Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

May 2023

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Current Reviews – Review Stage

8 Live Reviews

Since the last update:

SIR Adult 7 - Review completed with ongoing action plan.

DHR Adult T – Review completed with ongoing action plan.

1 DHR - Commenced.

There are currently 8 live reviews in Sheffield, including:

3 Safeguarding Adult Reviews

1 Serious Incident Review

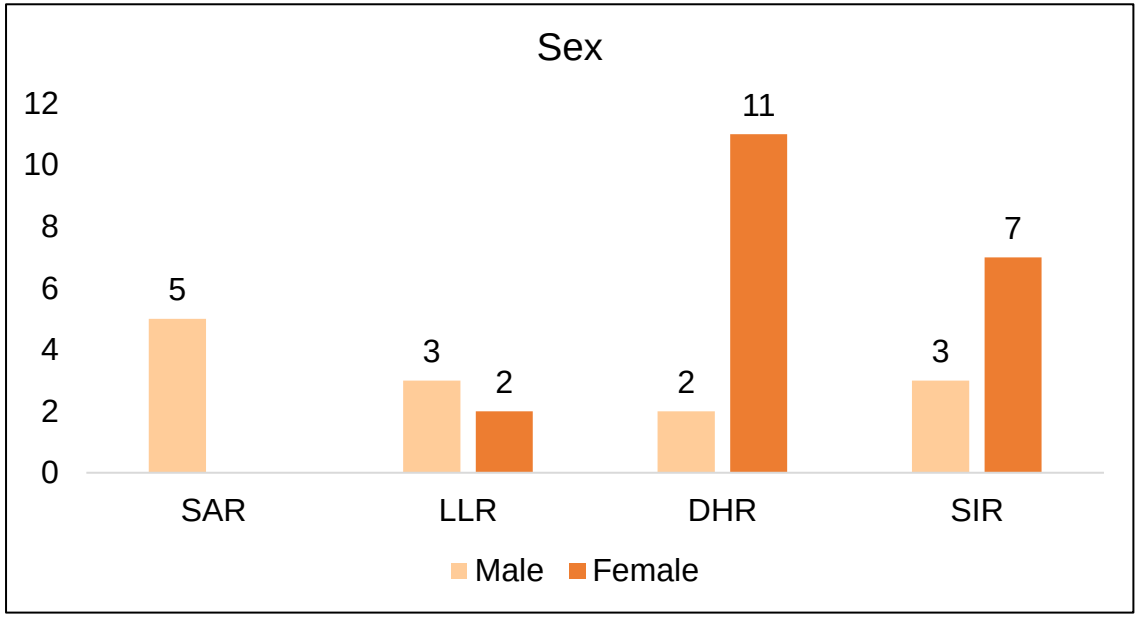
4 Domestic Homicide Reviews

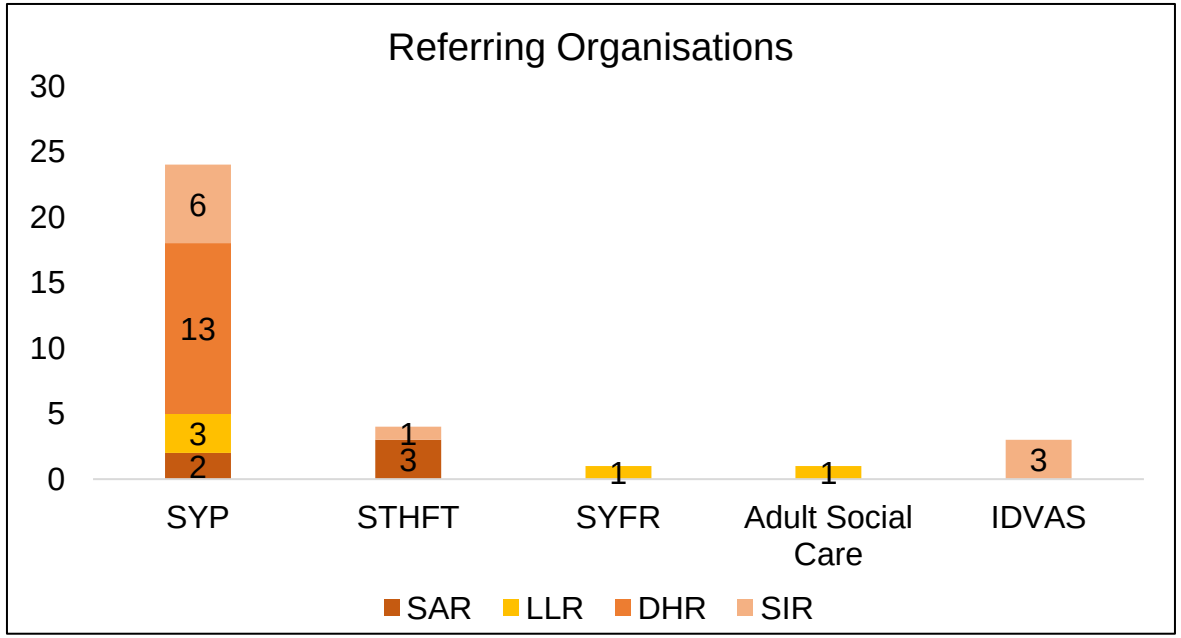
Case Insights (Closed/Ongoing Action Plans Only)

