reviews

Was Not Bought **SAR Person I**	Person I is a young man with a learning disability and autism. He was known to services such as college, day centre and respite care but became less visible when he stopped attending following decisions made through contact with his stepfather. Respite care was cancelled at the start of Covid at which point he became invisible to services. He was admitted to Intensive Care malnourished, in a neglected state. He has since recovered. **Learning: When someone is not brought to appointments/services, consider the impact on those who lack capacity and if domestic abuse might be occurring. Share information about non-attendance and any concerns with other involved agencies.**
Mental Health **SAR Harris**	Harris had emotionally unstable personality disorder (EUPD), used drugs, and was reported as having a brain injury from childhood. A number of services discharged him in the year up to his death due to non-engagement and beliefs he wouldn't benefit from some treatments due to difficulties building therapeutic relationships previously. It was noted that he would not attend therapy and was disruptive in group sessions. Continually not being contactable was seen as confirmation he would be difficult to engage. **Learning: Confirmation bias can prevent professional curiosity around what might help safeguard the person in the future. Take time to be professionally curious in your work, ask questions to establish the facts.**
Domestic Abuse **SIR Adult 9**	Adult 9 was forced to marry her cousin and brought to the UK in 2019 against her will. She was then forced into domestic servitude, was frequently locked in her bedroom and denied food and medical assistance. As an example of good practice, despite the pressures of Covid-19, the GP surgery made regular attempts to contact Adult 9 to arrange routine screening appointments. **Learning: Raise awareness of forced marriage and modern slavery, in a domestic abuse context. Raise awareness of local modern slavery resources through the South Yorkshire Modern Slavery Partnership.**

Good Practice Identified

Reviews often recognise areas of good practice, some examples identified in reviews were:

SAR Harris

It was identified that the response from the Housing Homeless team when Harris presented as homeless was very good and in line with The Homelessness Reduction Act. **The history taking from Harris was extensive** and gave a good insight into Harris's needs.

SAR Person I

Maternity staff always enquired about Person I and their sibling's whereabouts at home and clinic visits, they were **professionally curious** and displayed an active concern for mother's ability to care for two children with learning disabilities, leading to the **Family Common Assessment Framework** being completed. This was good practice in supporting not just mother, but the wider family.

SIR Adult 9

SYP (South Yorkshire Police) are in the early stages of planning an **awareness campaign** across the force around Domestic Servitude and how to spot the potential signs of this strand of Modern Slavery.

DHR Adult M

The GP was **proactive around the perpetrator's** [of the domestic homicide] **mental health**, **making multiple referrals to the mental health team** and providing telephone and face to face support directly to the perpetrator and Adult M who was his partner and his carer.

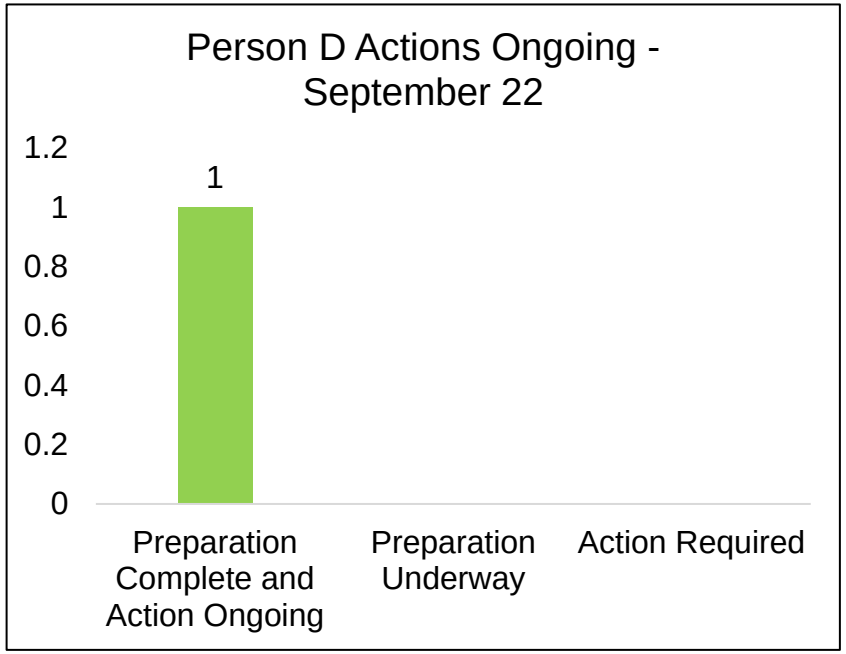
Current Reviews – Ongoing Action Plans (Single Agency) (SARs)

