Safeguarding Adults and Domestic Homicide Reviews

Quarterly Update

October/November 2023

Contents

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

Current Reviews – Review Stage

13 Live Reviews

Since the last update:

1 DHR - Commenced.

1 SIR – Commenced.

1 SAR – Commenced.

There are currently 13 live reviews in Sheffield, including:

5 Safeguarding Adult Reviews

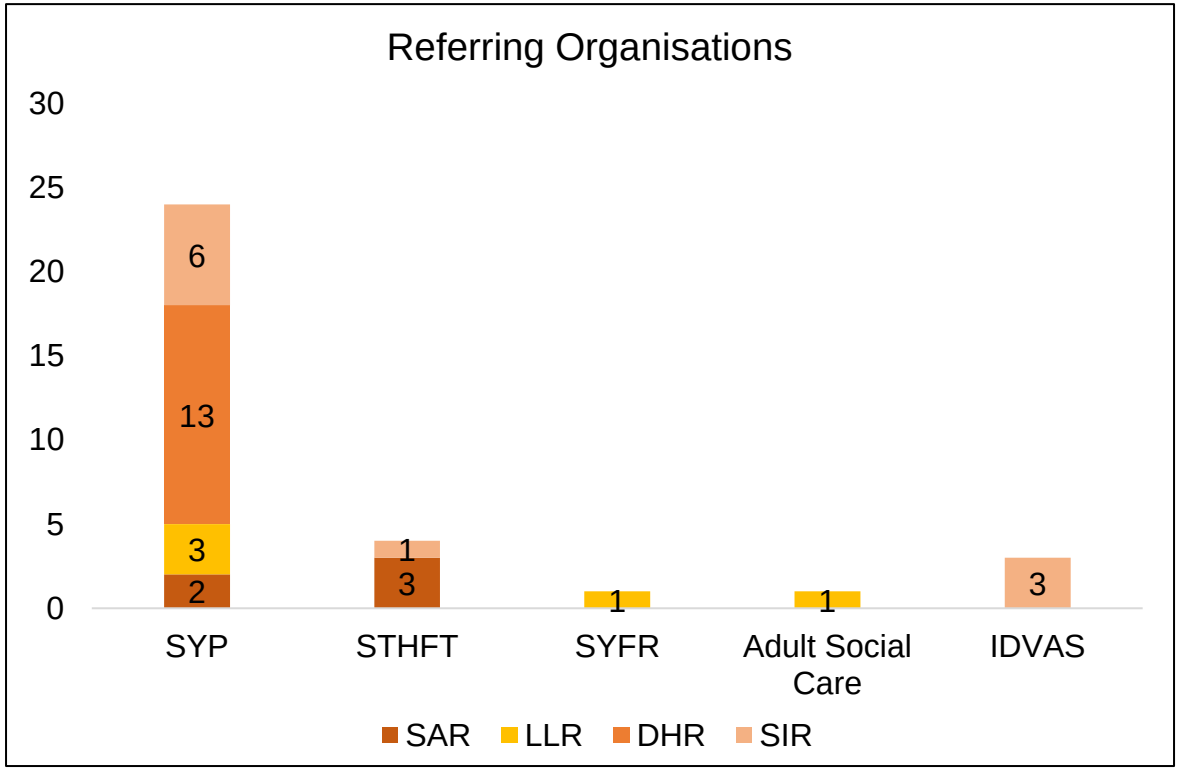
2 Serious Incident Review

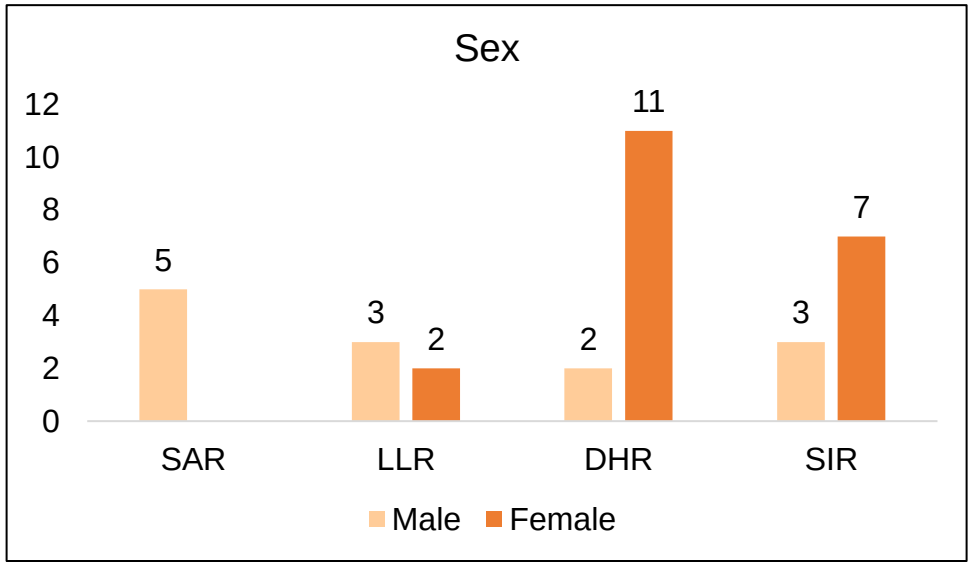
6 Domestic Homicide Reviews

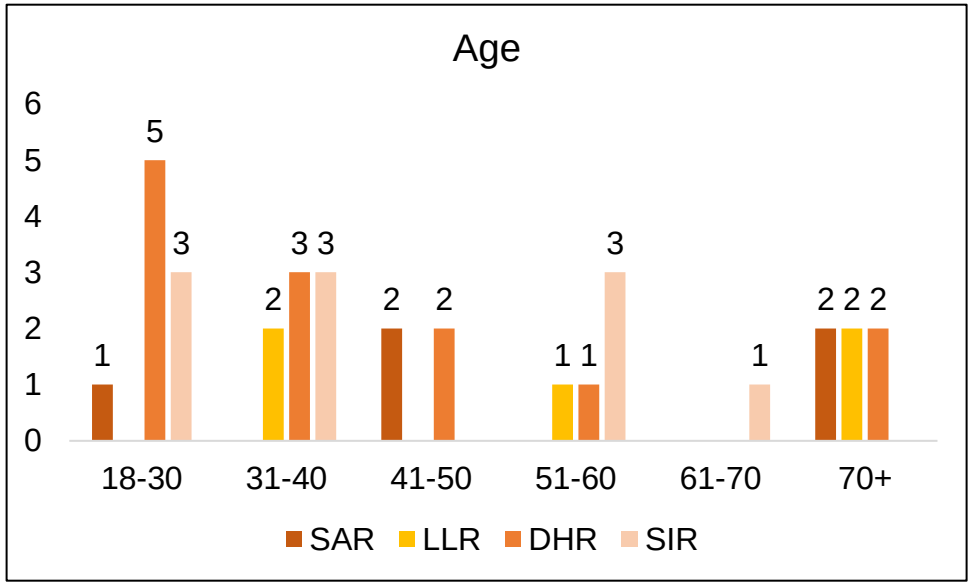
Case Insights (Closed/Ongoing Action Plans Only)

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.

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

In Focus

The theme Coercion and Control has been identified for “In Focus” this quarter. Coercion and Control has been a theme in 6 SARs and LLRs and 11 DHRs and SIRs.

