Teeswide Safeguarding Adults Board

Learning from Regional and National Learning Reviews

Title of Review:	Domestic Homicide Oversight Mechanism: Homicide Abuse Learning Together (HALT) Study Briefings
Theme of Review:	Domestic Homicide Reviews
Local Authority:	National Analysis Commissioned by Domestic Abuse Commissioner
Date Published:	December 2023
Link to Full Report:	https://domesticabusecommissioner.uk/reports/

Summary

The Domestic Abuse Commissioner commissioned researchers at the HALT study at Manchester Metropolitan University to conduct analysis of Domestic Homicide Reviews in relation to the following themes: criminal justice, health services, children's services, and adult social care.

Criminal Justice (based on a sample of 46 DHRs)

- All but two of the victims (96%) experienced victimisation or trauma prior to the homicide, largely at the hands of the domestic homicide perpetrators.
- Where victims have vulnerabilities such as alcohol misuse and/or mental health difficulties, organisational and individual understanding of the Vulnerable Adults Framework is key.
- Barriers to victim non- or dis-engagement should be understood and the onus placed on the service rather than the victim to increase engagement.
- Risk assessments need to be conducted with more detail, processes for referral need to be followed, and these should be regularly reviewed and audited, including the management of these by MARAC and MAPPA.
- Histories of both suspected perpetrator and victim should be examined to see if there are any patterns of behaviours, criminal reports, or past DVA.
- DVA training was widely recommended by DHRs. This should also include specific training on reducing the influence of problematic constructions and assumptions related to victims and perpetrators.
- Training in adult and child safeguarding; record keeping, information sharing, multi-agency professional working, and on missing persons enquiries were recommended. All of these should be monitored for effectiveness.
- Unconscious bias training should also be conducted, as cases involving minoritised victims were found to be assessed at a lower risk than those cases involving White British victims.
- The ethnicity of victims and perpetrators must be recorded by the police and sustained efforts made to counter cultural stereotypes and ensure interpreting services are routinely offered.
- Risk assessments should be conducted at crucial points such as being released from prison, or after a significant reduction in physical health or mobility.
- The dynamic and changing nature of risk, the influence of victims' and perpetrators' characteristics and the type of abuse experienced needs to be better understood and assessed.

Physical and Mental Health Services (based on a sample of 58 DHRs)

- The DHRs show that routine inquiry in a range of health settings is absent, with lost opportunities for intervention. Recommendations for improvement were targeted most often at Health Trusts, CCGs (now ICBs) and GPs.
- Improving DVA risk assessments in health settings is crucial to ensuring safety for DVA victims.

- Communication between different clinical specialisms dealing with patients experiencing DVA needs to be strengthened.
- A lack of multi-agency working and poor information management was recorded in 39 of the 58 DHRs (67%).
- Clear and concise national guidance on when HCPs can share information with other agencies, particularly where a patient does not give consent is called for.
- Co-ordinated care is also hampered by non-aligned IT systems or not using IT capacity - to 'flag' DVA perpetrators, victims, and frequent or non-attenders.
- The key challenges to practice are to develop skills to engage with those who are constructed as 'difficult'; to consider the possibility of DVA in 'devoted' relationships pertaining to older couples; working holistically; awareness of symptoms that may not appear related to DVA (e.g. unexplained pelvic pain, headaches); frequent attenders at GPs and non-attenders where DVA might be masked.

