Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

August 2023

Contents

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

Current Reviews – Review Stage

10 Live Reviews

Since the last update:

1 DHR - Commenced.

1 SAR – Commenced.

There are currently 10 live reviews in Sheffield, including:

4 Safeguarding Adult Reviews

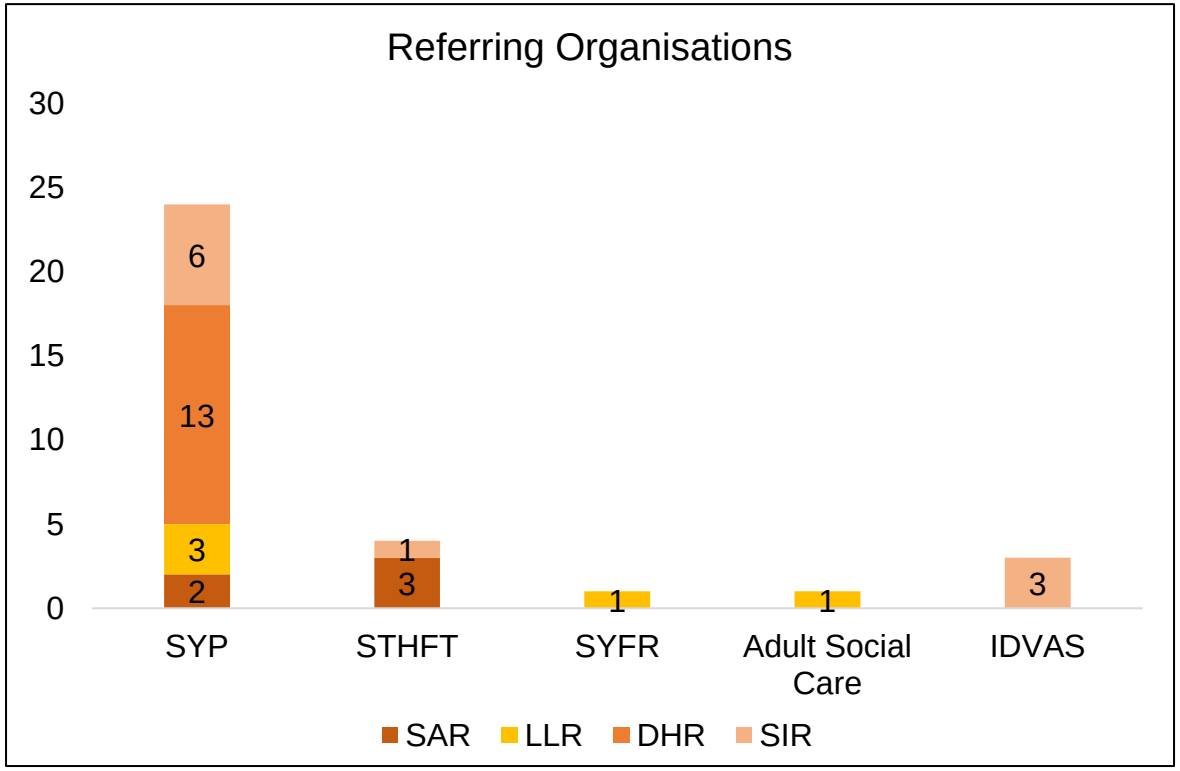
1 Serious Incident Review

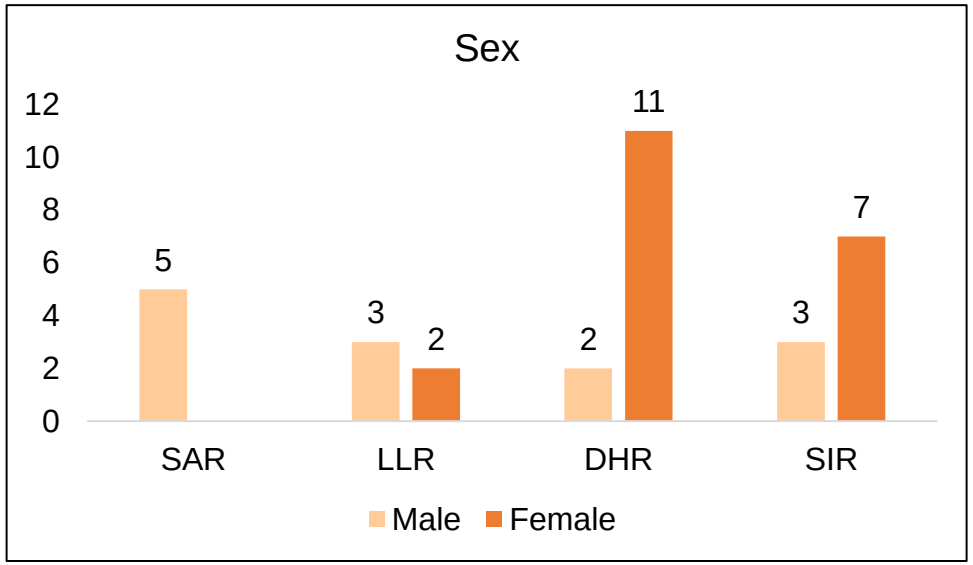
5 Domestic Homicide Reviews

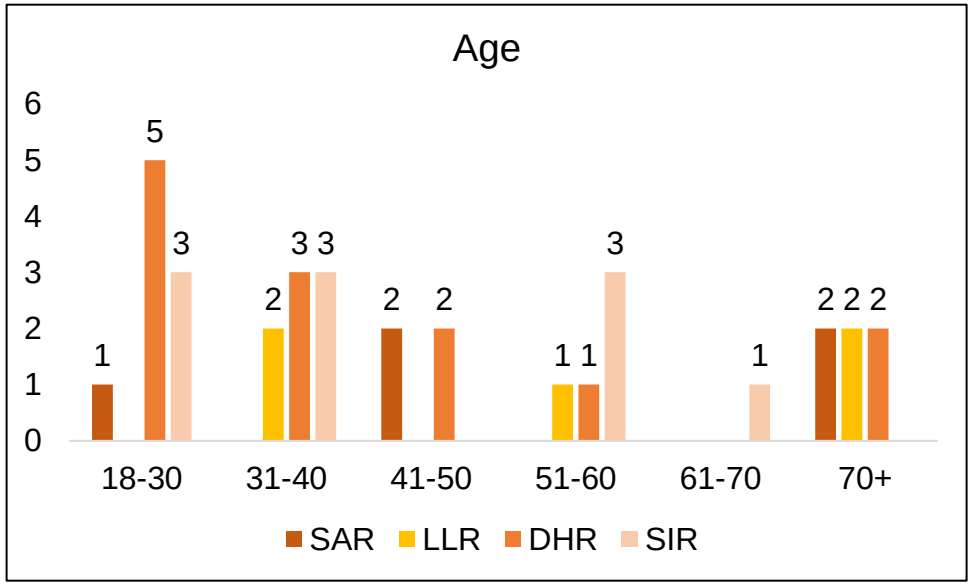
Case Insights (Closed/Ongoing Action Plans Only)

Insights

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







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 were 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						

There were no additional DHRs, or SIRs were completed this quarter. Therefore, the themes are the same as the previous quarter, with no changes in the numbers.

In Focus

The theme of **Professional Curiosity** has been identified for “In Focus” this quarter.

- Professional Curiosity is integral to safeguarding and identifying risk of harm.
- Identifying abuse or neglect can be difficult, an adult at risk may not always disclose abuse, or be able to disclose abuse. Additionally, individuals who are victims of domestic abuse often do not disclose due to lots of different reasons including fear and coercion and control. **Therefore, it is important that practitioners are professionally curious.**
- Professional Curiosity refers to having the skills and capacity to explore and understand what is happening with and/or to a person and not taking things and single sources of information at face value.
- Professional Curiosity requires thinking outside of the box, questioning our own assumptions about what is happening, and looking at situations more holistically. It involves asking questions, enquiring deeper and looking out for signs that things may not be right.
- It may involve a combination of different communication skills including looking, listening, asking direct questions, checking out and reflecting on information received.
- Professional Curiosity (lack thereof or missed opportunities to be Professionally Curious) has been a theme in 6 SARs/LLRs in Sheffield and 13 DHRs/SIRs.

Reviews in Sheffield – Professional Curiosity

Click the review title for more information.

DHR - JESSICA