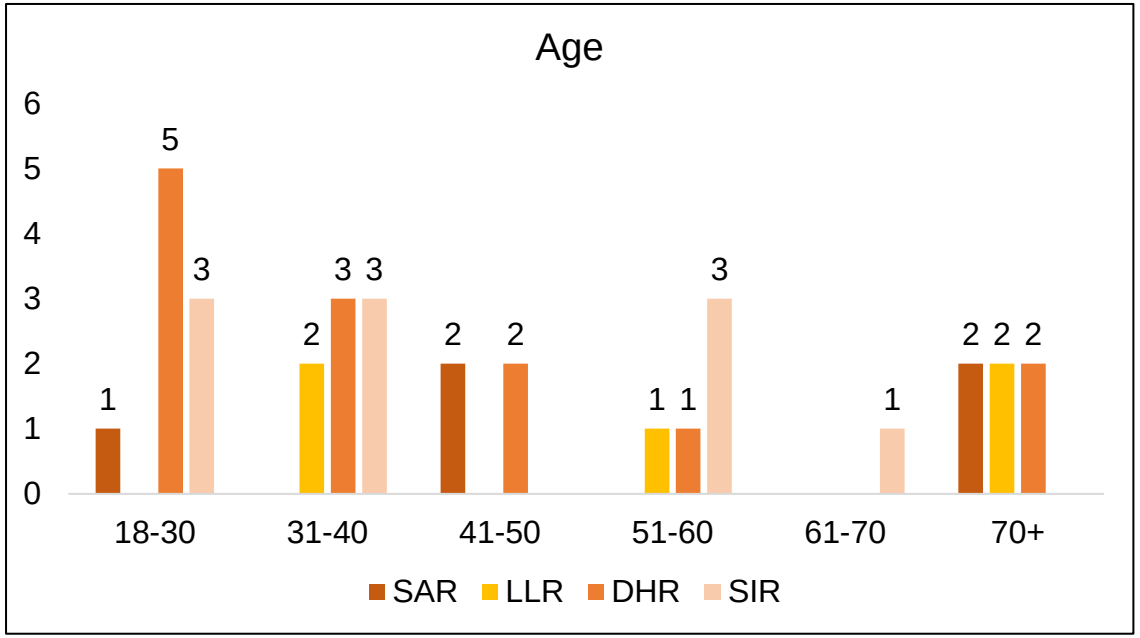
Insights

Please note that these graphs now represent figures from reviews which have **closed** or **have an action plan ongoing.**

In previous quarters the figures reported reflected live reviews and those in action plan stage, therefore figures may look slightly different from previous updates.







Recently Published Reviews

Click to read the Learning Brief

DHR “Imran” (Adult T)

Case overview

DHR Adult T was a case of adult family violence (fratricide). Both victim (‘Imran’) and perpetrator (‘Hassan’) had a lengthy history of criminal behaviour from a young age. The brothers first came to the police’s attention in 2004 having allegedly committed a robbery, Imran was 12 at the time and Hassan (brother) was 14, they went on to lead difficult and transient lives. Both were engaged in serious violence and criminality and there was evidence of drug and alcohol misuse.

Themes

What did the review tell us?

Imran was an Asian British male, and it is possible that the events described were a source of dishonour and shame for the family in the eyes of the community, this would have been a barrier that prevented him from seeking help and support.

Several agencies did not have any awareness or understanding of the abuse perpetrated by Hassan towards Imran. There were no DASH risk assessments completed so the nature of the relationship and associated risk to Imran was not consistently identified by agencies. Therefore, adult family violence was not considered.

Although there is limited information about Imran and Hassan’s childhood and formative years. The review highlighted the possibility that the brothers had experienced emotional trauma or other distressing or disturbing events in their formative years. Need to consider the evidence of the links between adverse childhood experiences, family violence & youth offending & put in place interventions to mitigate the risk.

Adult Family Violence **Substance Misuse** **Focus on Incidents Not Patterns of Domestic Abuse**

Professional Curiosity **Cultural/Faith Issues** **Did Not Engage**

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 SARs completed this quarter. Therefore the themes are the same as the previous quarter, with no changes in the numbers.

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 23 DHRs/SIRs in total.

Themes in 1-4 DHR/SIRs		Themes in 5-8 DHR/SIRs		Themes in 9 - 12 DHR/SIRs		Themes in 13 + DHR/SIRs	
Suicide	3	Post Separation Abuse	8	Mental Health (Perpetrator)	12	Risk Assessment (Victim)	15
Sexual Abuse	2	Adult Family Violence	8	Information Sharing	12	Professional Curiosity / Challenge	13
Child Contact Issues	2	Caring Responsibilities	6	Coercion and Control	11	Asking about DA / Routine enquiry	14
No Recourse to Public Funds	1	Policies & Procedures about DA	8	Mental Health (Victim)	10		
Accessible Services	4	Public Awareness re. DA	8	Multi-Agency Working	9		
Focus on Incidents not Pattern of DA	4	Clarifying Pathways	8	Substance Misuse (Perpetrator)	10		
Support for Perpetrators	4	Whole Household Approach	7	Substance Misuse (Victim)	9		
Recognising Male Victms	4	Cultural/Faith Issues	6	Training Needs Identified	10		
Violent Resistence	2	Risk Assessment (Perpetrator)	5	Did not Engage with Services	10		
Serial Perpetrator	4	Record Keeping	6				
Modern Slavery	1						
Forced Marriage	1						
Use of Interpretors	1						
Recording who Accompanies who to Appointments	3						
Dual Diagnosis	1						
Adverse Childhood Experiences	2						
Lack of referral to Adult Safeguarding	1						

In Focus

The theme of **Trauma Informed Practice** has been identified for “In Focus” this quarter.