Children Services (based on a sample of 33 DHRs)
Key findings linked to Adults:

- Safeguarding children in the context of DVA is complex as a simultaneous focus is required on both child and parents/caregivers (either abusive or non-abusive)
- Improving record-keeping, sharing information with partner agencies and contributing to a multi-agency safeguarding plan is central to safeguarding children.
- In just over half of cases (17/33, 52%) children's social care and education were aware of domestic abuse in the relationship between the victim and perpetrator.
- In several DHRs, social work practitioners assumed that mothers could and should keep their children safe by managing the perpetrator's behaviour and DHRs rightly picked up on this, challenging service narratives. The responsibility for DVA rests with the perpetrator, not the victim, and children's social care should ensure their 'whole family' framework holds perpetrators accountable for their role as parents.
- Supporting care leavers so that their care experiences mitigate adverse childhood experiences is central to them developing a positive sense of self and understanding.
- Development of practice models to engage with adolescents need to be developed which are cognisant of them as both vulnerable and as potential aggressors. Specific interventions for adolescent boys at risk of perpetrating DVA were also recommended in some DHRs
- The premise that the child is a victim of domestic abuse should take precedence over the assumption that the abusing parent is entitled to contact. Contact provides further opportunities for perpetrators to manipulate the child and to further abuse the victim.

Adult Social Care (based on a sample of 24 DHRs)

- Domestic abuse and domestic homicide experienced by older people is poorly recognised.
- The lack of a statutory requirement for a multi-agency safeguarding hub (MASH) for adults is problematic.
- Training needs to focus on different types of abuse (e.g. adult family abuse, 'mate' abuse, coercive control) as well as their intersections with mental capacity, consent, and how this relates to specific long-term, debilitating, and life-changing diseases.
- Recognising and acting upon carer stress is vital, as is assessing whether a carer is capable.
- There is a gap in response to those who are self-funding care, despite the Care Act making clear that safeguarding applies regardless of funding arrangements.
- Private sector care agencies are missing from multi-agency arrangements, and they also appear to be less likely to have domestic abuse policy or training.
- More assertive and enquiring practice is called for.
- Understanding an individual within their context and 'think family' was recommended in several DHRs.
- DHRs pertaining to Black and minoritised victims stressed the need to challenge supposed cultural norms and ensure communication with the victim (including with interpreters).

- Equality and diversity are scarcely considered within the DHRs with little understanding of the impact of ethnicity, gender, or disability on the lives of the people involved. For the DHRs included in this report, physical disability was a factor in most cases, with severe mental illness also featuring frequently. At the very least an understanding of these disabilities and their impacts is crucial.

Key Findings and Considerations for TSAB

Some of the findings are not too dissimilar to those identified in the *National Analysis of SARs involving Adult Sexual Exploitation* and the real challenges for professionals to protect and support adults subject to this often-hidden form of abuse may be being coerced, dependent and fearful of perpetrators and isolated from others which makes breaking free from the cycle from abuse much more complex and challenging. Applying professional curiosity effectively is important in order to make relevant referrals.

It was interesting to note from the Criminal Justice study that the most prevalent risk factor for victims was experience of trauma (96% (44/46)) and was due mostly to DVA from the perpetrator. For perpetrators, experience of trauma was also relatively high (29/46, 63%). Findings from the Children's study talks about supporting care leavers so that their care experiences mitigate adverse childhood experiences and is central to them developing a positive sense of self and understanding. The study also mentions the need to engage with adolescents which are cognisant of them as both vulnerable and as potential aggressors and specific interventions for adolescent boys at risk of perpetrating DVA were also recommended in some DHRs. There seems to be growing understanding that experiencing trauma can be a catalyst for creating a detrimental impact on a person's physical and emotional development, poor physical/mental health and wellbeing and can negatively impact on a person's behaviours, perceptions and relationship with themselves, with others and their environment. It is crucial that Children and Adult Services continue to embed Trauma Informed Practice and recognising that children adversely affected by trauma can grow into adults with additional vulnerabilities and/or complex needs.

Continuing to strengthen the 'Think Family' approach. TSAB continues to build on this ethos, more recently in developing the Adult Exploitation Strategy (including transitions) and the Joint Working Protocol.

The Health Care study recommends improvements to IT systems so that they interface with each other and that 'flagging' domestic abuse concerns is more robust. Through previous local SARs it is known that work is ongoing regarding improving electronic records and flagging systems, particularly in health settings.