Jessica killed herself in the summer of 2019. She leaves behind young children whom she loved very much. Jessica died soon after she had been treated for severe injuries to her fingers and Kevin, her estranged partner, had breached a Domestic Violence Protection Order (DVPO). The police responded to 10 incidents between 2013 and 2019. None of the incidents was screened at high risk although with the benefit of the detailed analysis by the DHR some should have been.

LEARNING

- Agencies must understand that women can be frightened to talk to anybody about domestic abuse especially if they have children they fear they may lose.
- Emergency health care professionals need to be alert for potential domestic abuse; they should be encouraged to ask questions especially when completing procedures such as an X-ray or fracture care when a patient is on their own.

DHR – Adult H

H was born in Pakistan and came to the UK after marrying the perpetrator. Between 2000 and 2008 H separated from the perpetrator, and with her children lived in the south of the UK close to family. H suffered domestic abuse at the hands of the perpetrator over several years, this was known to members of both families. The perpetrator had a long history of offending and substance misuse. H was eventually persuaded to return to live in South Yorkshire in 2009. In 2014 the police attended an address in Sheffield and found that H had received multiple stab wounds. She was pronounced dead at the scene. Her husband was later found guilty of her murder and sentenced to life imprisonment.

LEARNING

- Specialist substance misuse services, and GPs if they are providing treatment for substance misuse, should always ask questions about home circumstances when assessing patients who present with issues of substance misuse.

SAR – Person F

Person F was well known to a number of services across Sheffield. Following Person F's death concerns were raised that Person F may have died prematurely as a result of not taking necessary life-saving medications which, it was purported, his wife (FW) believed were poisoning him and causing his symptoms of ill health. Professionals had raised numerous concerns over the 4-month period prior to Person F's death about FW's coercive control with regard to Person F's medications. Following Person F's death a police investigation was closed with no further action being taken, and the Coroner concluded Person F had died of managed cardiac failure.

LEARNING

- Professionals need to become more curious, ask more questions and establish the facts.
- Risk was not clearly articulated and was being rephrased as 'worry', anxious' or 'concerned'. Professionals were noting the behaviours, but they were not exploring the underlying reasons for the behaviours.

