ENFIELD SAB THEMATIC SAFEGUARDING ADULTS REVIEW:

SUMMARY REPORT

DOMESTIC ABUSE AND ADULTS AT RISK

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Enfield Safeguarding Adults Board

ENFIELD Council

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INTRODUCTION BY CHRISTABEL SHAWCROSS, INDEPENDENT CHAIR OF THE LONDON BOROUGH OF ENFIELD SAFEGUARDING ADULTS BOARD

The Enfield Safeguarding Adults Board commissioned a thematic safeguarding adults review (SAR) of response to domestic abuse (for adults in need of care and support) following concerns as to how effectively agencies were responding to the new 2014 Care Act criteria which were implemented in April 2015. We are grateful to Dr. Ravi Thiara with Dr. Christine Harrison, from the Centre for the Study of Safety and Well-being at the University of Warwick, who carried out this review with great care and diligence.

This Thematic Review specifically looked at how the abuse of adults in need of care and support (or adults at risk) as determined by the Care Act 2014 is addressed – rather than the general population – and how their specific needs, circumstances and vulnerabilities are recognised and engaged with.

Given the necessity of multi-agency responses to assisting victims with domestic abuse, it was anticipated that the report would reflect multiple agencies' responses. It also reflected input by Enfield's Community Safety Partnership which the Safeguarding Adults Board (SAB) has a key link with to work together on strategies for prevention.

The researchers, regrettably, due to changes of multi-agency personnel and lack of engagement by a range of key partners were unable to provide a comprehensive multi agency analysis. It proved hard to engage with service users who had experience of safeguarding adults and domestic abuse and the number of people who agreed to speak with the researchers was much smaller than originally planned. The Domestic Violence Strategy for the London Borough of Enfield has also since been reviewed and other actions completed.

Nonetheless the conclusions and recommendations based on the expert knowledge of the lead researcher, Dr Ravi Thiara, are highly relevant. As there was a focus on service users needing Care and Support, there was good engagement by Mental Health services and other adult social care teams in the research, and analysis of a small number of service user views so the findings are particularly relevant to them. However, it is clear that multi agency work is essential for effective safeguarding and so the recommendations and actions will need owning and implementing by all agencies.

The cases and views shared show that there is still a lot of learning to be had, across partners, on embedding approaches to preventing and protecting those suffering from domestic abuse of all ages. The publication here incorporates summaries, the key findings and conclusions from the themed review and analysis of Domestic Homicide Reviews from the Home Office and other institutions.

ACTIONS TAKEN

A Learning Event was held in May 2017 to consider the recommendations and to confirm agreement by all agencies to the recommendations which will be overseen by the SAB. There was unanimous agreement to this and sharing of a lot of very positive developments that have already taken place since this research was commissioned over a year ago. It was also agreed by agencies to provide a summary report linking with a summary of Home Office and academic reviews of Domestic Homicide Reviews (DHRs) to provide an overview for all local agencies on actions. This was completed in February 2017 by the Strategic Safeguarding Adults Team. This summary report, now being published in 2018 by the Enfield SAB combines these with the key points from the external review. This is following more work between Enfield SAB agencies to ensure the learning is embedded across the partnership, and more work will follow.

The Care Act (2014) requires the SAB and agencies to take a Making Safeguarding Personal Approach, we very much have the views of service users in mind to ensure significant improvements are implemented and monitored. These views ranged from very negative to very positive and show the complexity of situations and not just gaps in understanding the emotional impact but need for basic practical support.

SERVICE USERS VIEWS

There were a range of user views (although based on a smaller sample than originally planned – originally 10 service users agreed to be spoken with but 5 attended the interviews) and individual views are very important to listen to. Many were negative about the availability of support and understanding showing the importance of awareness raising for all staff. Where there were positive comments it reflected the sensitivity and awareness of staff involved.

> **For years I was crying, for ten years I was crying and when he left I stopped crying for a whole year.**
>
> **His presence is still here, still judging me, putting me down. I got used to being treated horribly, it's still in my head.**
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>
> **It's just talk talk. I leave there feeling low. There's no practical help. It just stirs everything up. It's not helpful.**
>
> **Nobody seems to be listening. I'm just doing it myself. They all focused on my illness. It's all about me and what's wrong with me. The system has let me down. It just creates problems for me.**
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> **I felt supported and encouraged.**

These statements show that those suffering from domestic abuse, who are also in need of care and support, are very vulnerable and this requires all agencies to develop innovative approaches to provide support at times of stress.