- Being exposed to trauma such as adverse childhood experiences, can impact a person’s neurological, biological, psychological and social development. Trauma can negatively impact on individuals and communities, and their ability to feel safe or develop trusting relationships with health and care services and their staff.

- Trauma-informed practice acknowledges the need to see beyond an individual’s presenting behaviours and to ask, **‘What does this person need?’ rather than ‘What is wrong with this person?’.**

- For trauma survivors, trauma-informed services can bring hope, empowerment and support that is not re-traumatising.

- Reviews in Sheffield have acknowledged and identified learning for organisations in relation to raising awareness of the impact of trauma and delivering services that are trauma informed.

Adverse Childhood Experiences

Sources:
Understanding trauma and adversity | Resources | YoungMinds
Adverse Childhood Experiences (ACEs) and Attachment - Royal Manchester Children's Hospital (mft.nhs.uk)

Adverse childhood experiences (ACEs) are highly stressful and potentially traumatic events or situations that occur during childhood and/or adolescence. It can be a single event, or prolonged threats to (and breaches of) the young person's safety, security, trust or bodily integrity.

The experiences we have early in our lives and particularly in early childhood have a huge impact on how we grow and develop, and our thoughts feelings and behaviour.

Examples of ACE's include **maltreatment and abuse, violence and coercion** (e.g. exposure to domestic abuse), **household dysfunction** (e.g. mental illness, substance misuse, intergenerational trauma, incarcerated relative, deprivation, divorce), **bereavement and survivorship** (e.g. traumatic deaths, illness, repeated medical procedures), **prejudice and discrimination, community violence, bullying, homelessness, impact of COVID-19.** This is not an exhaustive list, there are a wide range of events and situations which may be considered ACE's.

When an ACE or trauma occurs, our "fight or flight (or freeze)" reaction occurs. If these adverse experiences and associated stress are long-term, then this fight or flight reaction continues and can negatively affect our bodies and brains. **Stress can have an impact on physical and mental health. It can impact brain development,** especially early in life when the brain is still developing the parts involved in planning, memory, decision-making, managing emotions, and relationships.

It's not a straightforward relationship between ACEs or trauma and long term negative effects**. A number of positive factors can help to reduce the impact of these experiences. One important protective factor is resilience.** There are a number of ways to build resilience including experiencing a trusting and safe relationship with an adult. As services, we need to be considering the ways in which we can support our service users to develop or strengthen their resilience.

Trauma Informed Practice

Sources: Trauma-informed practice: toolkit - gov.scot (www.gov.scot) Working definition of trauma-informed practice - GOV.UK)

Key Principles

Trauma-informed practice acknowledges the need to see beyond an individual's presenting behaviours and to ask, 'What does this person need?' rather than 'What is wrong with this person?'. Trauma-informed services can bring hope, empowerment and support that is not re-traumatising. A trauma-informed approach involves promoting six trauma-informed principles.

Safety	Trustworthiness	Choice	Collaboration	Empowerment	Cultural Consideration
• Staff and clients should experience the setting and the interpersonal interactions within the setting as safe, inviting, and not a risk to their physical or psychological safety. • Services should support a person to feel safe, including; a safe physical environment, open body language, taking a curious, non-judgemental approach, and providing transparency, predictability and choice. • Staff should be empathetic and caring and receive training on trauma, its impact, and strategies for trauma informed approaches.	• The organisation and it's staff should explain what they are doing and why. • The organisation and staff should do what they say they will do, expectations are made clear and they don't overpromise. • Recognising the significant impact trauma can have on relationships and capacity for trust with others. Treating individuals with respect, honesty, transparency and consistency.	• Individuals should have choice and control. • Clients are supported in shared decision-making, choice and goal setting to determine the plan of action they need to heal and move forward. • Listening to the needs of clients and staff, and giving them a voice. • Explaining choices clearly and transparently.	• The value of staff and client experience is recognised in overcoming challenges and improving the system as a whole. • Asking clients and staff what they need and collaboratively considering how these needs can be met. • Working with and actively involving clients in the delivery of services.	• Efforts are made to share power and give clients and staff a voice in decision-making, at both individual and organisational level. • Clients are empowered by services that are person-centred, and based on belief in the resilience of individuals and their ability to heal and recover from trauma. • Validating feelings and concerns of staff and clients and listening to what people want and need.	• Move past cultural stereotypes and biases based on, for example, gender, sexual orientation, age, religion, disability, geography, race or ethnicity. • Recognise the impact of diversity, discrimination and racism. • Staff have an open non-judgemental attitude. • Clients are asked about their culture for example their preferred language, or whether their culture prohibits any healthcare procedures or tests.