National Learning from SARs – Professional Curiosity

Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 Professional curiosity, and the absence of it is a theme which is very common across SARs. Common examples of absence of professional curiosity, frequently picked up in safeguarding adult reviews include:

Workers not probing the circumstances with which they were faced. For example, absence of curiosity about the reasons for:

- Refusal of care and support or healthcare.
- The neglected state of someone's home.
- A reluctance to return home.
- For the retraction of allegations of abuse.

Failure to explore inconsistencies and mixed messages, or the impact that an individual's life experience might have on their current decisions.

Limited evidence of professional curiosity in relation to risk assessment, carers' needs and capabilities, family dynamics, the identity of someone claiming to be a next of kin, chaotic lifestyle, rapidly escalating health needs, repeated hospital attendance, or dropping from visibility.

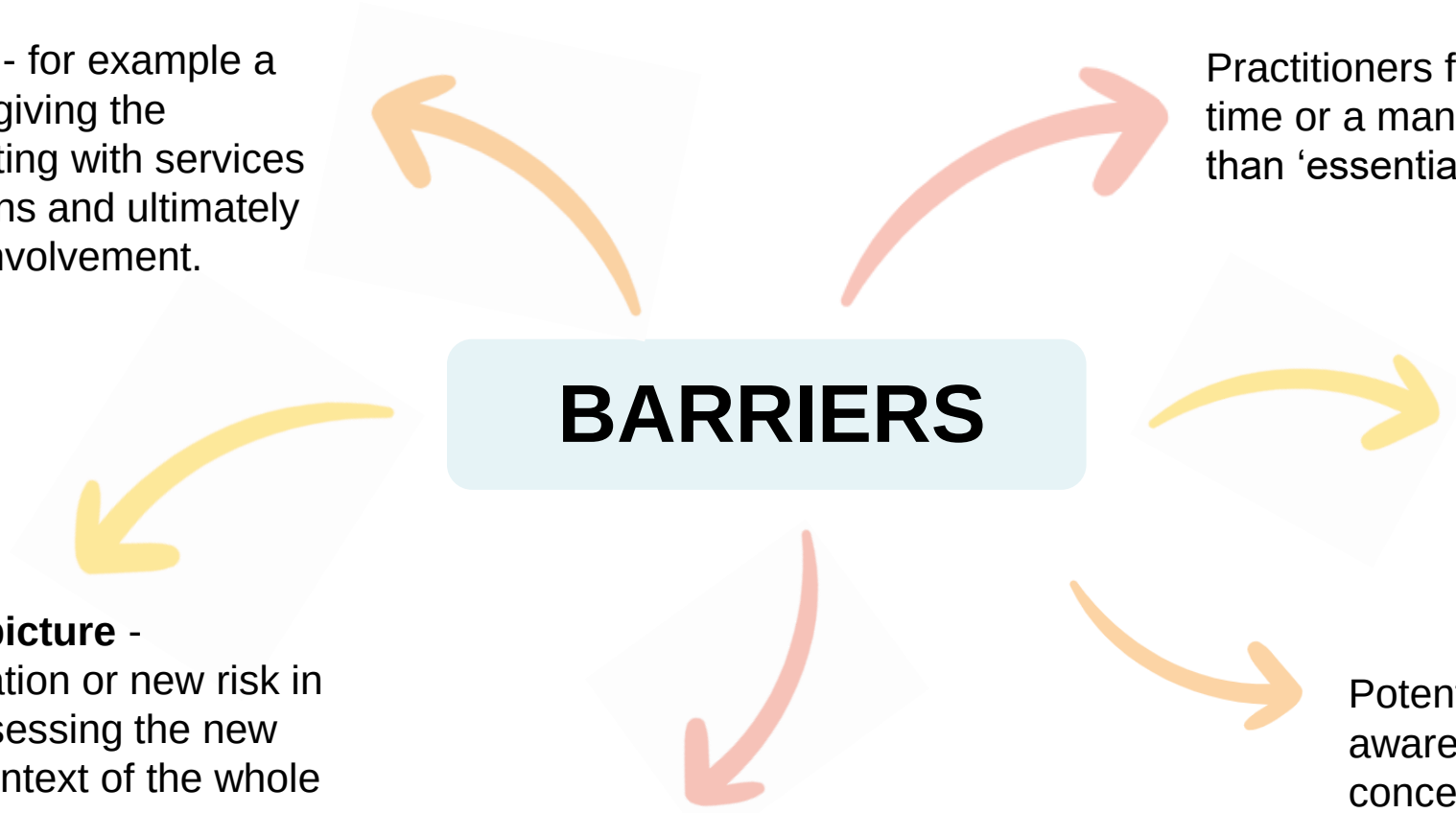
Barriers to Professional Curiosity

Professional Curiosity (Norfolk SAB)
Professional Curiosity for Practitioners (Leeds SAB)
Professional Curiosity (Manchester)

The absence of professional curiosity could be attributed to a range of factors including:

Disguised compliance - for example a family member or carer giving the appearance of co-operating with services to avoid raising suspicions and ultimately to reduce professional involvement.

Practitioners feeling they lacked time or a mandate to ask more than ‘essential’ questions.



Concerns about hostility.

Not seeing the whole picture - responding to each situation or new risk in isolation, rather than assessing the new information within the context of the whole person or other events.

Potential lack of cultural awareness or misplaced concerns about causing offence.

A culture of **professional optimism** preventing practitioners looking beyond the presenting circumstances to address ‘why’ questions.