What follows is a brief review of several recent reports (references below) that have given us analysis of Domestic Homicide Reviews (DHRs) in order to draw out themes and the Key Conclusions from Dr. Thiara and Dr. Harrison's report. We have then listed thematically recommendations/ actions arising from both analyses.

Within this summary, we have chosen to use the term 'domestic abuse' in order to recognise the range of abuses involved which may or may not include physical violence. However, there are several places where quotations are used and therefore the original terminology.

THEMES DRAWN FROM RESEARCH AROUND DOMESTIC HOMICIDE REVIEWS

Between April 2011 (when Domestic Homicide Reviews became a statutory requirement) and December 2016, the Home Office states that there have been over 400 Domestic Homicide Reviews completed. This has allowed professionals to gather a wealth of information around the practice of all agencies working with domestic abuse and identify lessons learned to reduce domestic homicide and abuse. National studies allow us to gain a more global picture of the themes and recommendations.

In compiling this report, 4 studies were looked at in depth:

- Home Office (2016) Domestic Homicide Reviews: Key Findings from Analysis of Domestic Homicide Reviews[1].

This report analyses 40 Domestic Homicide Reviews (33 involved intimate or former intimate partners and 7 were familial homicides) and their recommendations – breaking them down thematically and making further national recommendations.

- Sharp-Jeffs, N. and Kelly, L. (2016) Domestic Homicide Review (DHR) Case Analysis, Standing Together Against Domestic Violence and London Metropolitan University: London[2].

This study, completed by Standing Together and colleagues at London Metropolitan University, analyses 32 Domestic Homicide Reviews which took place between March 2012 and March 2015. 24 of these cases involved an intimate or former intimate partner and 8 involved other family members.

- Neville, L and Sanders-McDonagh (2014) Preventing Domestic Violence and Abuse: Common Themes and Lessons Learned from West Midlands' DHRs., Middlesex University, London[3].

This study looks at 13 individual cases within one geographical area across several years.

- Rowlands, J. (2014), Learning from Domestic Homicide & Near Miss Reviews: Implications for Practice, Safe in the City – Brighton and Hove Community Safety Partnership[4].

This looks at four Domestic Homicide Reviews conducted in the Brighton and Hove area in 2014 and as such could be considered a snap-shot of issues there at that time.

There is a great deal to be learned from these reports individually and collectively. Because these reports are reviews following homicides, the language used is 'victim' rather than the term survivor which is used within our own Multi-Agency Risk Assessment Conferences (MARAC) and other literature.

MENTAL ILLNESS AND SUBSTANCE OR ALCOHOL MISUSE/ABUSE AS INDICATORS FOR BOTH PERPETRATOR AND VICTIM – SPECIFICALLY

The Home Office report is very clear about prevalence of both substance or alcohol misuse/abuse and mental illness in domestic abuse homicides. In just over half (21) of the DHRs analysed by that report, substance abuse was a factor. In 7 of the DHRs, Health Services were not aware of the substance abuse but in the remaining cases they were aware.

In over 75% (32) of the DHRs (Including all of the familial homicides analysed) mental health issues were involved. 21 cases involved the perpetrator having mental health issues and 9 involving the victim having mental health issues – depression was the most frequent form of mental illness cited.

1 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/575232/HO-Domestic-Homicide-Review-Analysis-161206.pdf
2 http://www.standingtogether.org.uk/sites/default/files/docs/STADV_DHR_Report_Final.pdf
3 http://www.westmidlands-pcc.gov.uk/media/346469/13-spcb-11-sep-14-domestic-homicide-reviews-research-appendix-2.pdf
4 https://www.safeinthecity.info/sites/safeinthecity.info/files/sitc/Brighton%20%26%20Hove%20Learning%20from%20DHR%20and%20NMR%20Implications%20for%20Practice.pdf

This is in no way to suggest that substance or alcohol misuse/abuse or the presence of mental illness meant that a person is likely to become a perpetrator of violence or abuse (as it is clear that the vast majority of people dealing with these issues are not) but simply that these factors might indicate a need to look more closely. They may also be indicators that a person is a victim of domestic abuse and so it is important not to jump to conclusions but rather to use professional curiosity to look at risk.