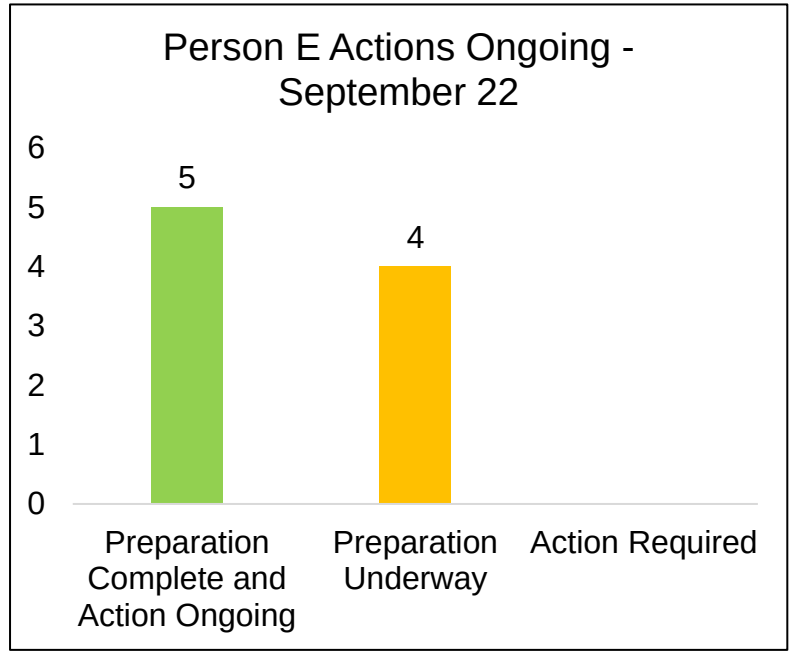
These graphs present the number of actions still ongoing from single agency action plans.

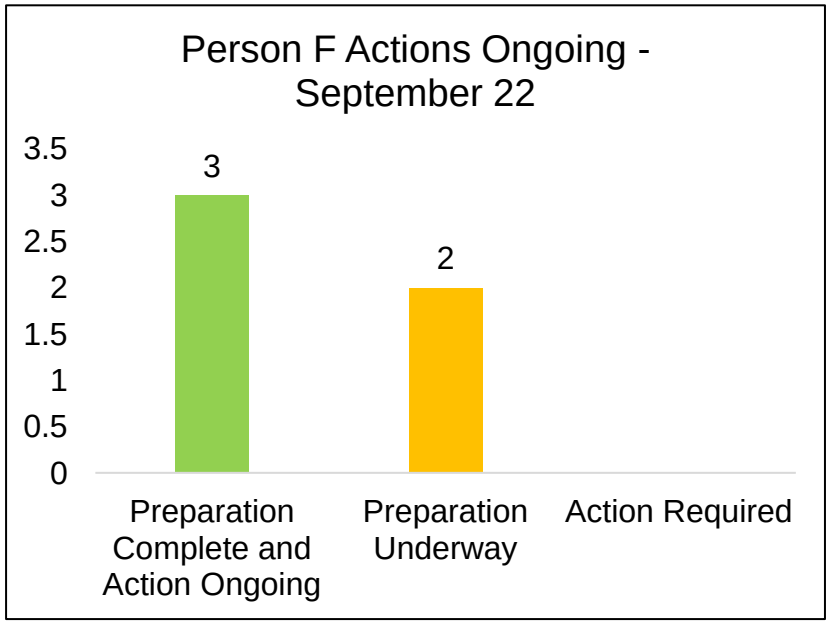
There are actions ongoing for all 5 SARs that have been completed.

