If you have any suggestions for content for future newsletters please contact kate.sanders@sheffield.gov.uk

Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

February 2023

Contents

SAR – Safeguarding Adults Review
LLR – Learnt Lessons Review
DHR – Domestic Homicide Review
SIR – Serious Incident Review

Page 2. Current Reviews – Review Stage

Page 3. Case Insights

Page 4. Recently Published Reviews

Page 5 & 6. Themes in Reviews

Page 7, 8, 9 & 10. In Focus - Carers

Page 11. Good Practice Identified

Page 12 & 13. Actions and Achievements - SARs

Page 14 & 15. Actions and Achievements – DHRs/SIRs

Page 16. Published Reports and Learning Briefs

Page 17. Information and Resources

Page 18. Acronyms

Current Reviews – Review Stage

9 Live Reviews

SAR Person L
SAR Person M
SAR Person N
DHR Adult T
DHR Adult V
DHR Adult W
DHR Adult X
SIR Adult 7
SIR Adult 7a

Since the last update:

- SAR Person M was agreed.
- DHR Adult X commenced.
- SIR Adult 10 went to action plan stage.

SAR Person N – 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 M – Male with a learning disability who died as a result of a series of self-inflicted nose bleeds. He moved around services and areas. There were concerns sufficient handovers did not take place and that recommendations made in regard to his nose picking were not acted upon and care planned for.

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. He 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.

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.

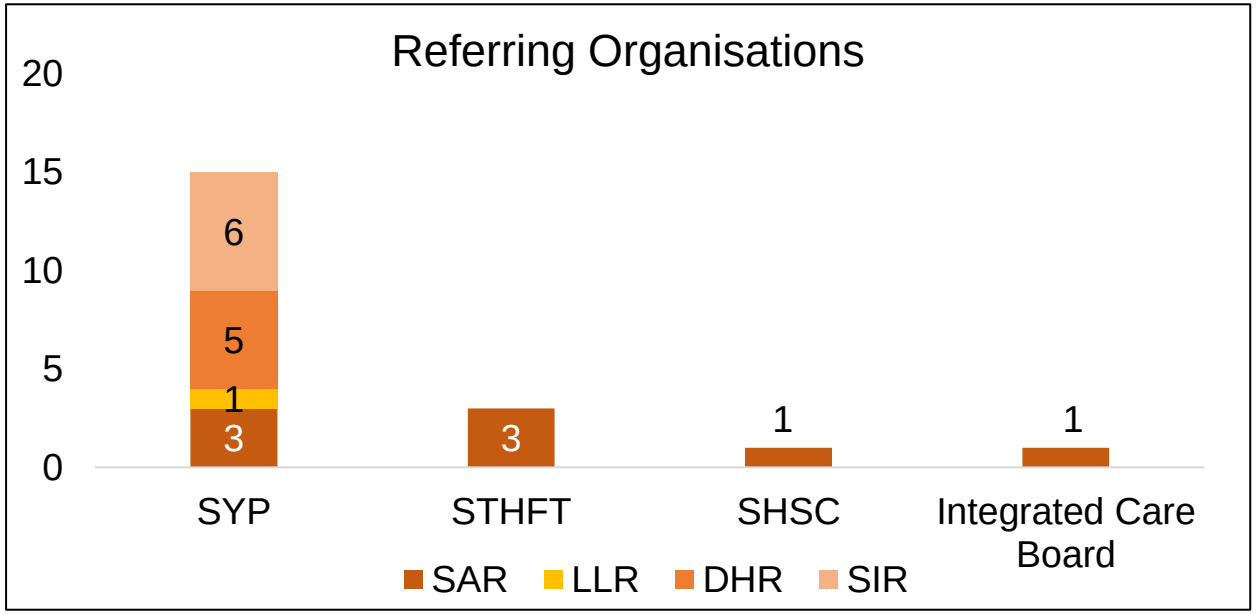
DHR Adult X - Woman in her 20s found hanging by her friend, who contacted the police as her ex-partner and father of their child had been telling her to kill herself following years of domestic abuse.