How Can We Be Professionally Curious?

Top Tips

Question your own assumptions about the situation and think about what else might be happening, remain open minded and expect the unexpected.

Recognise your own feelings e.g., are you feeling tired or rushed? How might those feelings be impacting how you view the situation or person on that day?

Think about the reasons why someone may not be telling you the truth. Is there underlying fear, coercion, anxiety?

Be willing to have challenging conversations, be respectfully nosey and probe. Address any professional anxiety around having those conversations e.g., in supervision. It is good practice and ok to question what you've been told when appropriate.

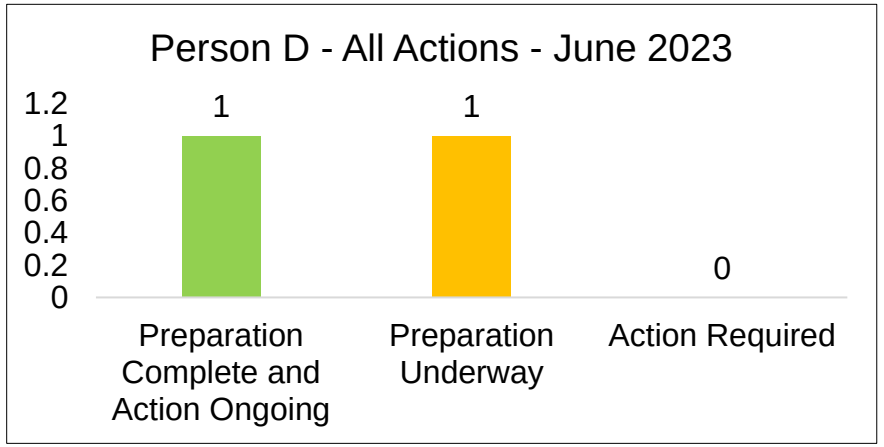
Ensure practice is reflective and that you can reflect on cases in supervision, unpick how it made you feel and whether you would have done something different if a similar situation arose again.

Click the image below to take you to our Professional Curiosity Video. It will take you through what it is, what skills it requires and why it's important that we are all professionally curious.

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 4 SARs that have been completed.

Person E – All actions from single agency action plans have now been completed.



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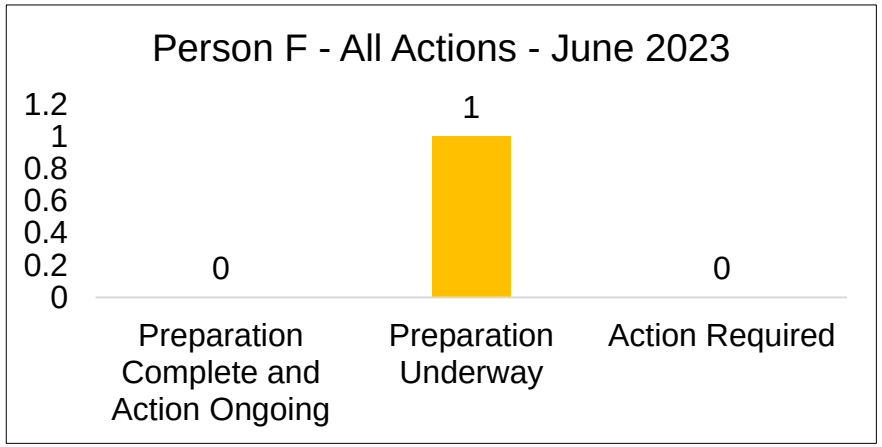
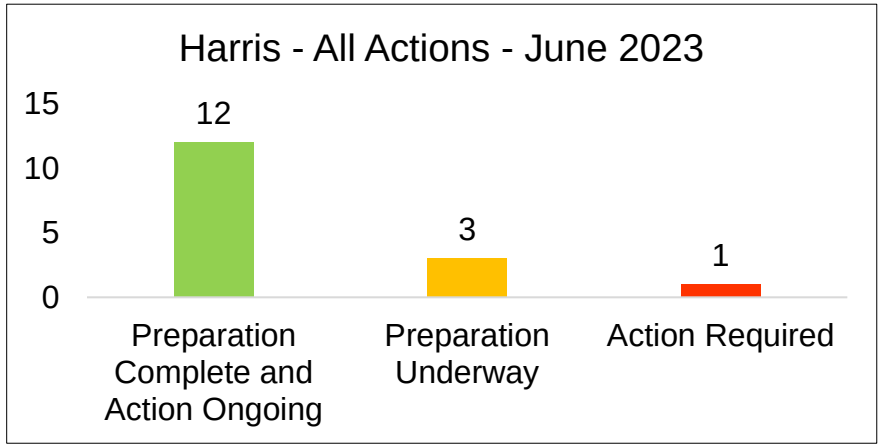