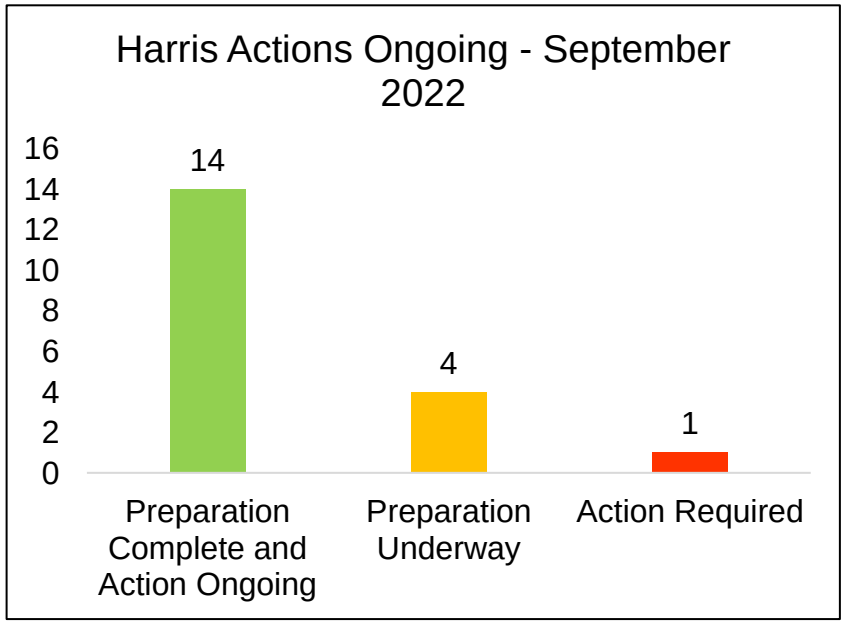
A significant number of actions have also been completed (85 actions).

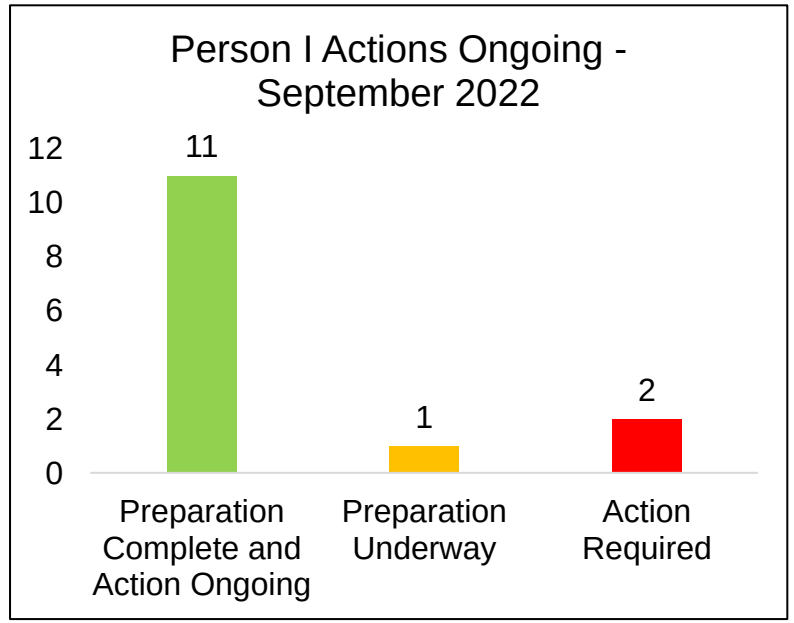
There are several actions that have not yet been allocated an action status by Adult Social Care, who have recently undertaken a review of their actions in order to achieve the recommendations. These apply to Person D, E, F and Harris. Please note they are therefore not included in the graphs.