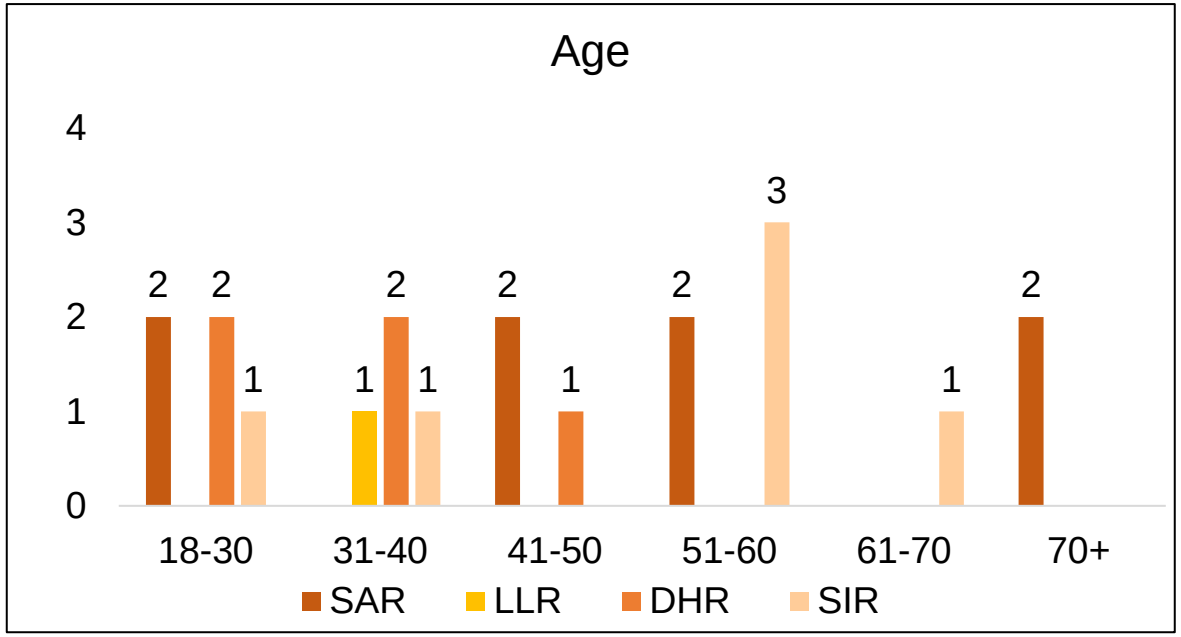
Reviews commenced since last update

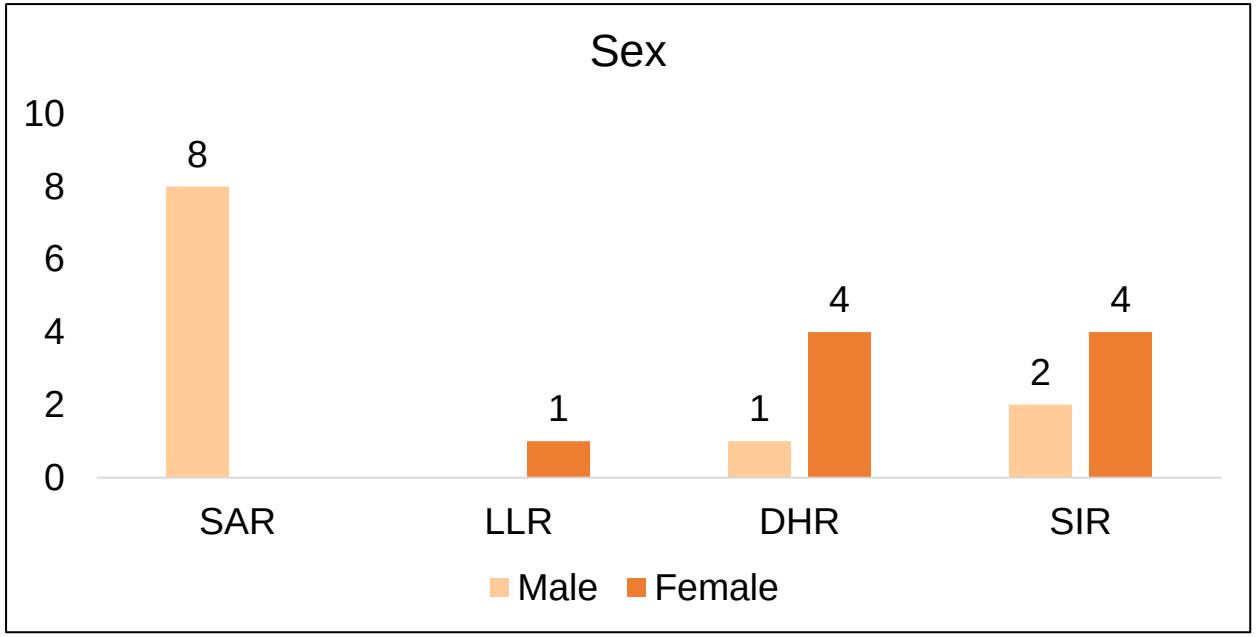
Case Insights (Open/Ongoing Action Plans Only)

Insights

- South Yorkshire Police were the referring organisation for 75% (15 out of 20) of all reviews that are currently open or have an ongoing action plan.
- All 8 SARs which are in review stage or have ongoing action plans in Sheffield, are male. There have been no SARs completed where the individual was female. This differs from the picture nationally as a whole, where analysis (of SARs completed between 2017 and 2019) found neither gender to be over/under represented in SARs, although slightly more men did feature (however this varied between areas).