Reviews in Sheffield – Being Trauma Informed

SAR "Harris"

Harris was known to a range of services due to his mental health needs, drug use and needs from a head injury. Several services discharged him in the year before his death. He had difficulties in his marriage and alleged domestic abuse led to a breakdown in the relationship. Harris had a diagnosis of Emotionally Unstable Personality Disorder (EUPD).

In the year before his death, he had a period of homeless. His death was recorded as drug related from opiate toxicity.

Learning

Use a trauma informed approach when working with those with a personality disorder. **Building of a therapeutic relationship may be hard and take time** but it is the underpinning principle to be able to work successfully with those with EUPD.

A barrier to application of professional curiosity may be the normalisation of EUPD and its impacts. Behaviours that are presented may be seen as 'normal' for the person and the level of risk is therefore not apparent. For Harris, his non-attendance at appointments and not being contactable was seen as 'confirmation' that it was right that he would be hard to engage. **'Confirmation bias' can prevent services from being curious as to what might help to safeguard the person in the future** using a wider safeguarding lens.

DHR "Leah" (Person S)

Leah, a mother and a victim of domestic abuse, died by suicide following an overdose of prescription drugs and alcohol. Her partner had breached a 14-day Domestic Abuse Violence Protection Order (DVPO) and was with Leah leading up to her death. As a child he [Leah's Partner] experienced domestic abuse and became a Looked After Child. He struggled with alcohol, drug use and poor mental health. He had a criminal history and was supervised by Probation.

Leah had been assaulted as a young person and abused by previous partners; she had made suicide attempts and had problematic alcohol use. As a victim of controlling behaviour, she would minimise the abuse and struggled to engage with support including IDVAs and criminal justice processes. 6 weeks before her death, Leah retaliated in self-defence and was heard at MARAC as a perpetrator.

Learning

Agencies focused on Leah's partners mental health and self-harm and didn't identify him as a perpetrator**. A trauma informed approach was required to better understand Leah and Partner in the context of their life histories and experience. This may have changed practitioner's attitudes towards them, built trust and engagement in support.**

Professionals did not use a trauma informed approach or professional curiosity with Leah. Therefore, they did not always understand the risk to her and why she distrusted children's agencies.

Had Leah's act of self-defence / violent resistance being identified as such, then a trauma-informed approach could have been used, a safety plan agreed, and her needs considered.

Learning from Other Reviews in Sheffield

Joint Case Reviews

In households where a parent, carer or other family member has mental ill health, misuses drugs and/or alcohol, has a gambling addiction and/or there is domestic abuse, adult services and children services must work collaboratively to ensure that the voice of the child/adult at risk is heard and their circumstances safeguarded. The purpose of the Joint Case Review is to look into the case of a family with multi-agency involvement, help identify what worked well, what could be improved in terms of supporting the whole family, and any learning that can influence future practice.

Learning Identified from Joint Case Reviews – Trauma Informed Approach

Early recognition of attachment disorder. If there are any emotional dysregulation/trauma-based problems or attachment issues, consideration should be given to support that could be provided before issues become entrenched.

People don't disengage with services; services disengage with people. Need to be more creative and flexible in our approach to help engage complex, vulnerable families.

Acknowledge the complexity of past experiences and prior involvement and aim to gain a fuller understanding of how this may impact on what is happening 'in the now.'

Consideration should be given to both the current presenting problem and past trauma including historical contact with services.

. Do we regularly check with the services we refer to about meaningful contact and engagement, sustained motivation and actual change? Need to keep checking if the collective involvement is working to address the cause or just treating the symptoms.

Professional Curiosity. Workers need to think holistically. When seeing children with behaviour or eating issues, consider or ask about what is happening at home.

Family Z to R Learning Briefs can be found here: https://www.safeguardingsheffieldchildren.org/scsp/learning-from-practice/learning-briefs

Children SHEFFIELD Safeguarding Partnership

National Learning from SARs – Trauma Informed Approach

An Analysis of Safeguarding Adult Reviews found that reviews have often identified gaps in knowledge and practice when it comes to agencies and professionals considering and understanding how trauma and adverse life events can impact a person and their behaviours. Here are some examples of themes and common learning identified in the analysis:

Knowledge of the individual's history was sometimes lacking, making it difficult for practitioners to understand the reasons for the person's present behaviour and limiting their ability to make a personalised response.

Further exploration of life-biography may have highlighted experiences that could explain current circumstances e.g. self neglect, reluctance and non engagement with services.

Consideration of how to safeguard a person also needs to take account of the implications of adverse childhood experiences, trauma and loss.

The significance of the impact of a life event, such as loss of a parent was often not fully recognised and understood. That impact can be hidden from view, at least initially, and highlights both the importance of time to establish a trustworthy relationship and skill in sensitively exploring emotional distress.

Several SARs noted limited attempts at relationship-building and that more focus could have been placed on building a relationship of trust with the individual.

In some cases, the impact of adverse childhood experiences, significant events, trauma and bereavement was not taken into account, although linked to experiences in the present.