Amongst both perpetrators and victims, the presence of both substance or alcohol misuse and mental health issues was more common than either issues occurring alone. The Standing Together report also highlights this link and states:

'When responding to complex needs, agencies tend to focus on addressing mental health and substance misuse while missing the opportunity to identify and risk assess for domestic abuse, potentially the underlying drive for both issues.

Alcohol [misuse] and mental health have emerged as areas of concern for both victim and perpetrator – this cluster of issues should be recognised as an alert for domestic abuse.' (Pg. 10). This report also suggests that suicidal ideation could be used as a trigger to assess risk to others whether or not domestic abuse is already known to be occurring.

The West Midlands' report suggests that 'Addiction and mental health services should develop an assessment tool to identify potential perpetrators of domestic violence and have access to information about how to refer clients to appropriate services.'pg. 57[5]. All of the reports that were reviewed highlighted the need for these two service areas to work together in recognising the risks around domestic abuse for those they work with. Child Protection professionals have long been aware of the link between substance or alcohol misuse, mental health issues and domestic abuse – as well as the poor outcomes that these lead to for children present in the home. It is important that services share learning and good practice in this area.

The thematic review describes 'dumping' between services (though not specifically mental health or substance or alcohol misuse/abuse teams) and highlights the importance of services understanding each other's roles and responsibilities in order to work together to get the best outcome for the service user. One of the suggestions that came from the interviews was that a directory of Enfield services (all partners from the Safeguarding Adults Board could contribute to this – with the expectation that it should be kept reviewed annually) showing contact and referral routes for all services.

MULTI-AGENCY WORKING AND INFORMATION SHARING IN GENERAL

The Home Office report found a common theme (19 out of the 40 DHRs looked at) of agencies not understanding each other's roles and therefore not sharing information appropriately – concerns about confidentiality also caused issues. One quotation from the West Midland's report seems particularly apt; 'if the professionals are unclear about their roles and authority, the service users, who are vulnerable, will find it difficult to navigate through the services' pg. 21.

Throughout the reports, it is clear that ensuring agencies work together productively is a national issue and the consequences of poor communication can be devastating. This is a common theme in SARs and Serious Case Reviews as well.

The Multi-Agency Risk Assessment Conference (MARAC) would be a central information sharing point but it seems that several DHRs found that partners (particularly primary health care partners) were unaware of MARAC and the processes there.

Within the Enfield review, it was found that for higher risk cases referrals are made to MARAC. Where there are referrals for someone with vulnerability, who does not have care and support needs, a referral

5 This paragraph references 'Complicated Matters: A Toolkit addressing domestic and sexual violence, substance use and mental ill-health' by the AVA Project as an example of tools which may link the two services. https://avaproject.org.uk/wp/wp-content/uploads/2016/03/Complicated-Matters-A-toolkit-addressing-domestic-and-sexual-violence-substance-use-and-mental-ill-health.pdf

is made to Solace. This clearly shows that there is work to be done around educating all partners in each other's roles and resources. According to 2015-16 figures from the London Borough of Enfield's Community Safety Unit, Enfield has a low referral rate of 1.6% for disabled adults subjected to domestic abuse which demographically the figure should be 17%. Referral rates are increasing over time but there is clearly room for improvement through educating professionals – particularly those who come into regular contact with disabled adults such as primary health care and social care staff.

This is reflected in the reports around Domestic Homicide Reviews in that there is a repeated around professionals not being aware of (and not referring/directing to) local resources whether MARAC or services for lower risk cases. GPs are highlighted as professionals who may often be the first point of professional contact but also who may be unsure about what information they can share where adults appear to have capacity. Protocols need to be reviewed to ensure that they are particularly clear and robust in this area.