Recently Published Reviews

Click to read the Learning Brief

Since the last newsletter, SIR Adult 10 has been published:

Case overview

Woman in her 50s stabbed by her father (the two were sharing a home along with Adult 10's husband). There was a history of domestic abuse exacerbated by the father's dementia. Adult 10 has a lengthy history of mental health difficulties and substance misuse issues. In addition to this serious incident, there were a total of 9 police incidents recorded in relation to the family including 5 domestic incidents.

What did the review tell us?

Caring, and being cared for can be overwhelming and very difficult for both parties.

Domestic abuse and the risk posed by adult family violence can sometimes be 'lost' where one party is the registered carer for another.

Adult 10 shared with multiple agencies how stressful caring was for her, this tells us we need to do more to support carers at stressful times, especially when we are aware of complicating factors, such as domestic abuse in the household, mental health and substance misuse issues.

Themes

Carer Relationship **Mental Health (Victim and Perpetrator)** **Whole Household Approach**

Adult Family Violence **Professional Curiosity** **Information Sharing**

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.

There were no additional SAR reviews completed this quarter, therefore the themes are the same as the previous quarter, with no changes in numbers.

This quarter, the newsletter will focus on the theme of Carers. There have been 3 SARs where carers was a theme these were:

- SAR Person D
- SAR Person F
- SAR 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 21 DHRs/SIRs in total.

Themes in 1-4 DHR/SIRs		Themes in 5-8 DHR/SIRs		Themes in 9 + DHR/SIRs	
Suicide	3	Post Separation Abuse	7	Risk Assessment (Victim)	13
Sexual Abuse	2	Multi-Agency Working	8	Professional Curiosity / Challenge	11
Risk Assessment (Perpetrator)	3	Adult Family Violence	7	Mental Health (Perpetrator)	11
Child Contact Issues	1	Caring Responsibilities	6	Asking about DA / Routine enquiry	12
No Recourse to Public Funds	1	Substance Misuse (Perpetrator)	8	Information Sharing	11
Accessible Services	3	Substance Misuse (Victim)	7	Coercion and Control	9
Focus on Incidents not Pattern of DA	3	Policies & Procedures about DA	7	Mental Health (Victim)	9
Record Keeping	4	Public Awareness re. DA	8		
Support for Perpetrators	4	Clarifying Pathways	7		
Recognising Male Victms	3	Training Needs Identified	8		
Violent Resistence	2	Whole Household Approach	7		
Serial Perpetrator	2	Cultural/Faith Issues	5		
Modern Slavery	1	Did not Engage with Services	8		
Forced Marriage	1				
Use of Interpretors	1				
Recording who Accompanies who to Appointments	3				

In Focus

The theme of Carers has been identified for “In Focus” for this quarter:

- In a number of reviews, there has been a carer relationship identified as well as missed opportunities to refer carers for a carers assessment.
- Carers has been a theme in 3 SARs.
- Carers has been a theme in 6 DHRs/SIRs.
- National Analysis of SARs shows this to be a theme seen nationally, for example carers’ needs being overlooked by agencies including an absence of carer’s assessment and a failure to recognise a family member’s own vulnerabilities.

Examples of Reviews In Sheffield where Carers was Identified as a Theme

SAR Person D – Elderly man who passed away in hospital with sepsis and hypothermia. Following a previous hospital admission he had been discharged to a family members home despite other family members concerns about the suitability of the arrangements. He was visited at the home by health care staff and an occupational therapist who had concerns about Person D's living conditions. A safeguarding concern was raised which was not progressed and Person D and the family carer declined the offer of formal care support. Ongoing medical support from the GP and District Nursing was provided to Person D and the family carer.

SAR Person F - An elderly man who lived with his wife and a son. He ceased taking/being administered prescribed medication and suffered a stroke. Professionals were concerned his wife was withholding treatment and submitted a Safeguarding Concern. A multi-agency meeting agreed employed carers would administer medication in future, but his wife continued to be involved in his care including decisions around his medication. His condition deteriorated, and he died of heart failure.

DHR Adult F - Daughter with history of severe depressive illness, caring for her 93 year old mother, admitted manslaughter on grounds of diminished responsibility. She had consulted her mum's GP with increased anxiety, weight loss feelings of exhaustion and difficulty coping with her mum's care

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.