Date Report Published: September 2021



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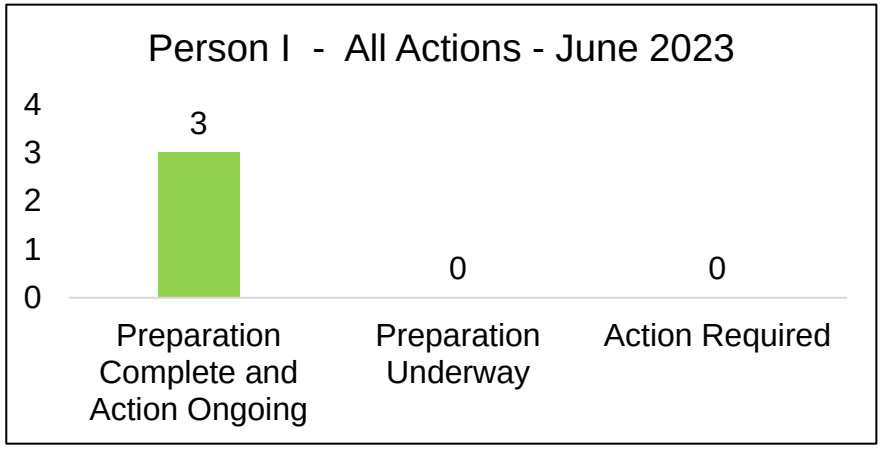


Date Report Published: June 2022

Achievements - SARs

Day Centre - A new client evaluation form is now embedded, and the evaluation asks these questions: What do you like?, What do you want to change?, Do you feel safe? What would you like to work towards? Staff feedback, Parent/carer feedback and Actions. This will hopefully help to improve lines of communication with the client and their family/carer and help the service understand their wishes and feelings about attending, which may prompt questions and professional curiosity if they are suddenly no longer attending **[SAR Person I].**

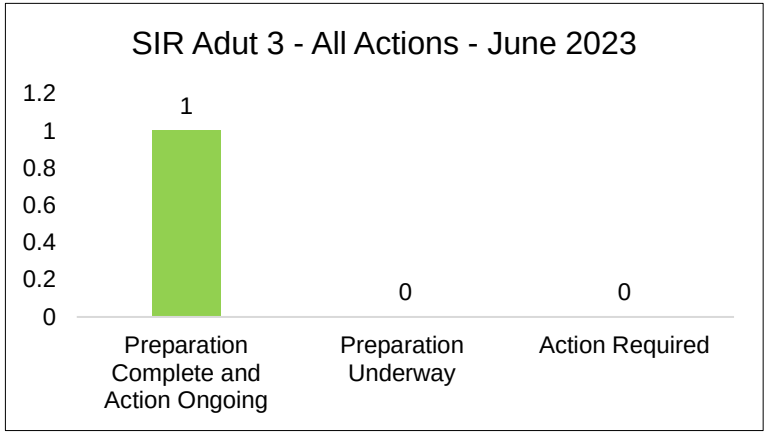
SYP - The forces crime recording system enables the addition of 'keywords' to investigations. These keywords allow for more effective management and investigation. These keywords will also appear on partner referrals that are automatically transferred through the system. The system has now been updated so the keywords of 'self-neglect' and 'hoarding' can be added to any appropriate investigations **[SAR Person E].**

Adult Care and Wellbeing - Guidance (following covid) has been reviewed and re-worked, to make it clear that visits are the general rule and not the exception. It re-iterates the need to offer face to face visits as the default. It includes a list of things to consider if the person has expressed a preference for a virtual or telephone communication to thought provoke a decision to visit or not **[SAR Person D].**

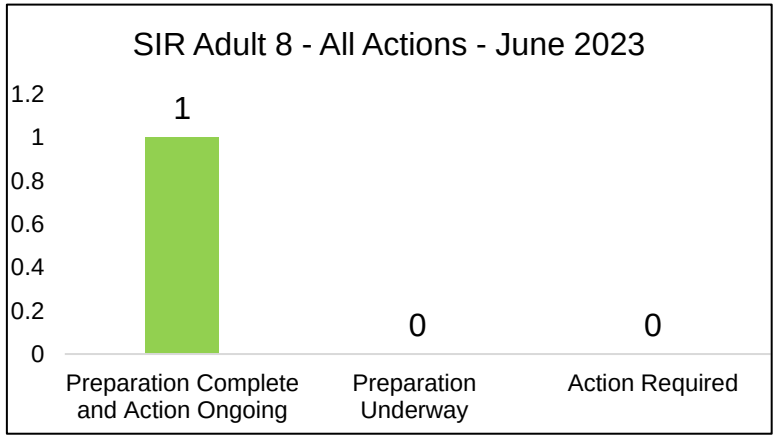
Current Reviews – Ongoing Action Plans (DHRs and SIRs)

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

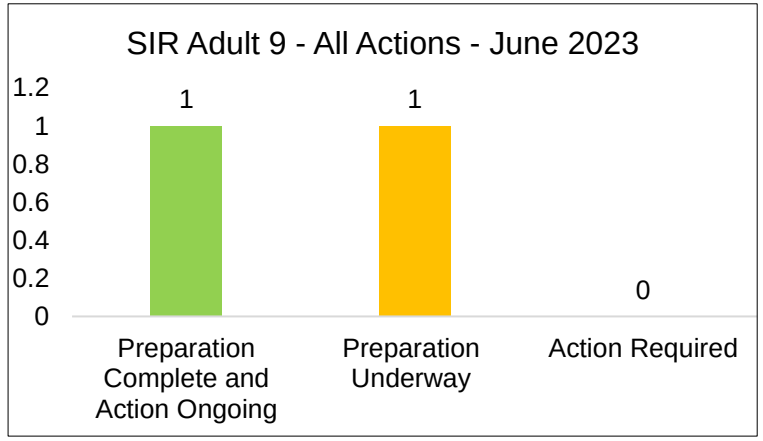
- Actions "unable to be fulfilled" are actions that an organisation are no longer able to put into practice. In the future it may be that things change and they can introduce that particular recommendation, however at present, it is agreed by the DHR/SIR subgroup that we will no longer pursue this for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