RECORD KEEPING

The Home Office report identified record keeping as a factor in 28 out of the 40 Domestic Homicide Reviews they studied. This heading included records that were poor (unclear, not including all the information known, mislabelled etc. etc.) and also those that were absent entirely. This had an impact on information sharing, multi-agency working and risk assessment (all also identified as key areas of failings). In the West Midland's report, it is noted that 'recording systems and working practices' were 'inadequate' in at least one case (with failings in information sharing and risk assessment in many more).

RISK ASSESSMENTS

Lack of consistent or competent risk assessment was a factor in 82% of the cases that the Home Office Report looked at. Problems included entirely absent risk assessments but also many risk assessments that were flawed by not taking into account all the information (some hampered by the correct information not being available or mislabelled and others by only assessing a single incident or injurious event rather than the on-going pattern of events/abuse and an understanding of the nature of coercive control). Whilst the West Midland's report does not highlight risk assessment as a specific area/heading, it does (as mentioned above) speak at length about the importance of risk assessment being done holistically and information shared across agencies in more than one section. There are, throughout the reports, examples of cases where the 'rule of optimism' is applied in terms of the behaviour of informal carers and a lack of response to changing circumstances/ lack of engagement – which should have prompted a further risk assessment leading to proactive action.

The Standing Together and Home Office report both raise issues with the DASH Risk Assessment not necessarily given a reflection of the level of risk in all cases – this may be because it is based on research on victims/survivors being women of child-bearing age in intimate partner (or former intimate partner) relationships, and therefore seeks specific answers about this area, whereas familial abuse has different characteristics and may therefore give an artificially low 'score' (for example a 74-year-old being abused by an adult child will not be pregnant). The Home Office and various bodies continue to research the best ways to assess risk. However this change will take time and (in its current form) the DASH remains a useful tool for evidence-based risk assessment and does allow for some consistency in our risk assessment when used with professional judgement to highlight additional vulnerabilities.

Issues with the identification and understanding of domestic violence and abuse.

The Home Office report shows 24 (out of 40 Domestic Homicide Reviews studied) had issues with the identification and understanding of domestic abuse. This included cases where domestic abuse was not recognised and considered as anti-social behaviour for example or perpetrators were not recognised because of their age or gender, where vulnerabilities of the service users were not recognised and where non-physical elements were not taken into account. Not taking non-physical

incidents into account shows a misunderstanding of the nature of domestic abuse and coercive control (discussed further below) which would lead to professionals having a false impression of the risks involved or impact of the victim. A lack of awareness may also lead to a lack of professional curiosity (as referred to in the West Midlands report). It is frequently recorded that victims of domestic abuse have minimised or not reported their experiences without specific safe and skilled enquiry. Without a skilled workforce within a multi-agency team which shares information appropriately, these people would not be recognised as at risk.

The Standing Together report particularly highlights lack of awareness in primary healthcare settings and amongst the community as a frequent failing in Domestic Homicide Cases.

As discussed above, we are aware that reporting figures for abuse against disabled adults in Enfield are lower than would be expected for our population. So it is likely that there is unrecognised abuse taking place and escalating risk.

CARERS AS POTENTIAL VICTIMS/SURVIVORS OF DOMESTIC ABUSE AND POTENTIAL PERPETRATORS

The Standing Together report, the West Midlands' report and the Thematic Review highlight the key issues in relation to carers who may be both victims and perpetrators, including domestic homicides. This shows the need for carers to have their needs assessed in their own right and for some form of risk assessment for their caring role in terms of identifying if there is abuse from either side of that relationship (it would then trigger more detailed assessment if any 'red flags' were identified). A brief review of the current Enfield Carer's Assessment pro forma shows that there are some questions which might highlight red flags and the need for further enquiry but these are not explicit and could be strengthened (as with all such tools they would also require the professional completing the form to have an awareness of domestic abuse issues) . As with all risk assessment, such assessments would need to be reviewed at times of change in circumstances or statutory review such as Care Programme Approach meeting (as used in Mental Health Services) or an annual care plan review (as used in other social services teams).

The West Midland's report particularly highlights the benefits of involving carers in discussions around their cared-for loved ones in terms of reducing barriers to reporting and also learning about changes to their condition.