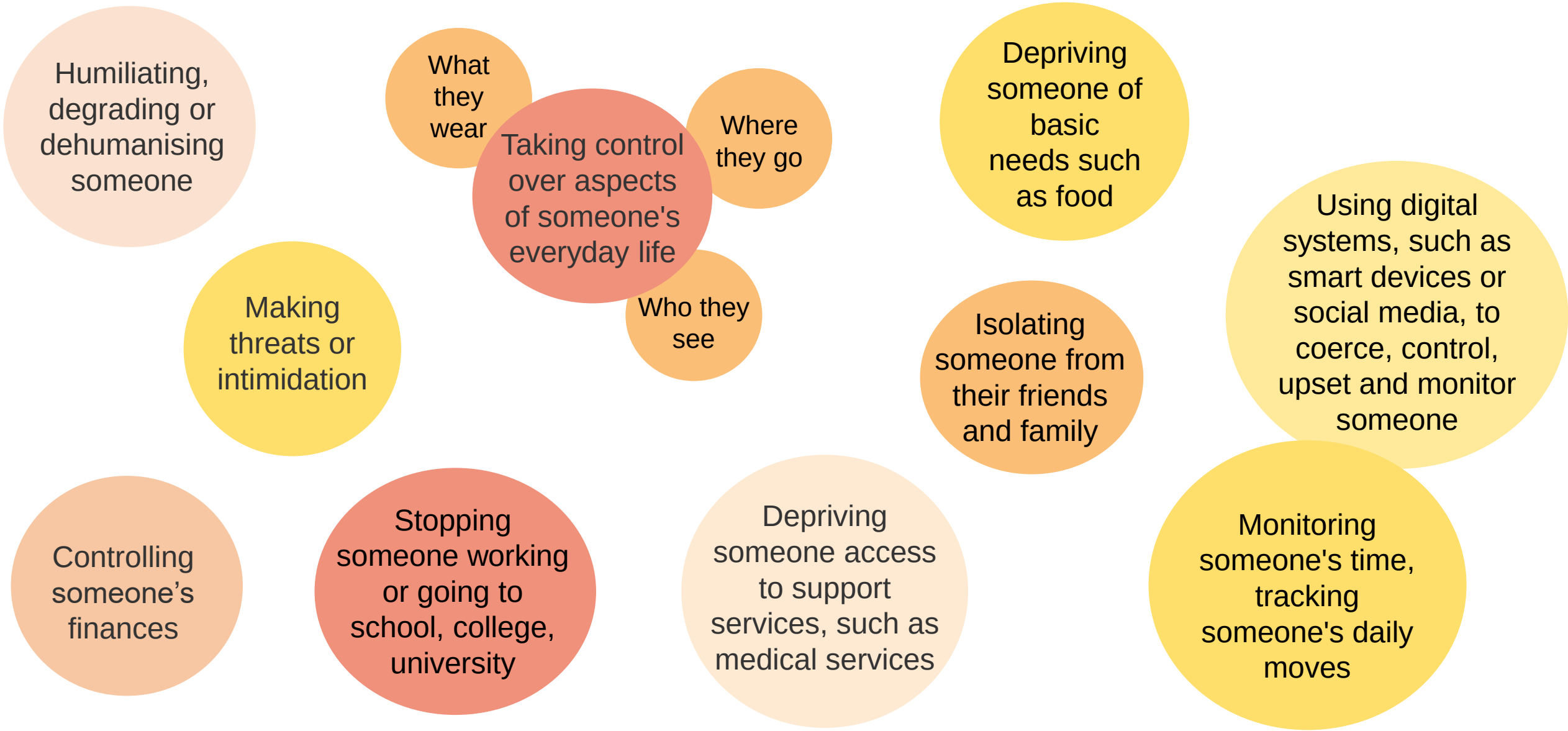
- Women’s Aid defines Coercive Control as an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten. This controlling behaviour is designed to make a person dependent by isolating them from support, exploiting them, depriving them of independence and regulating their everyday behaviour.

- Coercive and controlling behaviour is illegal and an offence under Section 76 of the Serious Crime Act 2015. The offence was brought into force in recognition of the severe impact of controlling or coercive behaviour which can comprise economic, emotional and psychological abuse, technology-facilitated domestic abuse, as well as threats, whether or not they are accompanied by physical and sexual violence or abuse.

- The offence of controlling or coercive behaviour applies to partners, ex-partners or family members, regardless of whether the victim and perpetrator live together.

Signs of Coercion and Control

Here are some common coercive control behaviours used by perpetrators:



Reviews in Sheffield – Coercion and Control

Click the review title for more information.

DHR Adult G

Adult G was murdered by her husband. She came to the UK with her children as a refugee, her fourth child was born in Sheffield.

G experienced physical abuse and coercive control living in almost total isolation outside of her family. Only professionals who came into the home (midwives, health visitors, refugee support worker, English tutor), met G who was rarely seen alone. At GP appointments she was always accompanied, and this may have been why she missed her own appointments/ and used the children's appointments to seek treatment for herself. G was prevented from having contact with her sister. Her sister believes that G was aware of the law but would not have asked for help, because of the shame that would have affected her family in the UK and in their home country, as well as affect the children as they grew up.

LEARNING

Female interpreters should always be used for enquiries about domestic abuse. A clear script needs to be developed for women who may have a different cultural understanding of domestic abuse.

SIR Rosie

Rosie' ex-partner Adam physically attacked her leaving her with life threatening injuries. Rosie has since recovered but is left with long term physical and psychological injuries.

Agencies held no information about domestic abuse perpetrated by Adam in his previous relationships and he had no criminal history of domestic abuse. For Rosie, this became her third abusive relationship. Adam's coercive and controlling behaviour started immediately and he was also physically violent. Within 9 months Rosie reported incidents to the police, had attended A&E with physical injuries and had been referred to MARAC. The abuse escalated when Rosie fell pregnant. The relationship ended four months before the serious incident and when the baby was less than a year old.

LEARNING

Professionals should consider the use of coercive and controlling behaviour by the perpetrator when assessing a victim of domestic abuse and consider how that may impact on the victim and ensure that they are seen on their own.