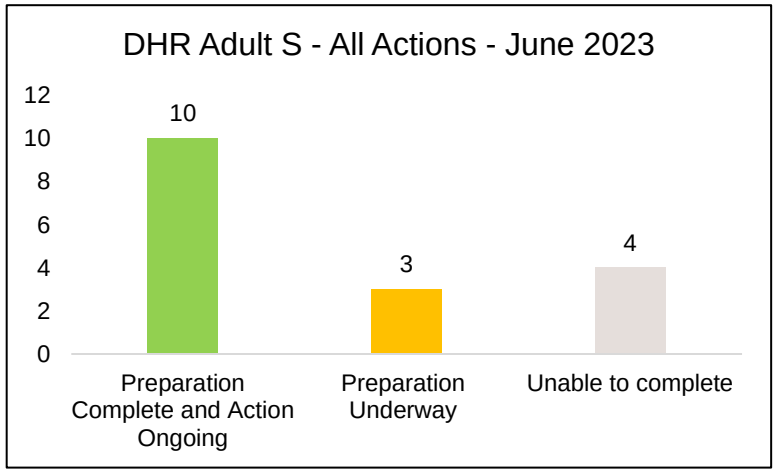
Adult SIR 3 action plan commenced Oct 2017



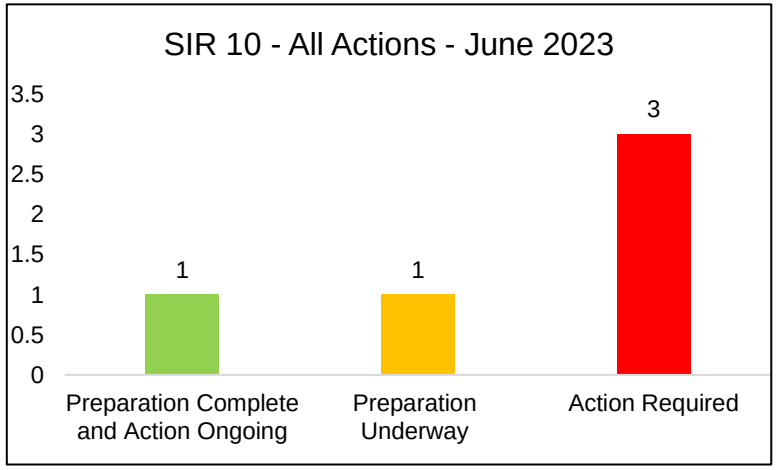
Adult SIR 8 action plan commenced Aug 2022



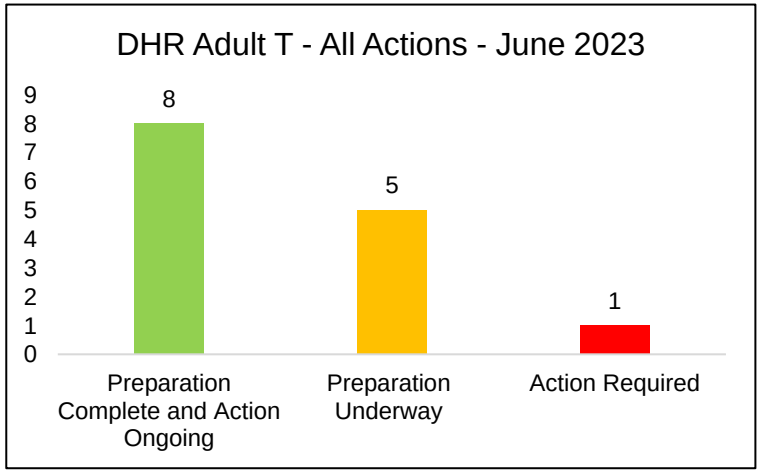
Adult SIR 9 action plan commenced Aug 2022