SPECIFIC ISSUES AROUND THE IDENTIFICATION OF COERCIVE CONTROL

The Standing Together report states that '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' The Home Office report also talks about a tendency to deal with a case in light of a single injurious incident is a repeated flaw in both risk assessment and recording. A lack of recognition that such behaviour is part of the domestic abuse as an on-going pattern and experience for victims/ survivors is key to working well to address risk appropriately.

Identifying coercive control requires looking at patterns of behaviour over time – therefore appropriate information sharing between agencies and record keeping is again highlighted as vital.

Legislation of criminalising coercive behaviour (The Serious Crime Act 2015) is relatively new (although the phenomenon has been recognised for much longer) so it is vital that all relevant partner agencies have received training around what coercive control is, the law itself, and how it may impact on those experiencing it.

The Enfield thematic review highlighted that 'The link between coercive control and capacity was regarded as the biggest challenge for practitioners in dealing with DVA cases and sits at the heart of a positive response to an adult with care and support needs who is experiencing DVA.'

There are also issues around public awareness of coercive control which the Standing Together report highlights; given that the majority of survivors/ victims of abuse will confide in a friend or relative before a professional, it is vital that the public are educated and aware that this is abusive behaviour and how to seek support. The Home Office report further highlights the importance of this awareness as they identify 14 DHRs where family members were informed but either did not know how to report or felt they had to respect the wishes of the victim. Expanding public awareness of domestic abuse resources in general and coercive control in particular is therefore a key area for improvement – recent work has been done by the Community Safety Unit in this area.

SPECIFIC TRAINING AROUND HOW ADULTS WITH CAPACITY CAN BE SUPPORTED WITH DOMESTIC ABUSE ISSUES – TRAINING AROUND HOW ABUSE MAY AFFECT CAPACITY, COERCION AND THE TENSION BETWEEN CONFIDENTIALITY AND MULTI-AGENCY INFORMATION SHARING

The Enfield Thematic review made the following key point around capacity, 'The issue of capacity was seen by some to exclude people from getting assistance from Adult Safeguarding; it was the view of external agencies that 'most women, even those with serious mental health issues, are seen as having capacity and making a choice'. It is important to note that the statutory duty to safeguard adults at risk is not dependent on their capacity or otherwise (though it may affect the avenues of support available) and so practise needs to reflect this.

The Mental Capacity Act (2005) makes it clear that capacity is decision and time specific and case law is continually developing that encourages professionals to look at duress as a factor in the ability to make decisions. Whilst having capacity to make decisions in relation to a perpetrator should not bar a person from accessing social care services; it is important to note that capacity itself is something that needs to be assessed holistically by experienced professionals and assumptions should not be made in this area.

The term 'mental capacity' is not used extensively within the DHR reports (perhaps because this is relatively specialised language and this highlights the different language and structures which may be used around domestic abuse as opposed to Safeguarding Adults) ; however, it is an implicit thread during sections about information sharing with or without consent.

ENFIELD THEMATIC REVIEW KEY CONCLUSIONS

Domestic Violence and Abuse (DVA) is increasingly starting to be considered an issue for those with care and support needs compared to past professional practice, which tended to focus on the health needs of the individual rather than also considering its underlying causes. Enfield has responded positively to fulfil its statutory and legal duties required of local authorities under the Care Act 2014, through the development of local procedures, guidance and processes. The requisite parallel structures and processes for DVA are also in place. In general, positive developments were reported in the progress towards safeguarding adults against abuse. The recent introduction of the Multi-Agency Safeguarding Hub has been positively received across agencies. However, a number of challenges also remain in practice in responding to adults with care and support needs who are experiencing DVA. Overall, the review indicates that practice across the range of teams and agencies is variable, sometimes betraying a lack of a joined up responses. Historically, the two areas – adult safeguarding and DVA – have developed as separate arenas of practice and making the link between the two remains a challenge for many though many positive developments have occurred in Enfield to close this gap. In general, it is widely established that DVA among adults with care and support needs is both under-recognised and under-reported.

Remaining and on-going challenges can be broadly grouped as structural (limited and oversubscribed resources; compartmentalised practice), knowledge based (understanding and skill of practitioners) and attitudinal (negative views and assumptions).