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

What health professionals required was greater clarity on whether Person F was making a choice not to take his medication or whether FW was coercing and controlling him. Increased partnership working and a dedicated meeting where information could be shared, risks discussed, and a clear plan of action developed, was required.

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

Make enquiries about possible domestic abuse as appropriate to your role. How you ask is important to someone's ability to understand that they are experiencing domestic abuse and to feel safe to share what's happening to them. Remember domestic abuse isn't just between partners.

Coercive Control Findings From the National SARs Analysis

An analysis of SARs nationally found some common trends in relation to coercion and control. The national SAR analysis found that:

Coercive and controlling behaviour did not always receive due attention in practice.

In some cases, the impact of coercion from adult children on the decision making of an older person was not recognised, despite that coercion and control being witnessed.

In some cases, power relations within a family or household were characterised by coercion and control that was not identified, or if recognised was not challenged for example, a family member being allowed to control conversations and questions, without the individual's view being sought.

Mental Capacity Act and Coercion and Control - even where an assessment resulted in a finding that the individual had mental capacity within the meaning of the Mental Capacity Act, there was sometimes insufficient recognition of the possibility that decision making was being impaired by third party influence, coercion or control.

Adult safeguarding practice is challenging, as evidenced by these SARs when they focus on the balance to be struck between an individual's autonomy and a duty of care, on protecting individuals from abuse when their decision making is impacted by another person's coercive and controlling behaviour, and on responding to risk when a person is disinclined to engage.

Coercive Control Findings From National DHR Analysis

In an analysis of 124 DHRs published between October 2019 and September 2020:

- In 64% of the DHRs aggravating factors were identified, with coercive control being the most common (in 65% of these DHRs coercive control was identified).
- The project analysed in more detail a sample of 50 of the DHRs. One of the areas identified for improvement was “the need for greater contact with victims and recognition that the perpetrator can control the victim’s contacts with agencies”.

Findings from a Standing Together report looking at 84 DHRs in London recommended that:

- Training on risk and domestic abuse must move away from stereotypical understandings of domestic abuse as isolated incidents of physical violence. Awareness of the inherent high risk posed by coercive, controlling behaviours that are not physical or sexual - such as harassment and jealous surveillance - is paramount.
- Change the language used relating to lack of engagement and focus on the ways in which the survivor of abuse has tried to address the abuse and keep her or her children safe under coercively controlling abuse
- Agencies should recognise the risks using family members as interpreters can pose. Where a person is subjected to coercive control, either using them as interpreters or interpreting for the perpetrator increases risk.

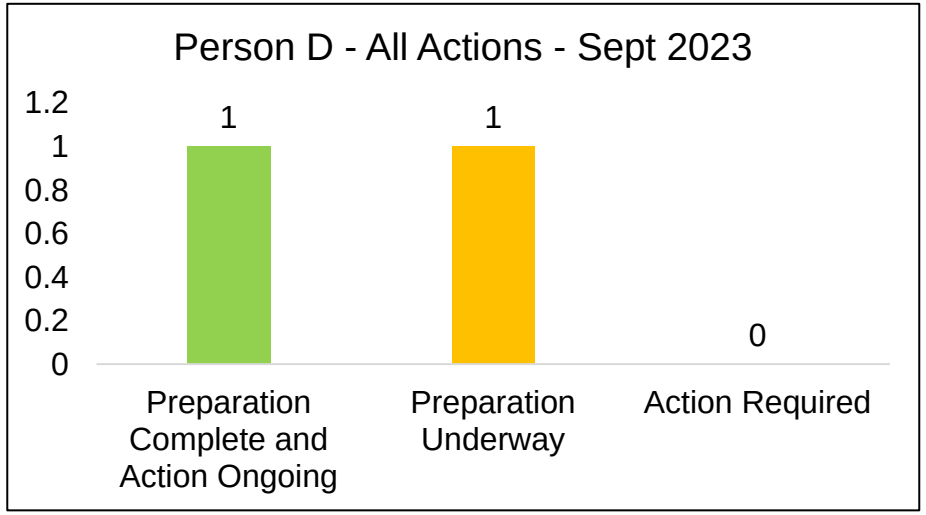
More Information About Coercive Control

For more information on coercive control following the links below:

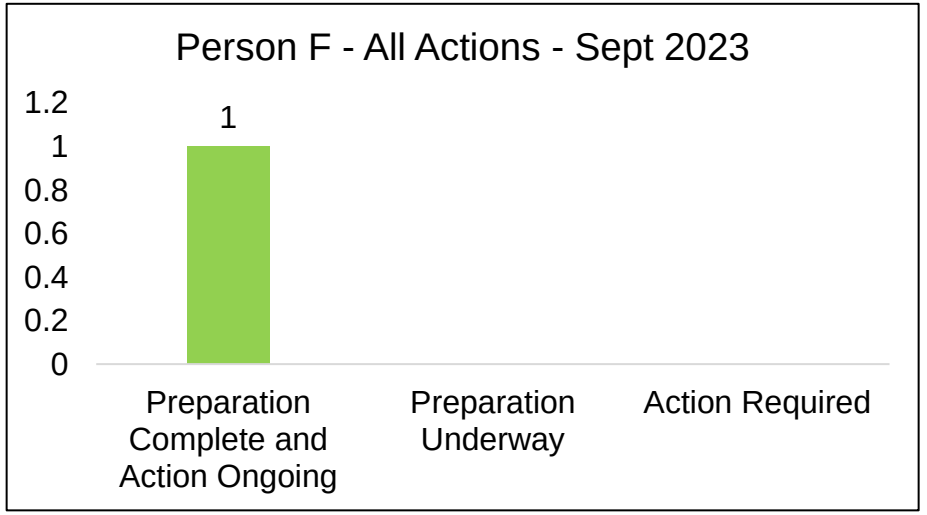
- Sheffield DACT - Coercive and Controlling Behaviour
- Domestic abuse - South Yorkshire Police
- Research In Practice for Adults - Coercive Control
- Home Office - Controlling or Coercive Behaviour Statutory Guidance
- The Crown Prosecution Service - Controlling or Coercive Behaviour in an Intimate or Family Relationship
- Safelives - An Introduction to Coercive Control

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.



Date Report Published: March 2021



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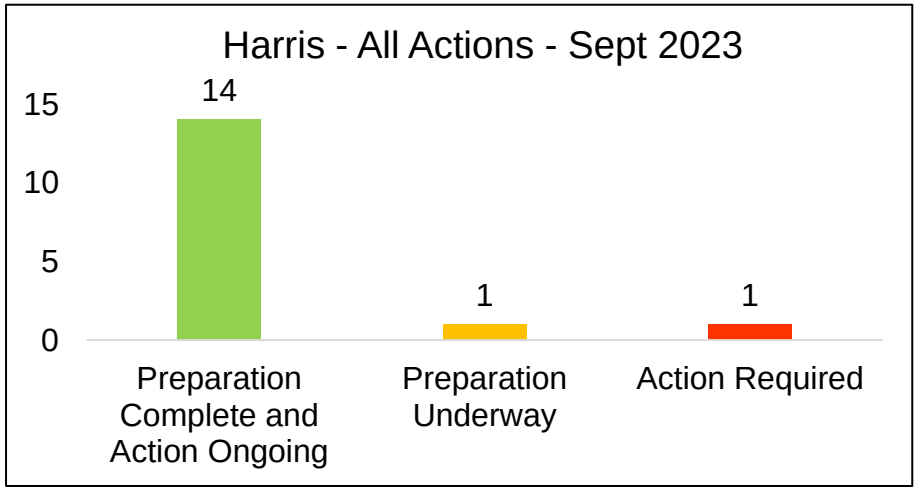