Suggested Actions:

A local SAR "Bernadette" featured learning around Domestic Abuse. **The findings from these reports can be considered as part of the action planning process to maximise learning** including:

- Barriers to victim non- or dis-engagement should be understood and the onus placed on the service rather than the victim to increase engagement.
- When to override a person's consent (The Health Care study recommends that there is clear and concise national guidance on when HCPs can share information with other agencies, particularly where a patient does not give consent is called for).
- MARAC and risk assessments - should be conducted at crucial points such as being released from prison, or after a significant reduction in physical health or mobility.
- Working holistically; awareness of symptoms that may not appear related to DVA (e.g. unexplained pelvic pain, headaches); frequent attenders at GPs and non-attenders where DVA might be masked.
- Assertive outreach

Training and strengthening a number of areas linked to domestic abuse was recommended such as; record keeping, risk assessments, information sharing, multi-agency professional working, missing persons enquiries, unconscious bias, adult family abuse, 'mate' abuse, coercive control as well as their intersections with mental capacity, consent, and how this relates to specific long-term, debilitating, and life-changing diseases. **TSAB partners to consider if the above is incorporated into their training as appropriate within their organisation.**

The research highlighted that domestic abuse/homicide experienced by older people is poorly recognised. During 2022/23 TSAB completed some work to raise awareness of domestic abuse in older people and will continue to do so as opportunities arise. **TSAB partners can reflect on this specifically within their own training and resources to ensure it is covered adequately and to raise awareness internally as appropriate.**

One key finding was recognising and acting upon carer stress and assessing whether a carer is capable. For the DHRs included in this report, physical disability was a factor in most cases, with severe mental illness also featuring frequently. At the very least an understanding of these disabilities and their impacts is crucial. Due to a recent local SAR (James), a focus for TSAB during 2023/24 will be improving understanding the informal carer's role and raising awareness of completing Carers Assessments. **Recognising carer stress and their capability can be incorporated into relevant key messages. Organisations who support carers and people with physical disabilities / poor mental health can be targeted to raise awareness.**

The research found a gap in response to those who are self-funding care, despite the Care Act making clear that safeguarding applies regardless of funding arrangements and that private sector care agencies are missing from multi-agency arrangements, and they also appear to be less likely to have domestic abuse policy or training. **TSAB partners to consider if private sector professionals are included where relevant as part of existing safeguarding arrangements. Domestic Abuse Strategic Partnerships to consider how they engage with private sector care agencies.**

DHRs pertaining to Black and minoritised victims stressed the need to challenge supposed cultural norms and ensure communication with the victim (including with interpreters). Equality and diversity are scarcely considered within the DHRs with little understanding of the impact of ethnicity, gender, or disability on the lives of the people involved. **TSAB partners and Community Safety Partnerships to consider how cultural competence and understanding of protected characteristics is incorporated into daily practice and can re-share TSAB's Preventing Abuse and Neglect Leaflet.**

The research highlighted that for primary care, the IRIS programme needs to be maintained and extended to GP practices where there is currently no programme. IRIS nationally has been found to be effective in recognising domestic abuse, together with referral to appropriate services. **Is this successful in the practices that have adopted this programme and is it available in GP practices across Tees?**

This report to be shared with TSAB Members (includes voluntary sector, Children Safeguarding Partnership Leads and OPCC), SAR Sub-Group Members, Operational Leads Sub-Group, LTD Sub-Group, Domestic Abuse Strategic Partnerships, Community Safety Partnerships to consider and action where appropriate. This report will be logged as evidence against the Bernadette SAR Action Plan.

Useful Resources

- Shaping Our Lives Report (2021): A Review into Domestic Homicide and Safeguarding Adults Reviews Relating to Victims with Additional Vulnerabilities
- Homicide Abuse Learning Together Report (2019): Global Study on Homicide - Gender-related Killing of Women and Girls
- Stop Adult Abuse – Care Provider Response to DA and Supporting People Living with Dementia and their Carers