STRUCTURAL CHALLENGES

- Multi-agency and partnership work, especially with DVA specialists, is crucial in responding to DVA and adults at risk. This has consistently been highlighted in Safeguarding Adults Reviews and in Domestic Homicide Reviews. However, although most agencies are engaged in multi-agency work to respond to DVA and adults at risk, inter-agency working within the borough was said to require further strengthening, including greater understanding among all agencies about each other's remit. There also appear to be low referrals both to Solace and to MARAC and the need to generate more referrals was recognised by some agencies. It is also the case that specialist services for DVA were regarded to be 'oversubscribed' and voluntary and community sector groups increasingly impacted by the cuts in funding.
- GPs are a first point of contact for both victims and perpetrators, and thus are critically placed to identify DVA and to make referrals to other important services. NICE has produced guidance for health and social care professionals which underlines the importance of enquiry about DVA in situations of repeat visits of accidental injuries, alcohol or drug issues, history of depression and anxiety, failure to cope and social withdrawal. Although a response from primary care is not included in the review, this is an area that requires consideration in responding to adults at risk and DVA.
- A lack of resources was widely cited as a barrier to positively responding to adults at risk and DVA. These include limited dedicated support services and provisions for victims of DVA, including for those who have no recourse to public funds.
- Services, albeit over-stretched, are in place for female victims (which tend to be under-accessed by older and by disabled women) and their children but services for male victims and for disabled people are extremely thin on the ground.
- Interventions for perpetrators, including carers, are virtually non-existent in the borough with the exception of probation, which only deals with those going through the criminal justice system. This makes it difficult to support victims who continue to live with perpetrators who were not receiving any help.
- Cuts in services have also impacted on the ability of some to respond to those affected by DVA, with a major concern being the high thresholds that had to be met before individuals could access support within mental health services. This left many who needed services without support, not least because of the absence of therapeutic services that can help those at risk at an earlier point.
- A lack of co-ordination within Adult Safeguarding teams was also indicated and a reported practice of 'dumping' on other services rather than working together to find solutions.
- Currently, some key partner agencies and teams are not integrated into MASH – DVA services and mental health – creating concern that adult issues are not given the same priority as children.
- Some groups of women, such as those who are physically disabled and those with mental ill health who were deemed to have capacity, were perceived not to be receiving an equal service.
- Work remains to be done on recording statistics for DVA and adults at risk cases.

KNOWLEDGE-BASED CHALLENGES

- Despite the existence of systems and processes, some practitioners lack the depth of understanding about the nature of DVA, why it occurs and why victims remain in abusive relationships. Responses of some were said to betray a reluctance to go beyond the basic responses required. DHRs show that this is a key barrier to effective risk assessment and management.

- Current DVA risk assessment tools have been developed from research on intimate partner violence (though limitations of these have also been aired) and since the current government definition of DVA conflates intimate partner violence with that by family members, these are also used in family violence situations. Clearly, the dynamics of IPV and family violence differ and it is likely that this may not be 'neat fit' and professionals may not be using the most appropriate tools and thus assessing risk appropriately.
- Professional responses are targeting single issues/single incidents rather than the range of issues presented by an individual. This results in an absence of joined up holistic responses to the person.
- It was evident that agencies are starting to address the issue of coercive control, especially through training (though DVA training is not mandated for Adult Social Care staff), and its impact on capacity to make decisions. However, taking account of coercion and control was considered to be still challenging. While some practitioners understand this well and adopt it into their practice others require further practice development. Issues of emotional co-dependence, victims protecting their children or grandchildren and elderly couples making choices to remain with each other were reported to be difficult to deal with when victims were deemed to have capacity.
- The area of carer assessment requires further development. Although they are largely being done, assessments rarely include conversations about the risk of harm from the person they care for or about the risk of harming.
- Responses to the complexity of different communities were under-developed and examples were provided where practitioners had been ill-informed in their responses.