Achievements - SARs

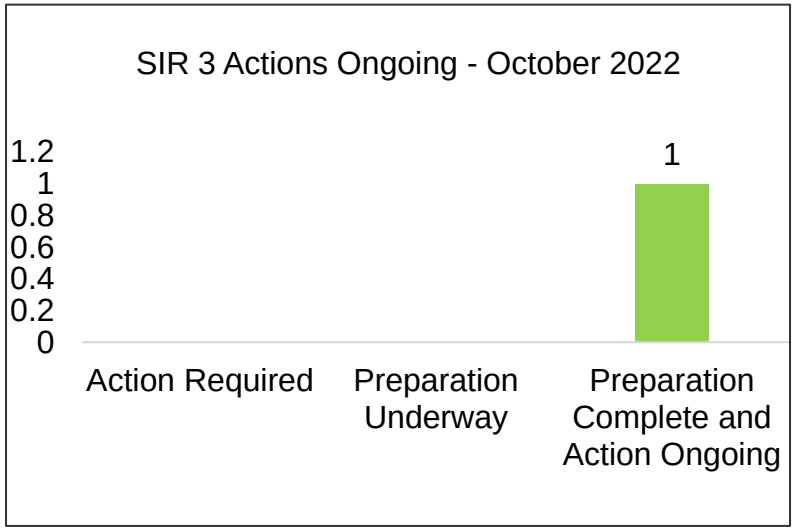
Recommendation	What's been Done?
Overarching Recommendation All services providing a service for a client with learning disabilities, to ensure they have established lines of communication with the client and their family/carer. Services must, wherever possible, communicate with the client and assess 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].**	**Preparation for Adulthood Team (PAT) -** Since the Person I case, staff have been much more conscious of highlighting the service user's voice within their work and assessments and relying less on parents' opinions. The team can now access Widgit Online (Inclusive Communication programme) to help aid communication with people who are non verbal / prefer pictures to help communicate. The team have Makaton and BSL training arranged to help communicate and engage with the people we work with, to ensure their voice is heard.
Sheffield Teaching Hospital Foundation Trust (STHFT) - Continence Advisory Service to be made aware of and refer to the STHFT 'Did Not Attend /Was Not Brought' Policy if two or more face-to-face appointments have been missed **[SAR Person I]**	**STHFT -** The Continence Service have updated their operational guidance to provide any young person who is transitioning to STHFT with a face to face appointment. The continence service is continually offering several options for clinical assessment to patients and carers including face to face. This is clearly documented throughout the Learning Disability template which is completed by all clinical staff. The Did not Attend/Was Not Bought Policy has been updated and submitted for ratification by the Trust Executive Group.
South Yorkshire Integrated Care Board – Sheffield Place (SY ICB) (Previously Sheffield CCG) Support the GP practice involved in this case to engage with the Domestic Abuse Routine Enquiry (DARE) Project that is being rolled out in Sheffield **[SAR Person Harris]**	**ICB -** DARE project has been relaunched. The first wave of training is to commence October 2022, with Township GP network. The training will eventually be offered to all Sheffield GP practices. The Designated Doctor and Deputy Designated Professional has contacted the GP practice and provided details of the relaunched DARE offer. IDAS colleagues have been provided with details of the GP lead and copied into the email in order for them to be able to make direct contact with the practice.

Current Reviews – Ongoing Action Plans (DHRs and SIRs)

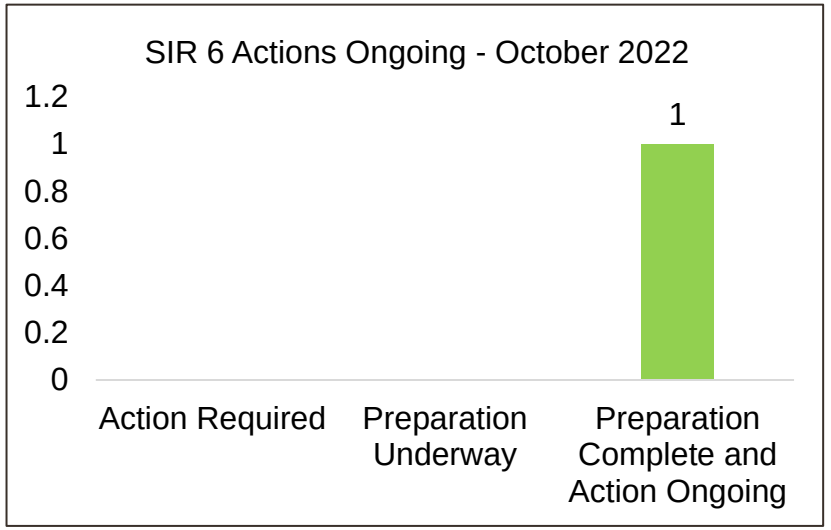
These graphs display the number of actions that are **ongoing** in action plans (DHRs and SIRs).