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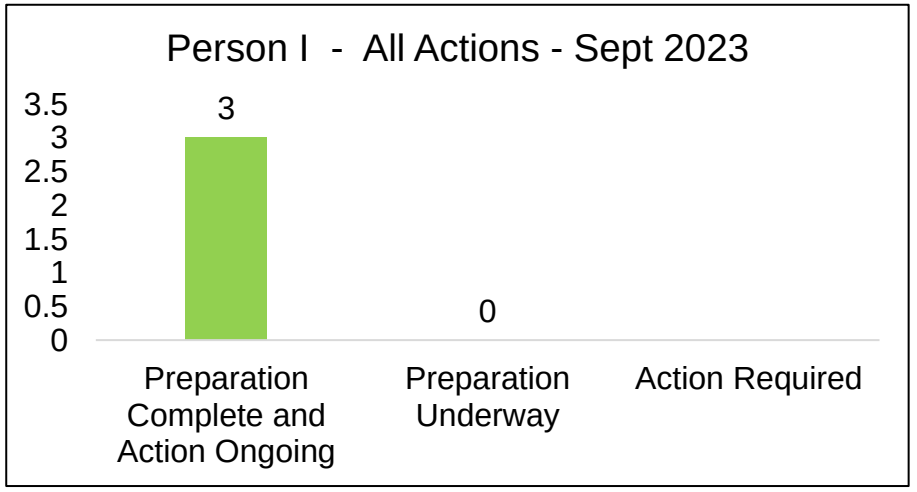
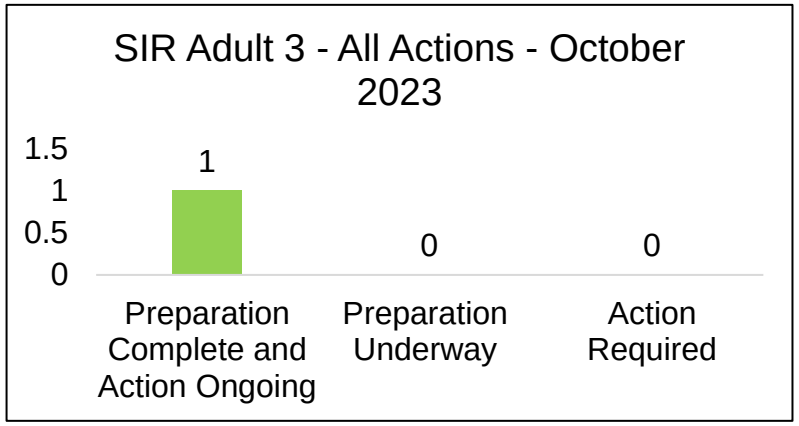


Date Report Published: June 2022

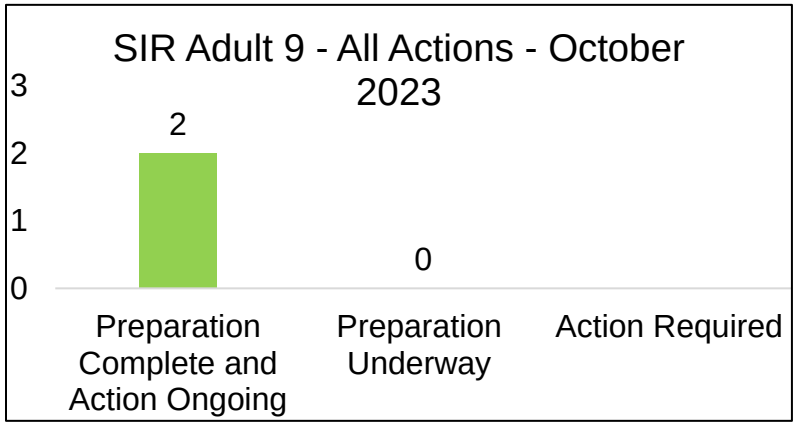
Current Reviews – Ongoing Action Plans (DHRs and SIRs)

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

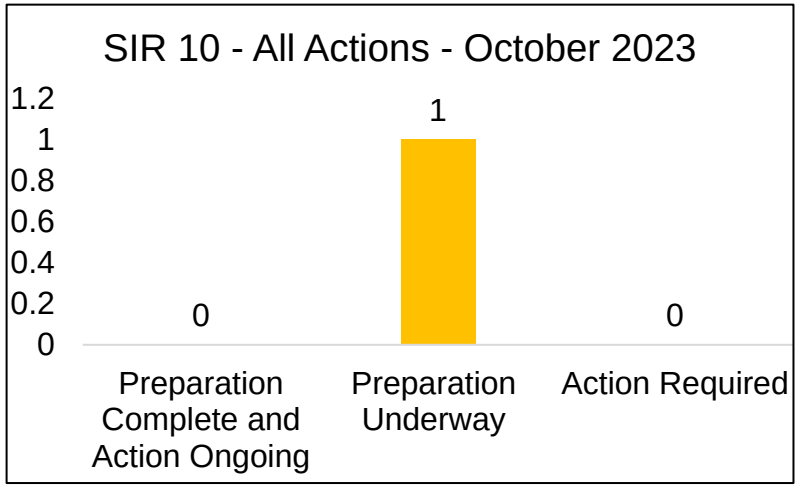
- Actions “unable to be fulfilled” are actions that an organisation are no longer able to put into practice. In the future it may be that things change and they can introduce that particular recommendation, however at present, it is agreed by the DHR/SIR subgroup that we will no longer pursue this for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