ATTITUDINAL

- Some responses were said to minimise victims' experiences of DVA and betray a reluctance to dig deeper into the issues and accept accounts at face value.
- Some staff within Adult Safeguarding still 'blame the victim' and fail to comprehend the complexity and nuance of intersectional barriers. Negative views about women still exist such as judgements about women as 'bad mothers' rather than understanding the impact of DVA on their mothering capacity and the role of the perpetrators in undermining women's mothering.
- Practitioners were reported to show a reluctance to challenge issues of power and control in Black Minority and Ethnic cases and reduce them to 'cultural' issues.
- In the absence of carers' assessments, collusion with the perpetrator can take many forms. Although services were considered to focus on the person rather than the carers, an over-reliance on the assumption that carers had the person's best interests at heart was seen to be common among services.

KEY RECOMMENDATIONS FROM THE THEMATIC REVIEW AND ANALYSIS OF DOMESTIC HOMICIDE REVIEWS

Recommendations made by the thematic review are listed first and then followed by those arising from the Domestic Homicide Review. The recommendations have been translated into a more detailed action plan by the Board's Working Group. It should be noted that the Thematic Review took some time to complete and so some practise has developed over that time. The review also did not incorporate the Domestic Abuse Strategy.

The Home Office report clearly identified that, across 40 Domestic Homicide reviews and 600 separate recommendations, training was the key mechanism for improvement suggested. It is worth noting that, at the moment, domestic abuse training is not mandatory for Adult Social Care staff and it may be helpful to review this for all partner agencies.

The thematic review strongly identified that there is a need to strengthen front-line practice with regard to adults at risk and DVA:

- Despite training, it is known that professionals' use of risk assessment tools can be inconsistent which can impact professional judgement about the risk posed. It is important therefore to ensure that, along with general training on Adult Safeguarding and DVA, all professionals are trained in identifying risk and conducting a risk assessment. Within this, the importance of nurturing an understanding of non-physical coercive and controlling behaviour and the risk this poses to victims is crucial. Professionals need to recognise the potential they have to enable victims to recognise how coercive control limits their freedom and decision-making.
- Just as with carer assessments, the importance of regularly assessing risk at 'critical points' also has to be considered as good practice.
- Training should be delivered on safe enquiry in different agency settings and staff encouraged to develop this practice as laid out in the NICE guidance.
- Targeted training to GPs on adult safeguarding should also be developed and should include guidance on routine enquiry, accurate record keeping, information sharing, and referral pathways.
- Training should also include the multiple issues and intersectional barriers faced by particular groups – such as older and disabled and people from BME communities – and links made between institutional forms of oppression.
- Further training on coercive control for all across the range of agencies including focused learning events, which draw on cases in the borough.
- An on-going/rolling programme of multi-agency training on safeguarding adults and DVA throughout the borough to improve responses. Training should encompass: a one day training course dedicated to adults at risk and DVA issues; a focused multi-agency case focused workshop to develop practice and multi-agency relationships.
- Focused capacity assessment for DVA and learning from cases of adults who had mental capacity but were experiencing duress where the 'Inherent Jurisdiction of the High Court' was used by Councils.

Further recommendations following Enfield multi-agency Roundtable and DHR reports analysis:

- Enfield Safeguarding Adults Board partners to consider mandatory Domestic Abuse training to incorporate risk assessment using the DASH tool but also to highlight the importance of professional judgement. Agencies should be aware of materials that have been developed to support better risk assessment – for example, the Safelives website at www.safelives.org.uk/knowledge-hub. The effectiveness of such training to be audited via the dip-sampling of practice suggested below.
- Relevant partner agencies to work together to produce a tool to quality assure/ assess case recording in order to ensure consistency between agencies.
- Relevant partner agencies to dip-sample risk assessments and reviewing internal quality assurance and performance management measures.
- Relevant partner agencies to dip-sample general case recording to quality assure that issues of domestic abuse are being recorded and flagged as such.
- Additional promotion of the MARAC meeting/functions amongst social care and health staff as well as the referral routes and options for those deemed to be at medium/low risk.

There is a need to strengthen multi-agency working and responses:

- Multi-agency protocols which outline clear referral pathways, information sharing and partnership work expectations.

- Dr. Thiara and Dr. Harrison's report clearly found that 'Where women were supported by a DVA agency, they saw this as a turning point in their lives and were extremely positive about the support they had received.'. This highlights the need for all partner agencies to be very clear about the way to refer and work with such services – even in cases where the adult at risk might not meet thresholds for other services.