Good Practice Identified

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

SAR Person F

Health staff were right to raise their concerns regarding the possibility that Person F was being wilfully neglected with the Local Authority safeguarding team. All the professionals wanted to sustain Person F's life and worked hard to this end.

SIR Rosie

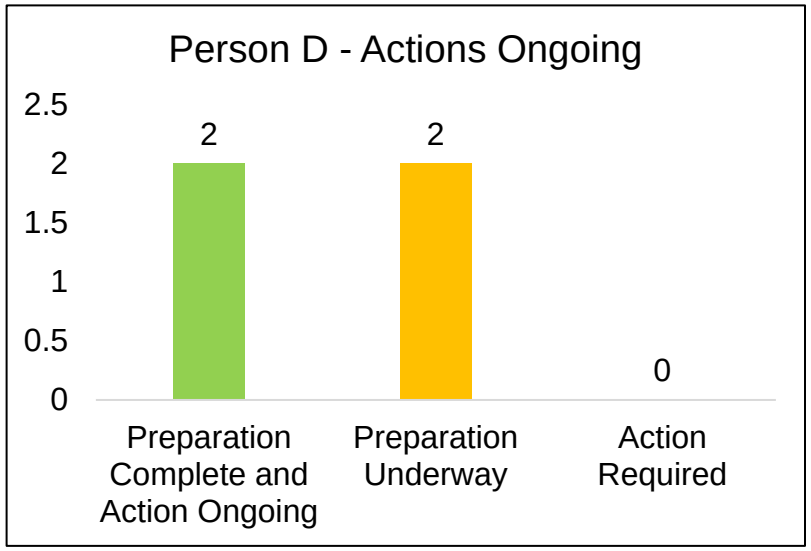
Agencies gave Rosie many opportunities to disclose [Domestic Abuse] – using routine enquiry, professional curiosity and challenge.

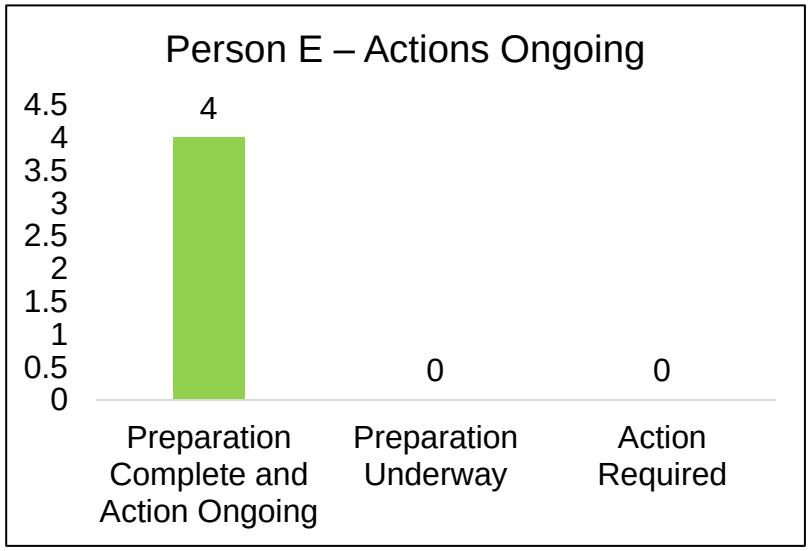
DHR Imran (Adult T)

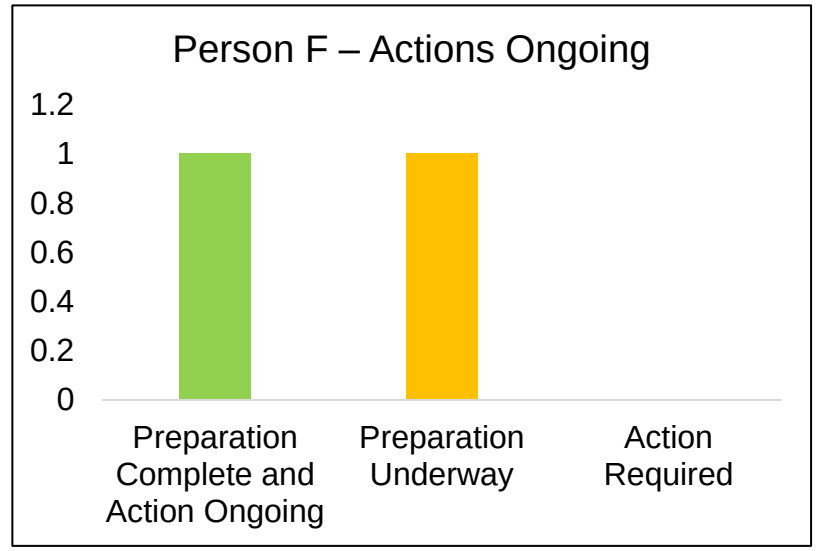
There were examples of good multi-agency working evident at MARAC.