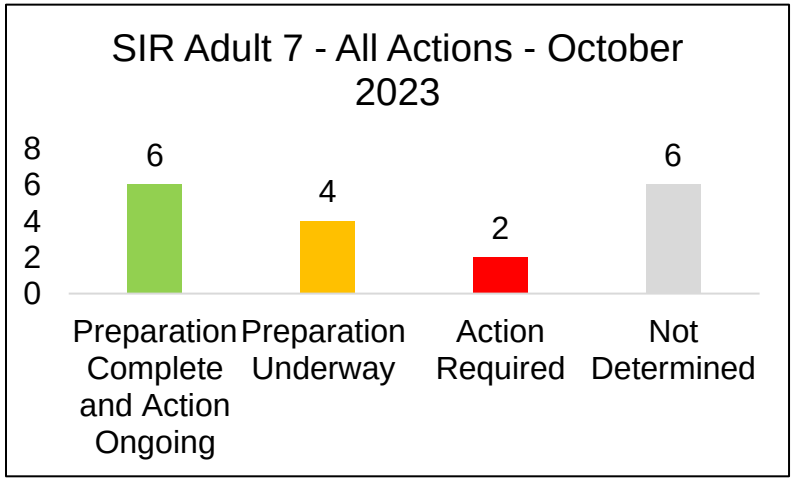
Adult SIR 3 action plan commented Oct 2017