Since the last update, the action plan for DHR Adult O has been completed.

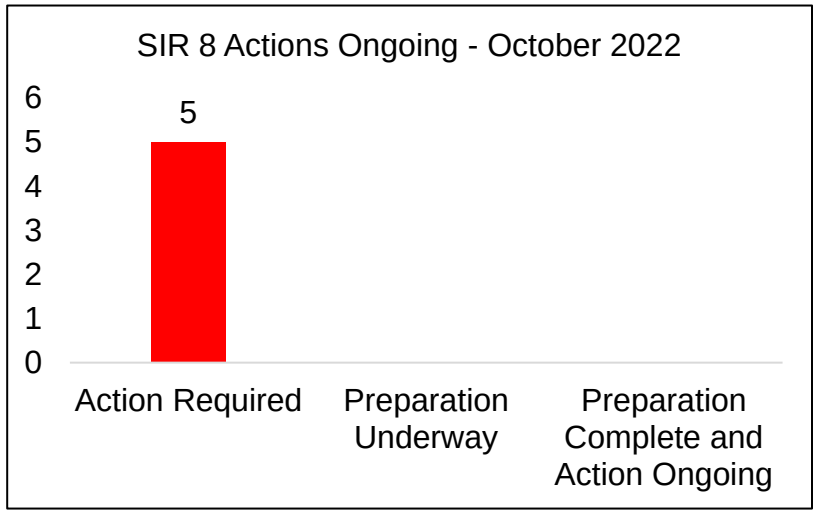
***DHR Adult S: Actions Unable to be Fulfilled**
These are actions that an agency can no longer fulfil and as an organisation they are unable to put it into practice. At some stage in the future it may be that things change and they can introduce that particular recommendation, however at presented it is agreed by the DHR/SIR subgroup that we will no longer pursue this for a particular DHR/SIR action plan.