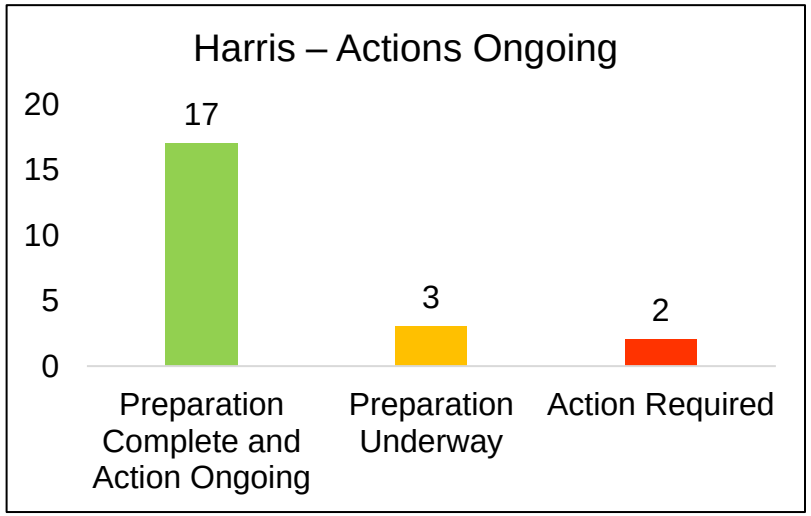
Current Reviews – Ongoing Action Plans (Single Agency) (SARs)

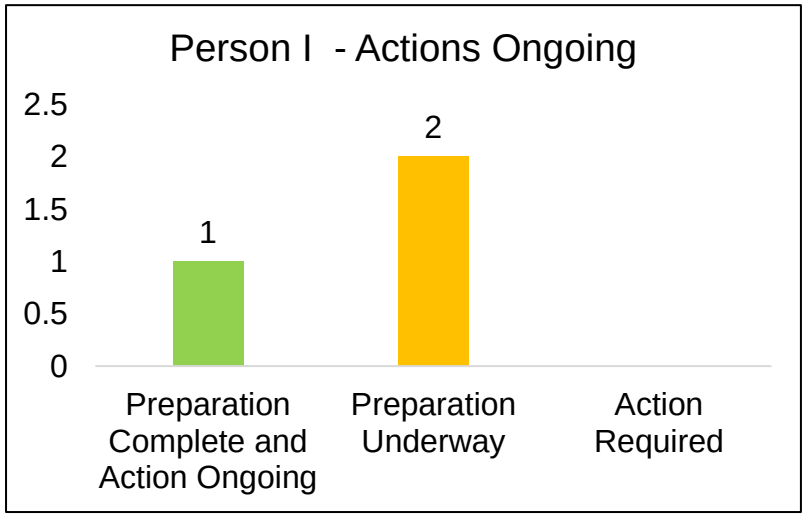
These graphs present the number of actions ongoing from single agency action plans. There are actions ongoing for all 5 SARs that have been completed.











Achievements - SARs

Adult Care and Wellbeing [SAR Person D] - The professional curiosity video tool created by SASP/SCSP has been shared on Elma (The Electronic Manual for Adult Health and Social Care). The professional curiosity video tool created by SASP/SCSP was also promoted in the E-bulletin. **Watch the video on YouTube by following this link** Professional Curiosity Video - YouTube

South Yorkshire Integrated Care Board [SAR Person F] – A learning from reviews masterclass was held in February with GPs. This included learning in relation to risk assessments as well as offering carers assessments.

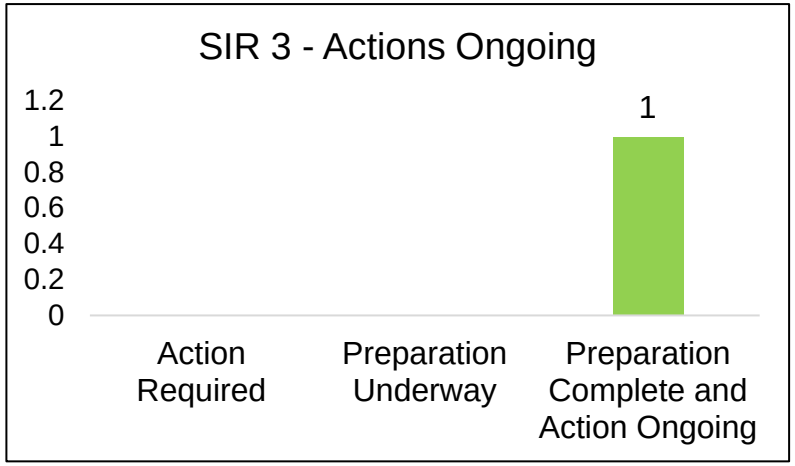
Adult Care and Wellbeing [SAR Harris] - All care managers (now called social care practitioners) are now doing safeguarding and receiving the internal practice development safeguarding training. They now have safeguarding in their job description.

Respite Home [SAR Person I] - Encouraging Professional Curiosity. Professional Curiosity now in-built into training programmes, trainer now discusses weight management within the nutrition and hydration section of the training, reflection and discussions are carried out in the weekly management meetings to ensure continuous improvement are made and lessons learnt are carried out and initiated for future reference.