Adult S action plan commenced Dec 2021

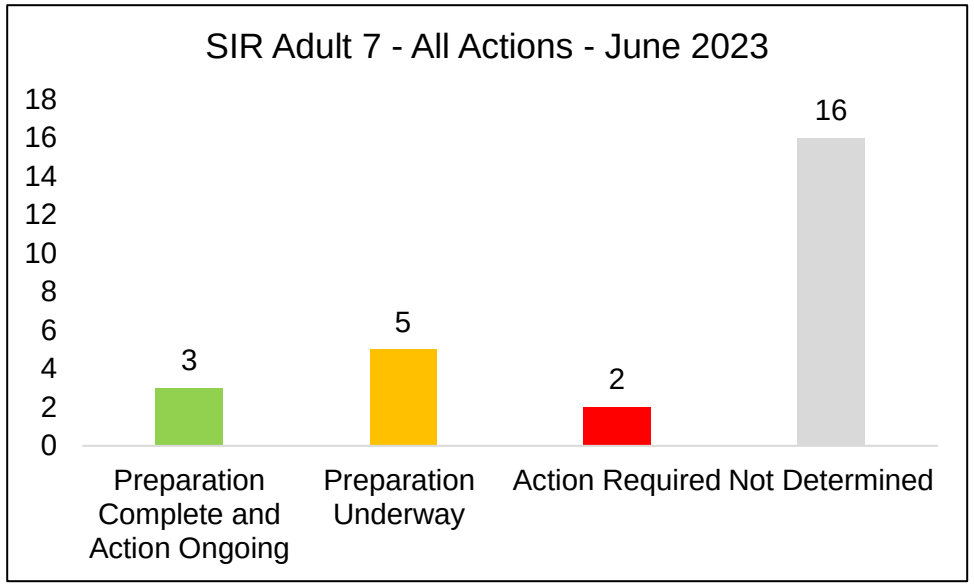


SIR 10 action plan commenced Feb 2023

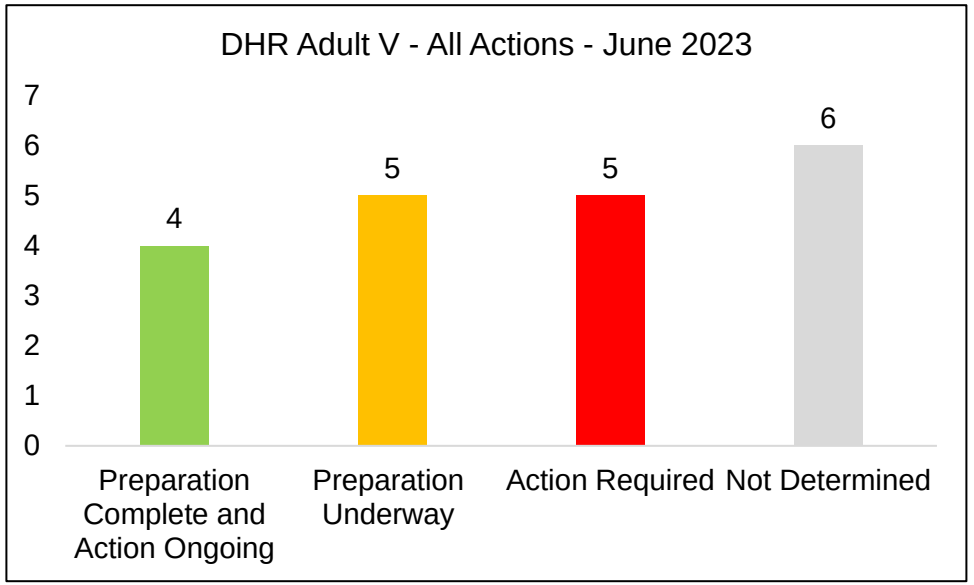


Adult T action plan commenced Feb 2023

Cont. Current Reviews – Ongoing Action Plans (DHRs and SIRs)



SIR Adult 7 action plan commenced Feb 2023



DHR Adult V action plan commenced Feb 2023

Achievements - DHRs and SIRs

IDAS - IDAS have developed and shared the specialist support complex needs leaflet [DHR Adult V].

IDAS - IDAS existing training has been updated to provide information to agencies to assist then in supporting victims/ survivors who are not engaging with DA services [Adult SIR 7].

GPs - GPs DARE (Domestic Abuse Routine Enquiry) training for GPs has been updated to include Adult Family Violence [Adult SIR 10].

Housing and Neighbourhood Service - Produced and launched a Housing Domestic Abuse Procedure across the different teams and Neighbourhood Officers [Various DHR and SIRs].

Cross Cutting Themes with SARs in Other Areas

Click the SAR title took take you to more information about the review

As we know, Safeguarding Adult Reviews nationally often see cross cutting themes. Person I in Sheffield shares very similar themes and learning with Kirklees SAR Adult O and Blackpool SAR ‘Jessica’.

Sheffield - Person I

Person I is a young man with a learning disability and autism. He lived with his mother, stepfather and 2 siblings, (a teenager with learning disabilities and a toddler). He was known to services in Sheffield having attended college, day centre and respite care but became less visible when he stopped attending day centre and college 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 and close to death and he has since recovered.

Kirklees - Adult O

At the time of her death Adult O had been living at her family home and was cared for primarily by her mother. Adult O had complex health needs from birth, including profound learning disability. In July 2018 (aged 19), Adult O left school and after that time her contact with health and social care services was minimal. Adult O did not go through a formal transition process from children to adult services. Adult O had previously been admitted to hospital in 2017 and 2018 and treated for sepsis. In October 2020, Adult O’s mum contacted her GP because she was concerned about Adult O’s physical health. The sepsis pathway was triggered. In A&E, a safeguarding alert was raised. The alert was made following significant concerns over Adult O’s physical condition, she was noted to have several grade four necrotic pressure sores. Adult O died in hospital, her formal cause of death was given as sepsis and bronchopneumonia.

Blackpool - 'Jessica'

Jessica was born with Down’s Syndrome. Jessica was independently mobile but required someone with her to access the community. Jessica was dependent on others for her meals and the provision of a clean and tidy home environment. Jessica lived with her mother (‘Ann’) and siblings. Jessica died at home, aged 24 years as a result of severe emaciation and neglect and widespread and severe scabies infection. There was no evidence of Jessica’s hygiene or personal needs having been met for a considerable length of time.