Identified Learning

In working with family/friend carers it is important to recognise their caring role, complete a carers assessment and put in place an appropriate support plan which may include referral to specialist carers agencies **[SAR Person D]**

Offer Carer's assessments to all carers and offer again if there is an increase in need. If refused, consider if the carer has capacity to undertake all the care needs and escalate to line managers if needed **[SAR Person F]**

Remember that some carers are themselves vulnerable for reasons including their own mental or physical health problems and may find it difficult to acknowledge their own needs. If a carer is depressed, make sure you ask them about risks to self and others, document that risk and take appropriate action to address it **[DHR Person F]**

Caring, and being cared for can be overwhelming and very difficult for both parties. Agencies to be alert to high stress (or 'trigger') points at which to signpost or refer carers for additional support, e.g. when an initial claim is made for carer's allowance or a hospital admission **[SIR Adult 10]**

Examples of Actions Implemented in Relation to Carers

Sheffield Teaching Hospitals Foundation Trust

- Safeguarding training presentations include references to carers for further discussion with the course facilitator. Safeguarding training includes further reference to family as carers.
- Information has been circulated to Safeguarding Champions. This information includes support for family members who may be carers and signposting to Sheffield Carers Centre.
- The STHFT Safeguarding Team will circulate a Newsletter in which an assessment of carer need and support will be included. Signposting to the Sheffield Carer Centre and the Young Carer Support Service will be included.

South Yorkshire ICB (Sheffield)

- Information regarding carer support was sent by the Planned Care Team to GP's to raise awareness of support for Carers. The content bought attention to Carers Rights Day 2022 and collated links to several resources and future events to be aware of. It included information about Carers Rights Day, links to the Sheffield Practitioners Carers Resource Pack (to support Primary Care links to Sheffield Carers Centre), information and contact details for the Sheffield Carers Centre Health Liaison Officer (explaining that the Sheffield Carers Centre are keen to work with Primary Care and would be happy to offer 1:1 support with any practice).
- Carer breakdown training was delivered to ICB colleagues from the care home support team and continuing care (June 2022).

Helpful Information and Resources

Caring and Safeguarding

Carers and safeguarding: a briefing

- Risk of abuse, either for the carer or the person they are caring for, increases when the carer is isolated and not receiving practical or emotional support from family, friends or professionals.
- **Making Safeguarding Personal** and **Professional Curiosity** are key to support safeguarding both carers and the person they care for.
- Assessment of both the carer and the adult they care for must consider the wellbeing of both people. A needs assessment of the adult cared for, or a carer's assessment, is an opportunity to explore circumstances and to consider whether there is information or support which could be offered to prevent abuse or neglect from occurring.
- A Domestic Homicide Project Spotlight Briefing notes "*In carrying out Care Act Assessments and reviews of Care Plans, relevant agencies should look beyond care needs and carer stress, and always consider vulnerability and domestic abuse. They should always consider a referral in these cases into multi-agency forms such as MARAC and Safeguarding*."

Caring and Domestic Abuse

- A national analysis of 124 DHR's found that in 8% of cases the victim was a carer. None of the victims with a caring role had received a carer's assessment of their support needs connected with their role as a carer.
- 13% of perpetrators were carers. Only one perpetrator had received a carer's assessment under the Care Act 2014.
- A Domestic Homicide Project Spotlight Briefing *notes "be aware that where domestic abuse and caring relationships overlap this may increase the risk to the victim. In completing DASH/DARA risk assessments, establish the nature of the caring relationship and ask how that might impact risk. Consider referring to MARAC and/or making an adult safeguarding referral in such cases".*

CARERS TRUST
Sheffield Carers Centre

If you identify someone as a carer, you can refer them to Sheffield Carers Centre for an assessment. Professionals can use an online form to refer a carer for an assessment via the Sheffield Carers Centre website. https://www.sheffieldcarers.org.uk/referral-for-our-carer-assessment -

For more information and guidance on whether a Referral to the Carers Centre might be appropriate take a look at the Sheffield Carers Centre Website and visit https://www.sheffieldcarers.org.uk/referral-guidance -

Carer Advice Line: 0114 272 8362

Good Practice Identified

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

SAR Person F

Decision making in Adult Social Care was well evidenced and in line with Making Safeguarding Personal with Person F being at the centre of professional's care.

LLR Person C

Vulnerable Adults Risk Management Model (VARMM) meetings were held in order to try and safeguard Person C as he was assessed as having the capacity to make decisions (although many deemed these unwise) around his financial affairs, care, residence and relationship. Professionals met once every 4-6 weeks to discuss progress and to discuss challenges/difficulties. Expertise and accountability was shared between services making them more effective as a group at managing complex risk and need.

SIR Adult 10

During Covid, a GP Practice made efforts to work with the family flexibly, for example, meeting outdoors to ensure that face to face care was not interrupted.

Adult 10 was signposted to carers support by a Consultant at the Memory Clinic.