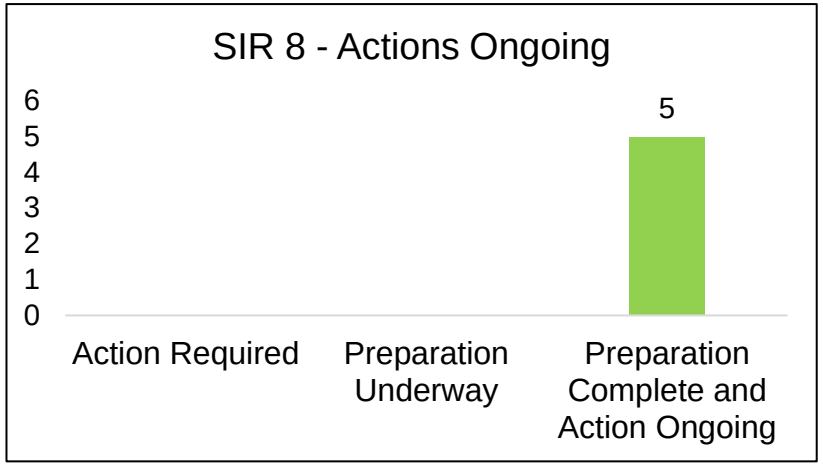
Current Reviews – Ongoing Action Plans (DHRs and SIRs)

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

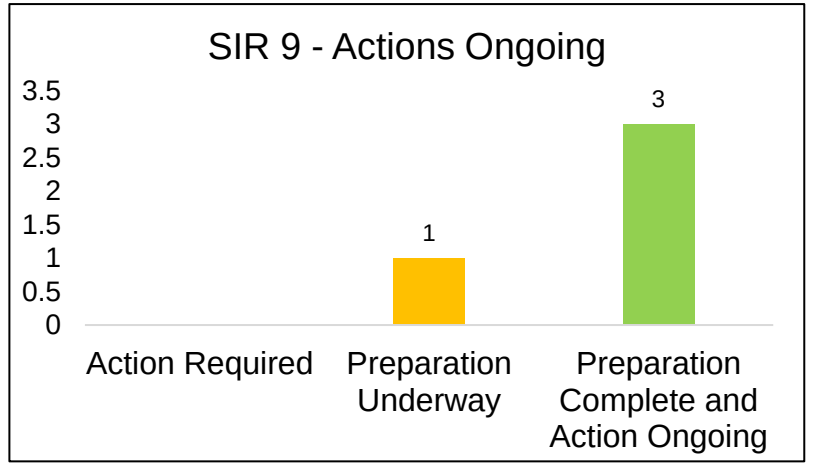
- Actions "unable to be fulfilled" are actions that an organisation are no longer able to put into practice. In the future it may be that things change and they can introduce that particular recommendation, however at present, it is agreed by the DHR/SIR subgroup that we will no longer pursue this for a particular action plan.