Adult SIR 9 action plan commenced Aug 2022

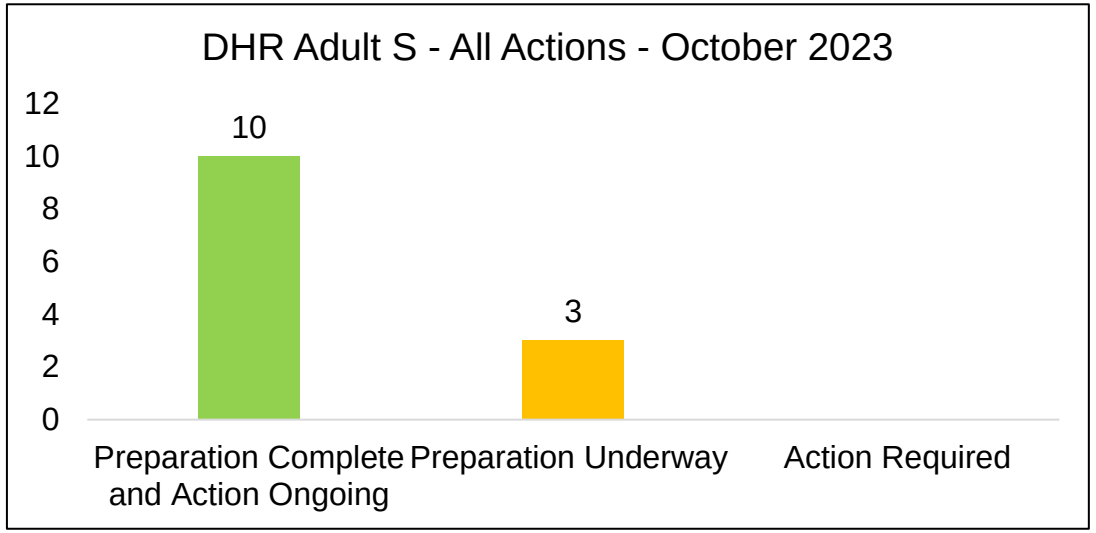


SIR 10 action plan commenced Feb 2023

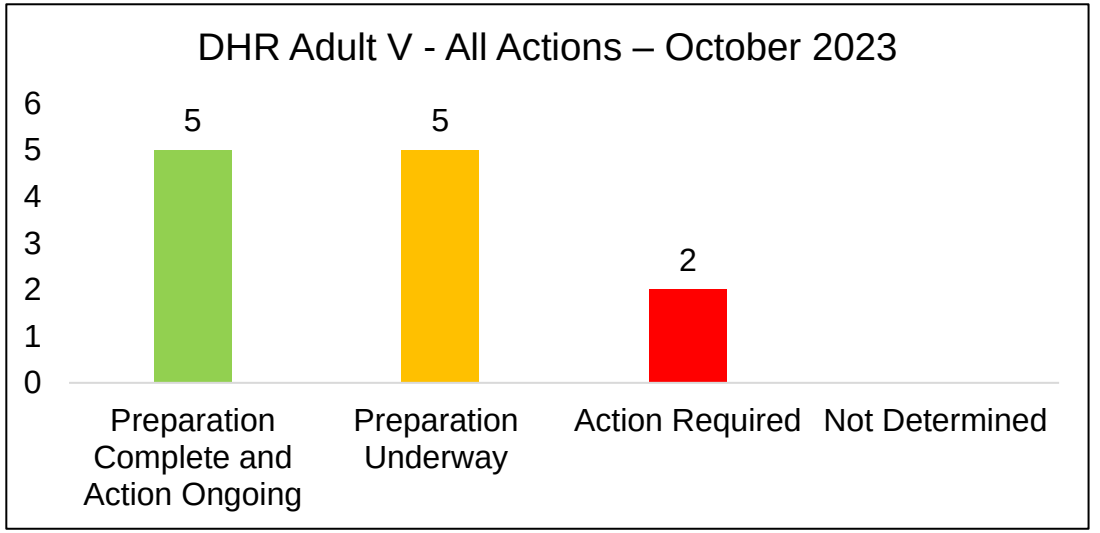


SIR Adult 7 action plan commenced Feb 2023

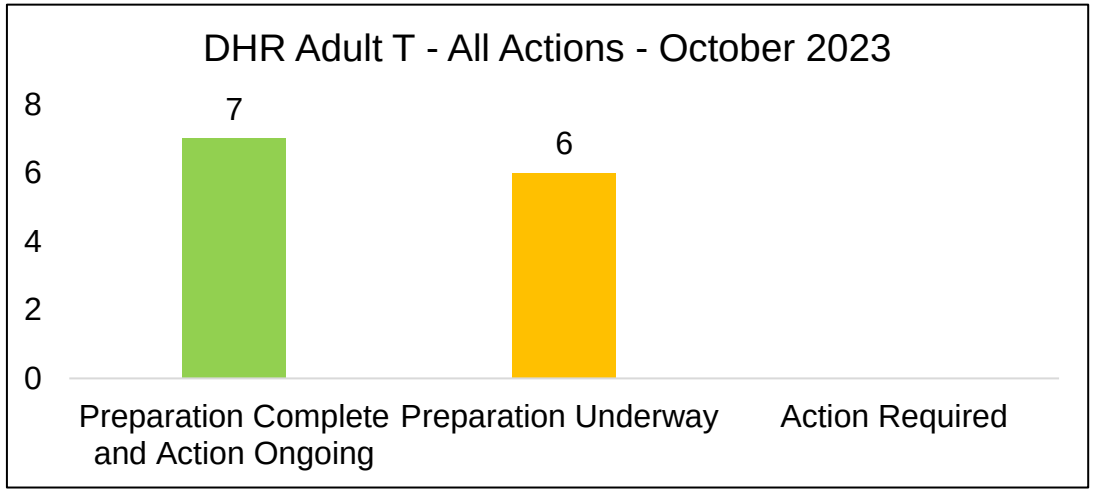
Cont. Current Reviews – Ongoing Action Plans (DHRs and SIRs)



Adult S action plan commenced Dec 2021



DHR Adult V action plan commenced Feb 2023



Adult T action plan commenced Feb 2023

Achievements

SIR Adult 3 – The Probation Service and Sheffield Health & Social Care have developed a joint working protocol.

DHR Adult T – Consultation taken place with male victims and report shared with Sheffield's Domestic and Sexual Abuse Strategic Board.

DHR Adult T – South Yorkshire Police have rolled out 30 sessions of Trauma Informed Training to Officers.

SAR Harris – A recommendation from SAR Harris proposed that following the new service model for the Adult Social Care front door, future multi agency case file audits should include safeguarding decision making as a key question. Adult Care and Wellbeing have designed an multi agency safeguarding toolkit to audit cases in MASH. They then intend to role this out using a random sample moving forward each month. This audit tool asks the question "Is there clear evidence for decisions made throughout the safeguarding process?".

SAR Harris – A recommendation from SAR Harris recommended that SASP should ensure that the work being undertaken within the children's partnership on improving the model for family safeguarding includes agencies that work with adults including adult social care. The Hidden Harm group which has multi agency membership and looks at whole family working now has attendance from Adult Care and Wellbeing. Sheffield Children's Safeguarding Partnership has run several Parental Mental Health Workshops which have been attended by agencies who work with adults and children.

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
- Standing Together London DHR Review Report
- NEW DHR Library has now launched - Search DHRs: Search the Home Office Domestic Homicide Review Library
- Adult Family Violence Poster - Adult Family Violence Poster - IDAS

Coercive Control

- Sheffield DACT - Coercive and Controlling Behaviour
- Domestic abuse - South Yorkshire Police
- Research In Practice for Adults - Coercive Control
- Home Office - Controlling or Coercive Behaviour Statutory Guidance
- The Crown Prosecution Service - Controlling or Coercive Behaviour in an Intimate or Family Relationship
- Safelives - An Introduction to Coercive Control

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	