Common Themes Across the SARs

SAR Person I [Sheffield], SAR Adult O [Kirklees] and SAR 'Jessica' [Blackpool] all had similar learning, including but not limited to, the following 3 themes:

HEARING THE PERSONS VOICE

Sheffield Person I - At the point Person I was withdrawn from college and day care services, no one from those services sought to assess PI's mental capacity or seek his opinion [Decisions were made by mother/step-father].

Kirklees Adult O - When Adult O's mum declined day services for Adult O, steps should have been taken to support her to make this decision for herself, and to seek her views and wishes. A formal assessment of her mental capacity should have been assessed and a best interest decision made if she was deemed not to have been able to make that decision herself…There is no evidence in the records that consideration or support was given to Adult O so her voice could be heard when decisions were being made about her life.

Blackpool 'Jessica' – Instead of finding a way to communicate directly with Jessica, professionals often relied on her mother ('Ann') to speak on her behalf (although Ann denies that she deliberately spoke for Jessica and told the review that she always allowed Jessica to make her own decisions and would only repeat what Jessica had told her). Professionals needed to communicate with Jessica alone and consider her decision-making capacity.

WAS NOT BOUGHT

Sheffield Person I - There was a mixed response to Person I not being brought, with some agencies contacting the couple (Person I mother and/or step-father), and others sending further appointments. 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

Kirklees Adult O - There was no consistent agency response or approach when Adult O was not brought or was not seen by services. During the SAR it was reflected that in both child and adult services, all agencies involved did not have an effective 'was not brought' organisational policy, or they were still working under an organisational 'did not attend policy.'

Blackpool 'Jessica' - Jessica's voice was inaccurately represented when she was not presented for health appointments as her records showed that she 'Did Not Attend.' Yet Jessica lacked the physical ability and/or mental capacity to attend, or make the decision to attend, appointments.

TRANSFER AND SHARING OF INFORMATION

Sheffield Person I – The SAR found that ways of working are not supporting a multi-agency approach to working with adults who have a Learning Disability. The rich information gathered throughout childhood is not transferring to adult services during the transition period.

Kirklees Adult O - After Adult O left school a referral was made to Adult Social Care when Adult O was aged nineteen years old. This referral was made by Adult O's mum who was asking for access to day care services. Prior to this referral, Adult Social Care were not involved in Adult O's care and there had not been a formal transition process from children to adult services.

Blackpool 'Jessica' - Jessica and her family moved from Leeds to Blackpool. Jessica's Social Worker asked her mother if she would like her to make a referral into Blackpool on their behalf, but Ann declined. Professionals should have assessed whether Jessica had the mental capacity to decide whether a referral should have been made to Blackpool when she was moving. In the absence of a referral to Blackpool being made by Leeds, no information regarding Jessica's care and support needs was transferred. Most importantly, no information was shared evidencing Ann's historic and continual inability to meet Jessica's needs.

Learning from These Cases

HEARING THE PERSONS VOICE

- All services providing a service for a client with learning disabilities, should 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. [Sheffield Person I].
- It is reflected by agencies involved in this review [SAR Adult O] that the transition between childhood and adulthood can be a confusing time for parents and the legal duties and responsibilities need to be explained and parents need to be supported through the transitional changes themselves [Kirklees Adult O].
- Professionals should be empowering vulnerable adults by communicating with them directly and applying the Mental Capacity Act as and when required. It is important that parent carers know that they can no longer make decisions on their adult children's behalf – even when their adult child does not have the capacity to make the decision themselves. The author of SAR Jessica noted that professionals could signpost parent carers to the resource pack for family carers of people with a learning disability, produced by Mencap, that addresses the Mental Capacity Act and practical decision-making Mental Capacity Act Resource Pack.pdf (mencap.org.uk). [Blackpool – Jessica].

WAS NOT BOUGHT

- Was Not Brought Policies should consider the impact of not accessing their service on clients who may lack capacity, and include the requirement to consider domestic abuse, explore the issues and share information re non-attendance and concerns with other partner agencies involved in the client's care. 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 [Sheffield Person I].
- Re-labelling 'Did Not Attend' with 'Was Not Brought' for adults at risk could provoke professional curiosity [Kirklees Adult O].

TRANSFER AND SHARING OF INFORMATION

- Agencies are not routinely sharing or collating basic information regarding family demographics, health issues or other involved services at start of involvement and are not alerting other services when their involvement ceases…Guidance continues to be needed on care-coordination and information sharing in relation to people with learning disabilities, at individual and strategic levels [Sheffield Person I].
- Transferring of information between services in the different areas where Jessica lived was poor and sometimes non-existent. The omission of a referral into Blackpool [from Leeds] increased Jessica's vulnerability and there were missed occasions when Blackpool, having learned of Jessica residing in their area and having care and support needs, could have contacted agencies/professionals in the areas where Jessica had previously lived for information [Blackpool – Jessica].
- NICE guidelines for transition recommend that the process should start at the age of nine, and fourteen at the latest. There is a responsibility for both children and adult services to work in an integrated way (as set out in the Care Act 2014) to ensure good communication, high quality of care, and better outcomes for young people going through transition [Kirklees Adult O].

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 (SARs) April 2017 – March 2019

- **DHRs**
- Key Findings from Analysis of DHRs

- **Professional Curiosity**
- SASP Professional Curiosity Video – YouTube
- College of Policing - Professional Curiosity
- Professional Curiosity (Norfolk SAB)
- Professional Curiosity for Practitioners (Leeds SAB)
- Professional Curiosity (Manchester)

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	