South Gloucestershire Safeguarding Adults Board
Practitioner Learning Brief
Learning Review/DHR: Family S November 2020

Background Summary

Mr S* was in his early 60s when he died in 2019 and Miss S* from the same family died later in the same year in her late 30s.

A joint review took place to learn from what had happened for both adults. The element of the review about Miss S was a Domestic Homicide Review (DHR) Both Mr S and Miss S spent time in two different parts of the country together and so both regions took part in this review. The review was complex and the chronology contained over 1500 entries from agencies across both local authorities. This learning brief aims to share the key themes and learning identified.

*Names and identifying features have been changed to protect the identity of the family

Learning

18 agencies across 2 LAs took part in the review

The relationship between Mr S and Miss S was not a healthy one, at best co-dependent and at worst, controlling & abusive

Key Finding: Person centred work is critical

Themes for learning identified:

- Violence, Abuse and Exploitation
- Housing
- Engagement
- Safeguarding and Risk Management
- Professional Curiosity and Challenge
- Interagency Working

Miss S experienced repeated patterns of physical and sexual abuse and exploitation from a number of men including when she was a child and young adult. There are examples of Miss S being both a victim and a perpetrator of violence and abuse

Concerns were raised about Mr S potentially being a victim of financial abuse by Miss S

Good Practice identified:

- Continuous joint work to hold and manage risk
- Comprehensive and detailed safeguarding referrals
- Holistic, assertive, person centred approach taken with Miss S
- Attempts by one organisation to refer into links in another local authority when Miss S and Mr S moved from one place to another.

This work was not person dependent as different roles in each organisation worked with Miss S therefore the network and practice was embedded in the culture of the organisations.

Cross-boundary communication between Police Forces for investigations, arrests and concerns for welfare was, on the whole, timely and targeted

A good knowledge and understanding of domestic abuse (including financial abuse) and sexual violence and exploitation amongst practitioners

Sirona provided an effective, timely and comprehensive service to Mr S, the parallel organisation in the other LA was well organised but work was frustrated by continual moves

Engagement

Assertive Outreach proved the most effective method to reach complex families: This approach includes:

- Relationship building. Investing time in getting to know an individual, obtaining trust/respect and understanding triggers and behaviours in order to formulate a targeted response and make meaningful interventions;
- Assertiveness/Persistence. Proactively tracking her down and engaging, keeping in touch, going to where the individual is, sourcing options to meet needs, rethinking and representing options/approaches if they didn't work first time;
- Staying alongside/advocacy. Accompanying an individual to significant meetings when they would not otherwise attend and discussing and representing her needs to other agencies
- Proactive and pre-emptive. Working with others to anticipate risk and behaviours and identify solutions and responses

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The full review has not been published to protect the identity of the family

Mental Capacity

Mental capacity became a barrier to exercising professional curiosity for Mr S. Practitioners listened and respected his views and rights, but the issue of capacity prevented relationship building with him. Good practice in assessing mental capacity sits in a developed relationship with an individual, and this was never established with Mr S

Think Family

There were opportunities missed to adopt a whole family approach to safeguarding that would have established a fuller understanding of needs and risk (present and future) and enabled Mr S, Miss S and the children to be the subject of a joint, coordinated approach by Adult Social Care and Children's Services. Mr S, Miss S and the children's needs were responded to separately even though the welfare of all were clearly linked.

Information was taken at face value by practitioners who failed to recognise and factor in the complexity of their relationship. Without the bigger picture relating to Mr S and Miss S at the forefront of decision making and practice, the system response was to individuals and their needs in isolation.

Housing

The review found that securing accommodation was deemed a prerequisite to establish the stability and safety necessary to allow agencies to address Miss S's underlying trauma, experiences of abuse and alcoholism whilst at the same time these were the very issues which prevented her from sustaining any type of housing. There is a lack of accommodation available for vulnerable women with multiple and complex needs

Hearing the Voice of Mr S

Miss S often spoke for Mr S both in discussions with agencies in respect of his medical condition and in respect of wider decisions about his care. Efforts were made to speak to Mr S without her being present but are not able to do this for any sustained, meaningful period of time. There are few records of him engaging independently

Miss S was involved with 20 different agencies which she said was overwhelming

Moving between two counties impacted on the continuity of services and levels of engagement as well as the degree to which people could build a relationship with Mr S

Although Domestic Abuse was well understood there was less consideration for Coercive Control

You can book training about Coercive Control by clicking this circle

Complexity and Risk

Co-occurrence of mental health, substance abuse and domestic violence and abuse are a common presentation. Agencies need to find ways to work collaboratively to address this complex combination of needs rather than expect the individual to cease/manage a behaviour before they can receive support.

The review found a lack of clear recording in respect of the steps taken to explore the issues in respect of safeguarding. This had a number of consequences: It prevented a more coordinated approach being adopted from the outset, resulted in a lack of a shared approach to risk assessment and management and an absence of clarity in terms of roles and responsibilities.

Including Families

Within the safeguarding process there should be an opportunity to bring together the individual, their family and other agencies who have involvement to produce a clear plan of what is trying to be achieved and to agree a shared understanding of risk. Family members are usually best placed in knowing the individual and can provide a valuable perspective to planning and decision making relating to support and management of risk. This was missing for the family in this review.

Training about Mental Capacity is available by clicking this link

There has been excellent cooperation with this review from the partner agencies in both areas, which was essential in establishing the learning from this case

Action Planning

Although this learning Review/Domestic Homicide Review has not been published the Safeguarding Adults Board has an action plan to monitor the implementation of the recommendations.

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