SIR Adult 8

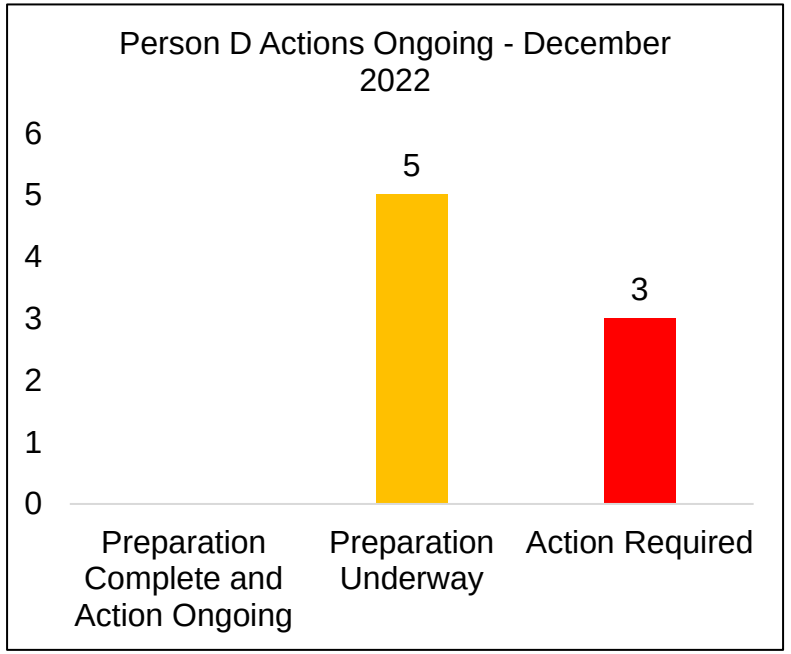
The police completed a DASH risk assessment.

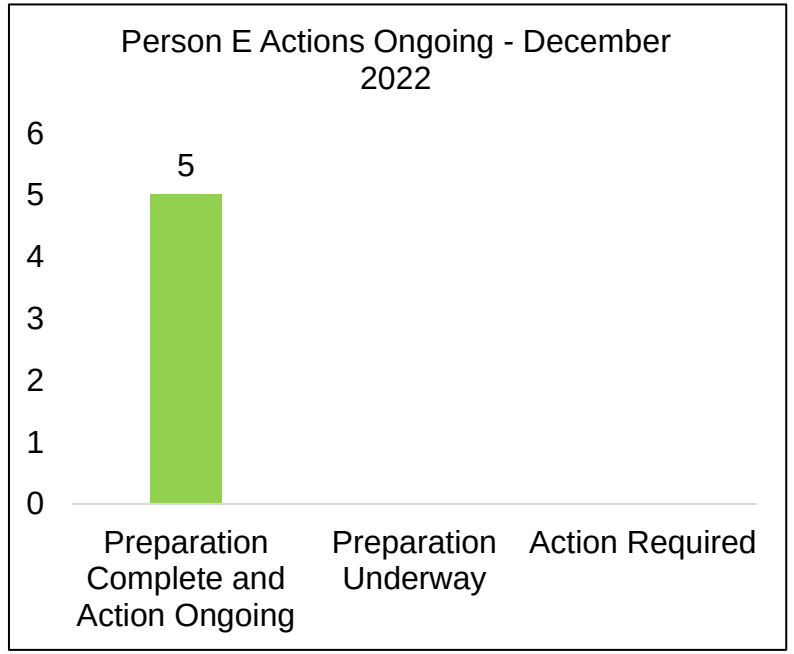
Adult Safeguarding used professional curiosity, offered to review the risk assessment and when domestic abuse support was refused, shared information by post.

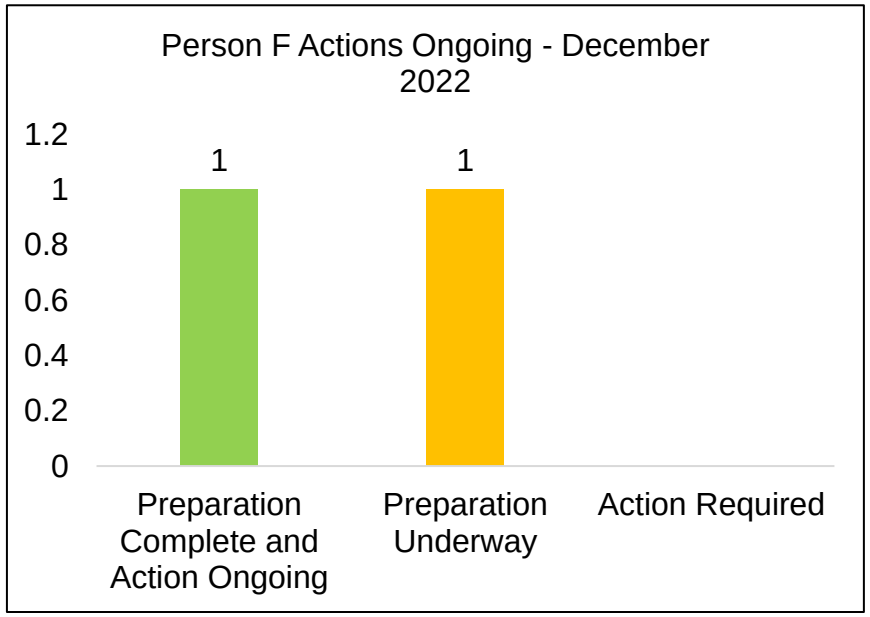
Current Reviews – Ongoing Action Plans (Single Agency) (SARs)