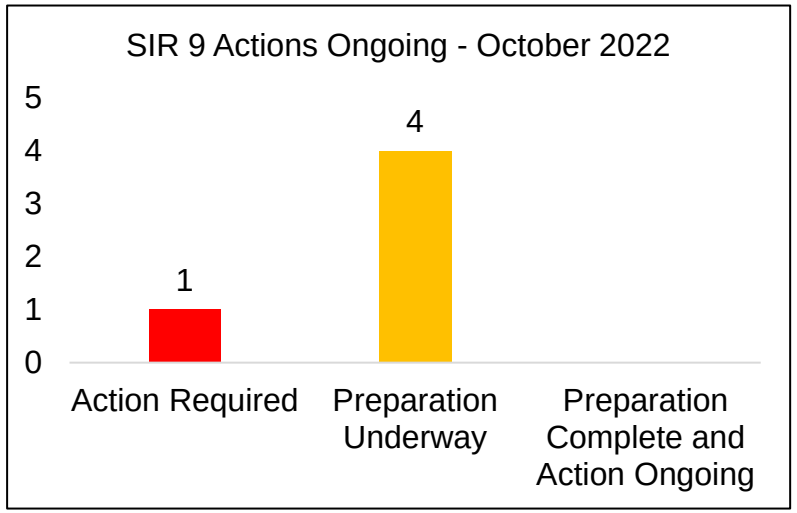
SIR 3 action plan commenced Oct 2017



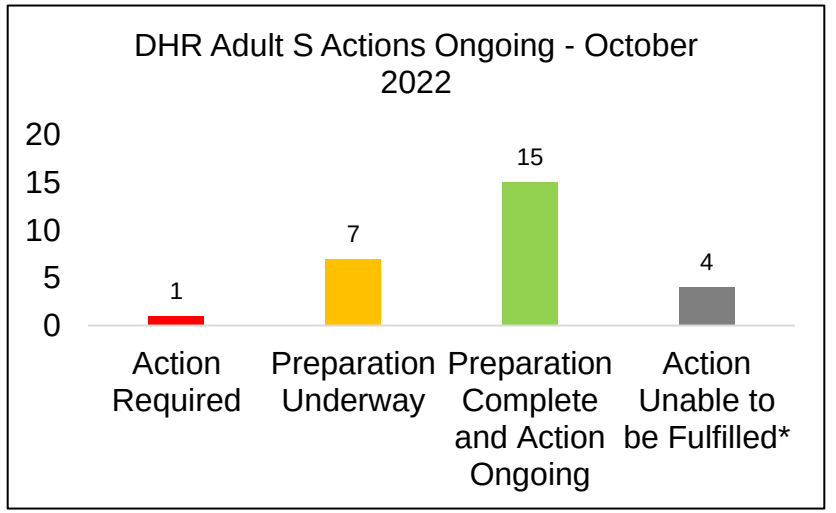
SIR 6 action plan commenced Jan 2021



SIR 8 action plan commenced Aug 2022



SIR 9 action plan commenced Aug 2022



Adult S action plan commenced Dec 2021

Achievements - DHRs and SIRs

Domestic Abuse services are now being asked to collect data with regard to clients they are working with who have experienced modern slavery. This is in order to better understand prevalence of modern slavery and encourage staff to discuss the issue with clients.

A Protected Learning Initiative event for GPs and other primary care staff was held in September 2022 on Adult Family Violence and a workshop on Adult Family Violence will be held in Safeguarding week (November 2022).

Housing and Neighbourhoods staff in Sheffield City Council have received training on Trauma Informed Approaches.

Suicide awareness training has been sourced by South Yorkshire Police and made available via their intranet.

Published Reports and Learning Briefs

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

Information and Resources

SARs

- 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

  (Full report: Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk))

DHRs

- Home Office Key Findings from Analysis of Domestic Homicide Reviews (September 2021) Domestic Homicide Reviews (publishing.service.gov.uk)
- Standing Together DHR Report

Adult Family Violence

- Vulnerability Knowledge and Practice Programme (VKPP) Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021
- AFV Briefing Sheet (Standing Together).

Acronym	Full Name	
AFV	Adult Family Violence	AFV is a form of Domestic Abuse where the perpetrator has a familial relationship to the victim e.g. son to mother. This form of violence often presents different dynamics and motivations to intimate partner violence.
AFH	Adult Family Homicide	Homicide where the victim and adult perpetrator had a familial relationship.
DHR	Domestic Homicide Review	Where the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a relative, a household member or someone he or she has been in an intimate relationship with, a DHR will be commissioned. A multi-agency review panel, led by an independent chair reviews each agency's involvement in the case and makes recommendations to improve responses in the future. DHRs are not enquiries into how someone died or to apportion blame.
DVPN /DVPO	Domestic Violence Protection Notice/Domestic Violence Protection Order	The police can issue a DVPN if there is reasonable grounds to believe violent or threatening behaviour has taken place and the notice is necessary to protect the victim from violence or threatened violence. The notice can last up to 48 hours and conditions may include for the suspect not to attend the address, not to contact victim, prohibit the suspect from coming within a specified distance of the premises etc. Within 48 hours of the DVPN being served, an application by police to a magistrates' court for a Domestic Violence Protection Order (DVPO) must be heard which can prevent the perpetrator from returning to a residence and from having contact with the victim for up to 28 days. This allows the victim a degree of breathing space to consider their options with the help of a support agency.
ICB	Integrated Care Board	Formerly, Clinical Commissioning Group (CCG)
LLR	Learnt Lessons Review	Where a case does not meet the criteria for a Safeguarding Adults Review but there is still potential learning to be had from the case, a Lessons Learned Review may be carried out.
MARAC	Multi Agency Risk Assessment Conference	A multi-agency meeting where information is shared on the highest risk domestic abuse cases between the agencies attending for example police, health, housing, probation etc.
SAR	Safeguarding Adult Review	Where an individual with care and support needs has died or come to serious harm due to abuse or neglect, and there is concern about agencies worked together the protect the adult, a SAR may take place. This is a Multi-Agency review process which seeks to determine what could have been done differently and promote learning from the case to improve practice. It is not to place blame on any partners involved.
SHSC	Sheffield Health and Social Care	
SIR	Serious Incident Review	Where an individual has come to serious harm as a result of domestic violence, an SIR may be carried out. Although the case doesn't meet the criteria for a DHR as the person has not died, there is still learning to be had.
STHFT	Sheffield Teaching Hospital Foundation Trust	
SYP	South Yorkshire Police	