- Missing key partner agencies and teams to be integrated into MASH – DVA services and mental health.
- Adult social care and mental health teams to work jointly with DVA agencies and IDVA on cases of DVA.
- To strengthen the response of mental health services, consideration be given to placing a dedicated IDVA within mental health.
- Given the issue of high thresholds, referral pathways should be established locally for those who may not be statutorily 'vulnerable' and do not meet the threshold for adult safeguarding but who would benefit from early intervention. Clear referral pathways for GPs also need to be developed.
- In partnership, the possibility of a specialist service for lower level mental health concerns should be explored.
- Confusion among agencies about each other's roles and parameters, including the role of primary care in supporting DVA and mental health issues, requires work within multi-agency for a to ensure greater understanding among all key player.
  - All relevant partner agencies to provide clear and concise information about their services remit, referral pathways and contact details. Such information can then be collated and distributed amongst partners to ensure the information is on hand. An annual review process will need to be established via the SAB in order to ensure that the information stays up-to-date.
  - All partner agencies to conduct a review of their training around domestic abuse to ensure that it covers safe enquiry, proper risk assessment, coercive control, inherent jurisdiction and the effects of duress on capacity (where such elements are relevant to the work undertaken by their staff). Some agencies already have this in place whereas others may have more work to do.
  - A specific Task and Finish group to be put together with key personnel from The Barnet, Enfield and Haringey Mental Health Trust, the Drug and Alcohol services, the Community Safety Unit and other key partners identified through MARAC to look at how cases are processed where there are complex needs that involve these services.

The possibility of reviewing and strengthening carer assessments and developing a pathway for perpetrator work:

- Caring contexts create pressure for carers as well as facilitate abuse by the carer. Local authorities have a duty to assess a carer's needs in order to maintain their well-being. To identify the risk posed by the carer and to the carer, carer assessments are paramount. In line with the Care Act, strategies should be developed for carer assessments (unpaid carers who may or may not be in receipt of carers allowance) to be routinely done to address the carers' mental health needs and to ensure they are not placing themselves and/or the person cared for at risk; and to provide information about where help and support could be obtained.
- A joint approach to perpetrator work between Children and Adult Safeguarding would enable resources to be maximised including the development of specific programmes for carers who are perpetrators.
  - The Strategic Safeguarding Adults Team and Community Safety Unit in the London Borough of Enfield are currently completely a bid to the Better Care Fund in order to provide a Perpetrator pathway/programme which services within the borough to refer to. The first stage of this work would be an in-depth needs analysis for all partner agencies and teams within the London Borough of Enfield and the aim would be to establish an on-going perpetrator programme by Quarter 3-4 of 2017/8.

- The London Borough of Enfield to ensure that risk of abuse (both towards the cared-for and the carer) is incorporated into Carer's Assessments – the current template incorporates some questions which may indicate risk but this could be made more explicit – and that those who conduct these assessments have training around Domestic Abuse issues so they can recognise these indicators.
- In line with previous recommendations, clear referral pathways and information to be available to all who work with carers with targeted work/training taking place with the Carer's Centre and specialist Carer's workers within Enfield.

Service responses to be survivor informed:

Explore mechanisms for successful consultation and feedback with adults at risk about their experiences of support and interventions:

- This piece of work was hampered (as others have been) due to the difficulty involved in gaining feedback from service users around professional input in distressing situations – as many service users decline to speak with professionals after the piece of work is finished. The Service-user, Carer and Patients' Sub-Group of the Safeguarding Adults Board should consider a piece of work around reviewing how such feedback is asked for and how we can strengthen this work (currently undertaken with HealthWatch Enfield in regard to general Safeguarding Adults) given the importance of service user views and experiences.
- There has regrettably been some delay in the publishing of this report this has been due to a variety of key changes in personnel and a focus on implementing the SAR action plan. Completing the overview of this themed DV SAR and using the recommendations and conclusions with other findings from the Home Office analysis took much longer than anticipated.
- We are pleased to say that the Working Group that was convened looked at the actions and recommendations from this report and a number of the recommendations have been incorporated into the Violence Against Women & Girls (VAWG) action plan.

Strategic Safeguarding Adults Service
Health, Housing and Adult Social Care

February 2019

ENFIELD Council