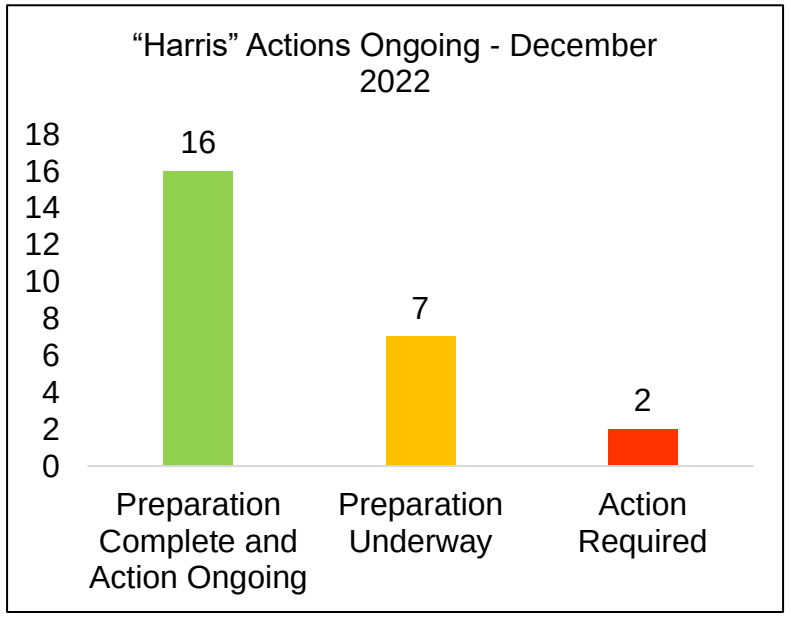
These graphs present the number of actions still ongoing from single agency action plans.

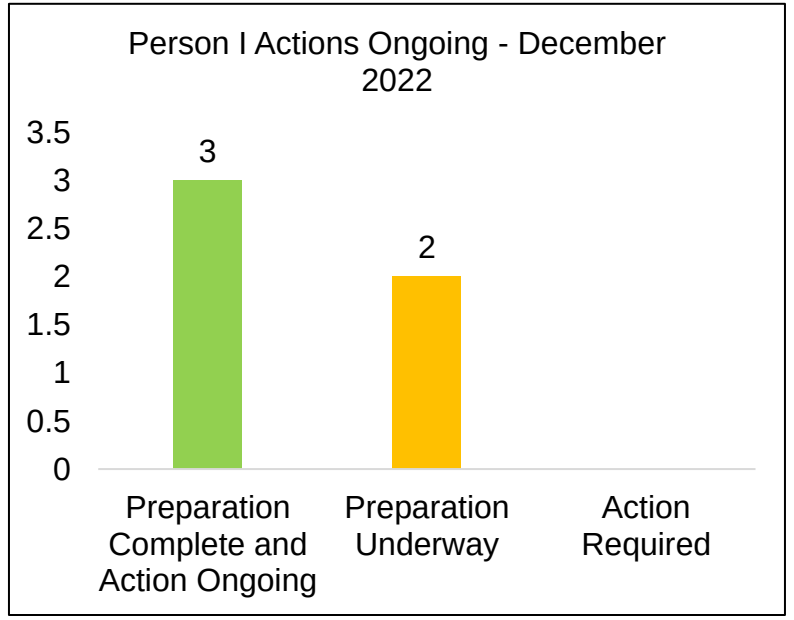
- There are actions ongoing for all 5 SARs that have been completed.
- Across the 5 action plans, there are 5 single agency actions where there is action required. There are 11 where preparation is underway.