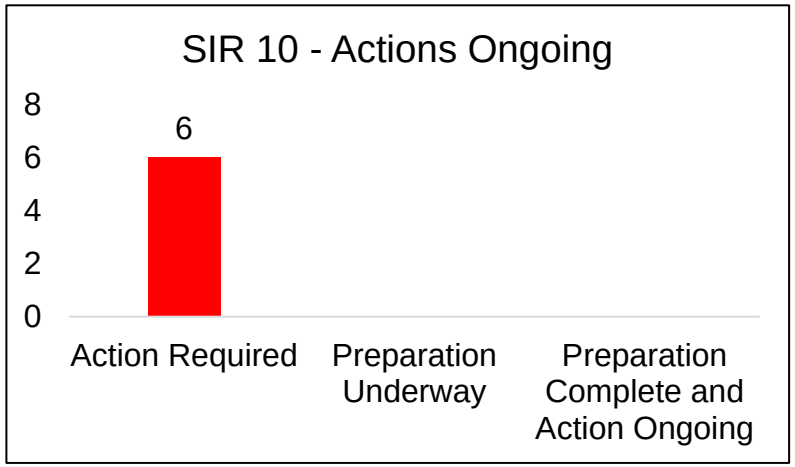
SIR 3 action plan commenced Oct 2017



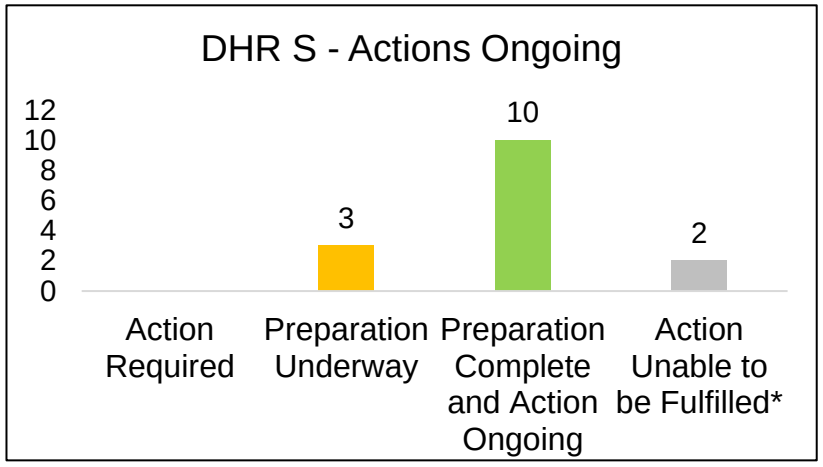
SIR 8 action plan commenced Aug 2022



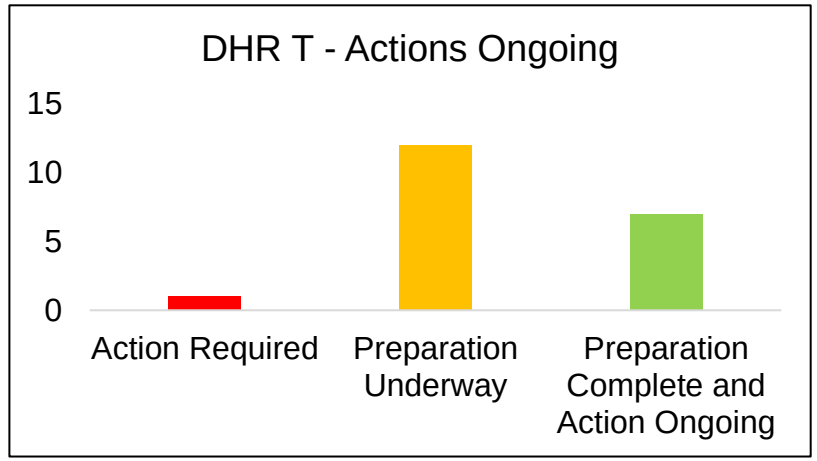
SIR 9 action plan commenced Aug 2022



SIR 10 action plan commenced Feb 2023



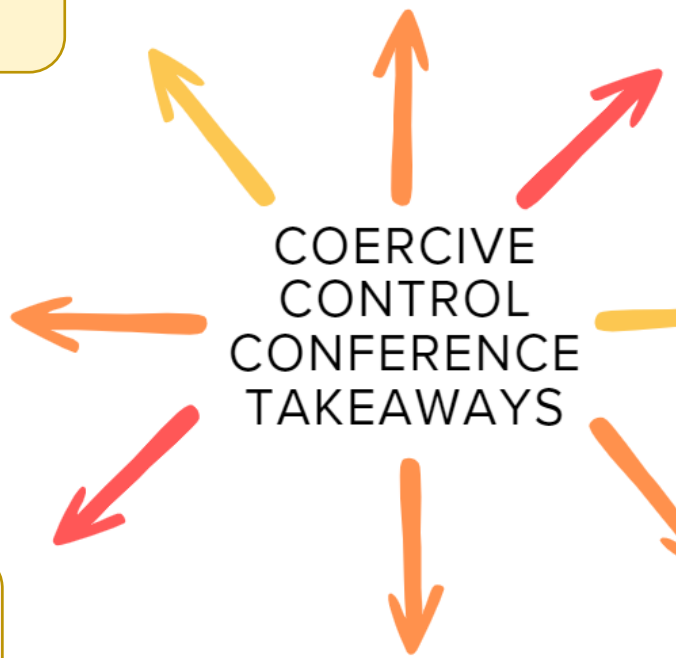
Adult S action plan commenced Dec 2021



Adult T action plan commenced Feb 2023

Achievements - DHRs and SIRs

Following DHR “Leah” (Person S) a conference on coercive control took place on the 15th of February for professionals in Sheffield. The conference was very well received, these are some of the key learnings attendees took away with them.



That children/families may not even recognise Coercive Control themselves.

Understanding how a child may not recognise any signs of control and think its just how they live.

Thought-provoking consideration of capacity. Impact of Coercive Control on individuals mental health and making decisions.

Considering capacity as part of an informed decision-making process when choices are impacted by what may happen.

77 people attended the event in person and of those, 92% reported that after the conference they felt more confident in recognising Coercive Control.

Really helpful to have it clarified how victim/survivors may think the abuse is normal but that doesn’t mean they aren’t terrified and ashamed.

I had already attended training on Coercive Control but this pulled my knowledge together and updated new knowledge in this very important area, especially looking at children/young people.

How important it is to put all the small pieces together. Listen, talk.

Hearing from someone who has been through Coercive Control, really brought the concerns to light.

Following DHR “Leah” (Person S), guidance on violent resistance has been published. Read it here: Domestic Abuse Best Practice Guide - Violent resistance/self defence by women in intimate partner relationships

Published Reports and Learning Briefs

Published SARs and Learning Briefs: Learning from Practice - Sheffield Adult Safeguarding Partnership

Published DHRs and SIRs Learning Briefs: Domestic Homicide Reviews and Serious Incident Reviews: Learning Briefs | Sheffield Domestic Abuse

Sheffield Children's Safeguarding Partnership Learning Briefs: Sheffield Children Safeguarding Partnership - Learning from Practice

Information and Resources

SARs

- Analysis of Safeguarding Adult Reviews, April 2017 – March 2019
- Professional Curiosity Video - YouTube

DHRs

- **Guidance on Violent Resistance:** Violent-Resistance-best-practice-guide-March-23.pdf (sheffielddact.org.uk)

Trauma Informed Practice

- Working definition of trauma-informed practice - GOV.UK
- Vulnerabilities: applying All Our Health - GOV.UK
- Trauma-informed practice: toolkit - gov.scot
- Trauma-Informed-Wales-Framework.pdf
- Understanding trauma and adversity | Resources | YoungMinds

Acronym	Full Name	Definition
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	