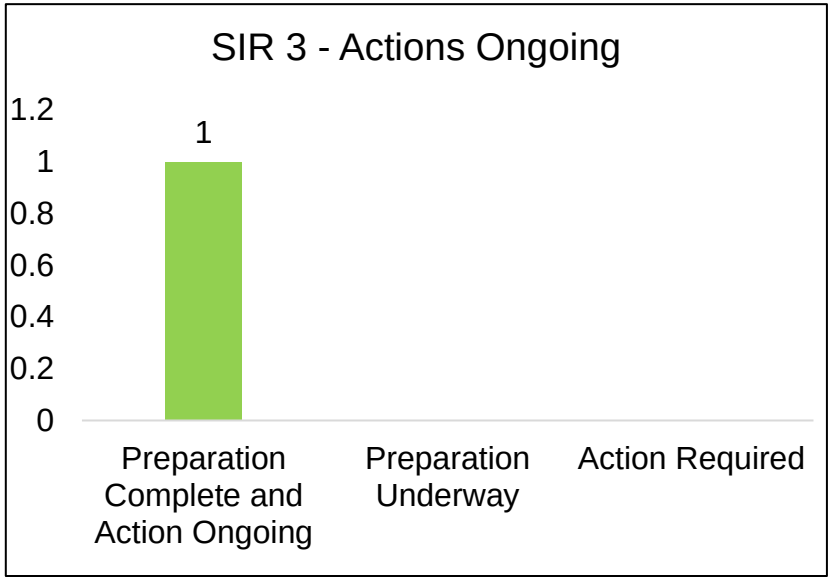
Achievements - SARs

Recommendation	What's been done?
Day Centre - 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. Exit interviews to be introduced to establish reasons for leaving service **[SAR Person I]**	Exit interview form for clients now completed that includes the following questions: (1) Why did you choose our service to begin with? (2) What did you like about our service? (3) Is there anything we could have done differently? (4) Have we communicated with you effectively? (5) Did we meet your expectations? What did we learn, do we need to change anything (internal question)
SASP should continue to develop and share the interactive tool for exploration of professional curiosity with partner organisations **[SAR Person Harris]**	The Tool has been finalised, edited and is now on the SASP website, has been shared on social media channels and will be shared in the SASP e-bulletin in January 2023. It was shared around the City Wide Best Practice Group and Adult Social Care committed to putting the tool on the Electronic Manual for Health and Social Care (ELMA) and in their newsletter. Via social media Doncaster Safeguarding Board noted it was a fantastic resource for professionals. **You can watch it here** Professional Curiosity Video - YouTube
Sheffield Teaching Hospitals Foundation Trust (STHFT) - NHS supply chain (who supply/deliver continence products) will now gather data on non-activated deliveries for patients with a learning disability. Clinicians will monitor this data on a regular basis **[SAR Person I]**	The supply chain send quarterly reports to the Continence Service on non-activated deliveries for patients with a learning disability. This data is monitored by the Continence Service.

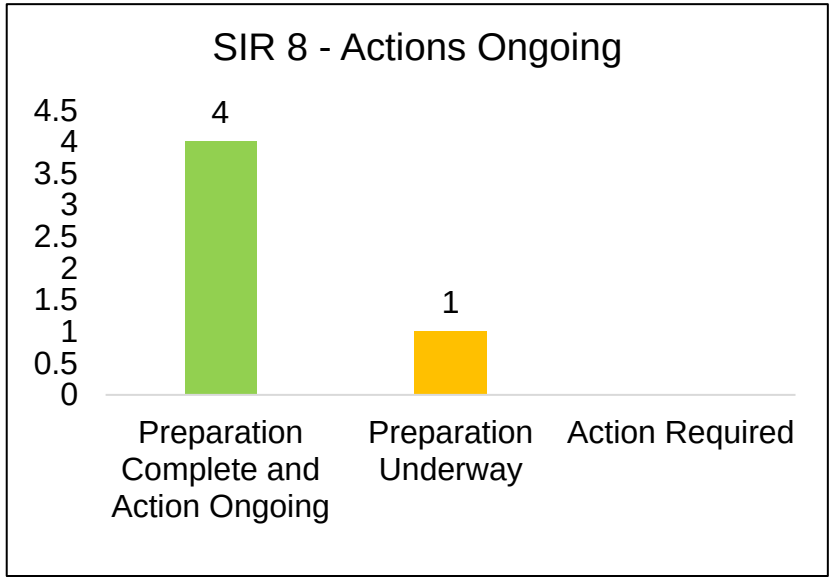
Current Reviews – Ongoing Action Plans (DHRs and SIRs)

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

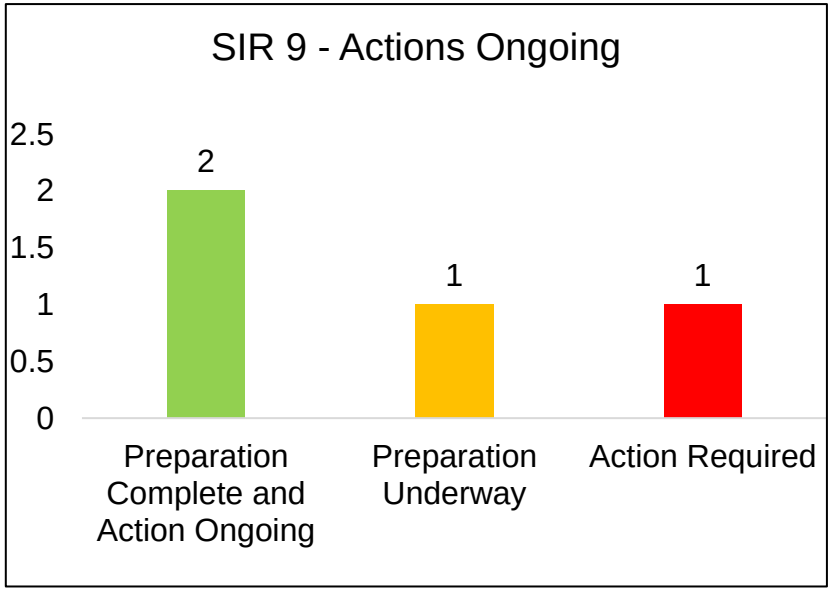
- Since the last update the action plan for SIR 6 has been completed and there are no longer any actions ongoing for this review.
- An action plan commenced for SIR 10 and progress of these actions will be included in future editions of this newsletter.
- There is 1 action where action is required, this is for SIR 9. Last quarter there were 7 actions where action was required.
- Actions “unable to be fulfilled” are actions that an organisation are no longer able to put it into practice. In the future it may be that things change and they can introduce that particular recommendation, however at present, it is agreed by the DHR/SIR subgroup that we will no longer pursue this for a particular action plan.



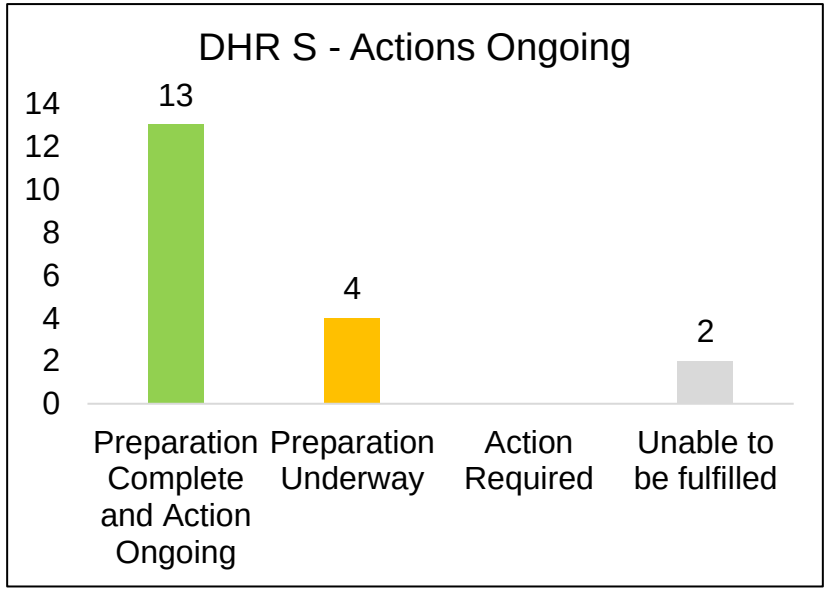
SIR 3 action plan commenced Oct 2017



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

Learning on Adult Family Violence from Standing Together against Domestic Violence's reviews of DHRs has been shared with agencies for them to disseminate.

Clinical nurse specialists have been employed as youth navigators in the Children's NHS Foundation Trust aimed at preventing youth violence.

Procedures for safeguarding children have been updated to ensure that social workers explore the full history of family dynamics when assessing a case e.g. historical domestic abuse, mental health issues and substance misuse.

Police officers have been reminded about the triggers for drug testing while in custody.

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

Carers

- Domestic Homicide Project Carers Spotlight Briefing (November 2022) VKPP-DH-Project-Carers-Spotlight-Briefing-November-2022.pdf
- Carers and Safeguarding Briefing (February 2022) Carers and safeguarding: a briefing for people who work with carers | Local Government Association
- Sheffield Carers Centre – helpful webpages for professionals
  Referral Guidance | Sheffield Carers Centre
  Referral for our Carer Assessment | Sheffield Carers Centre

Professional Curiosity

- Professional Curiosity Video – YouTube

If you have any suggestions for content for future newsletters, please contact kate.sanders@sheffield.gov.uk

Acronym	Full Name	
DA	Domestic Abuse	
DASH	Domestic Abuse, Stalking, Harassment and 'Honour' based violence (Risk Assessment)	DASH is a risk assessment form to help you work out the risk level for the victim. The questions are used to identify, assess, and manage risk. It can help to identify suitable cases to be reviewed at a MARAC.
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.
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.
SASP	Sheffield Adult Safeguarding Partnership	The Sheffield Adult Safeguarding Partnership brings together statutory and non-statutory organisations to actively promote effective working relationships between different agencies and professionals to address the issue of abuse and harm. The SAR Sub-Group of the Sheffield Adult Safeguarding Partnership (SASP) is responsible for recommending the commissioning of Safeguarding Adult Reviews (SARs) in line with the Care Act 2014 Guidance (Chapter 14)
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	