Professional Curiosity

Sharing the learning from Safeguarding Adults Reviews and Children's Serious Case Reviews where domestic abuse has been present.

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Aims and Outcomes

Aim

To build relationships between organisations; to share information and increase knowledge about the risk that Domestic Abuse (DA) poses for keeping both children and adults safe.

Outcomes

Examined key themes and learning arising from Serious Adult Reviews (SAR) Serious Case Reviews (SCR) and Domestic Homicide Reviews (DHR).

Considered how to utilise the learning from these reviews to influence your organisation and your own safeguarding practice.

Explored the impact of Domestic Abuse on the whole family .

A clearer professional understanding of Coercive Control.

Considered the importance of employing professional curiosity to see beyond just an 'isolated' incident

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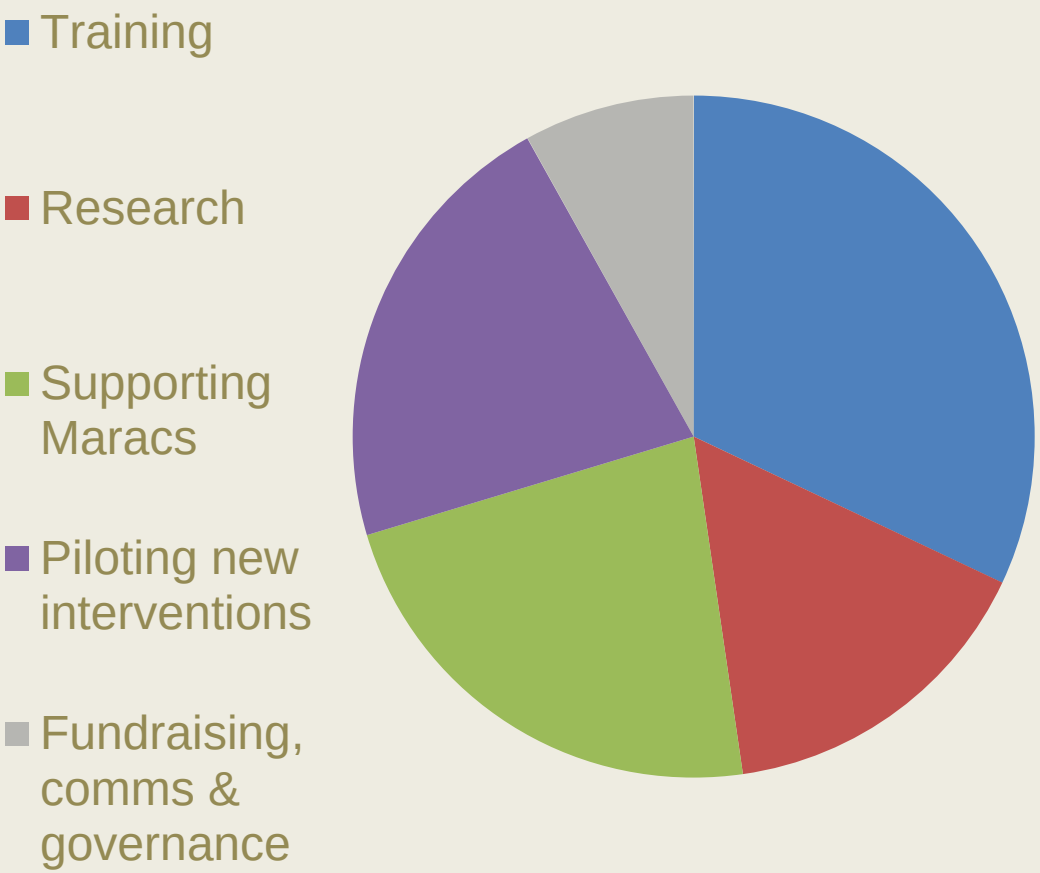
Domestic Abuse & Safeguarding

Suzanne Jacob and Lucy Giles

2nd March 2018

What we do



1,800
Idvas trained

289
Maracs supported

43,000
Cases in our research database

50
Services using our Insights data tool

Ending domestic abuse

About West Yorkshire

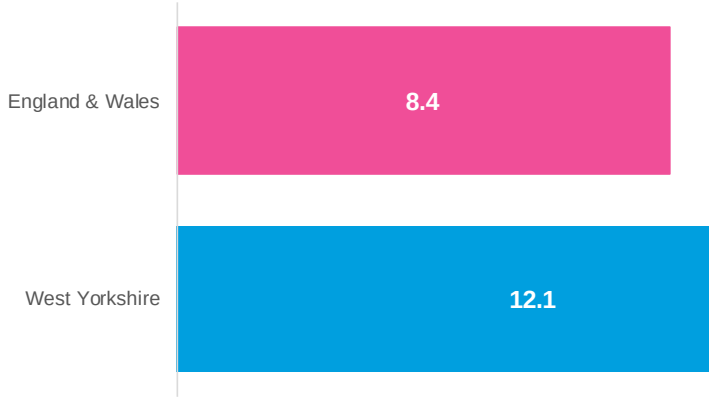
	West Yorkshire	National
Number of Maracs:	4	289
Number of cases discussed:	4,766	88,740
Cases per 10,000 adult females:	62	35
Repeat rate (%):	38%	27%
Number of Victims (no repeats)	2,935	64,610
Number of children (minus repeats)	3,899	83,163

Source: SafeLives Marac Dataset - October 2016 - September 2017

Local Idva Provision from SafeLives	
Idva Count 2016	24.7
Recommended Idva	49
Proportion of FTE Idvas in place	51%

Source: SafeLives Practitioner Survey 2017

Reports to the police regarding Domestic Abuse per 1,000 population



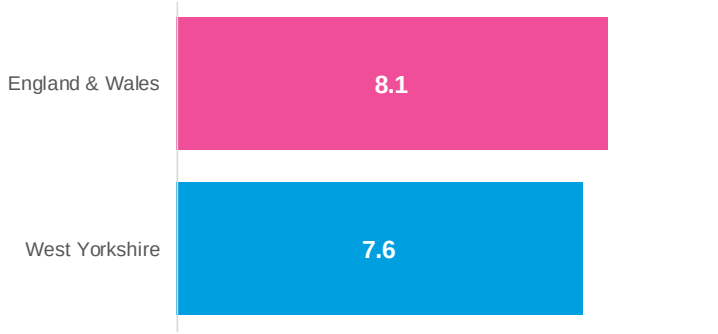
6.1% of the local population are estimated to have experienced abuse in the last year
7.6% of the **Female** population
4.5% of the **Male** population

Source: ONS Police Crime Survey 2016

Between March 2016 and March 2016 there were **24** Domestic Homicides in **West Yorkshire**

Source: ONS Police Crime Survey 2017

% of Females who were victims of Domestic Abuse in 2015 / 2016

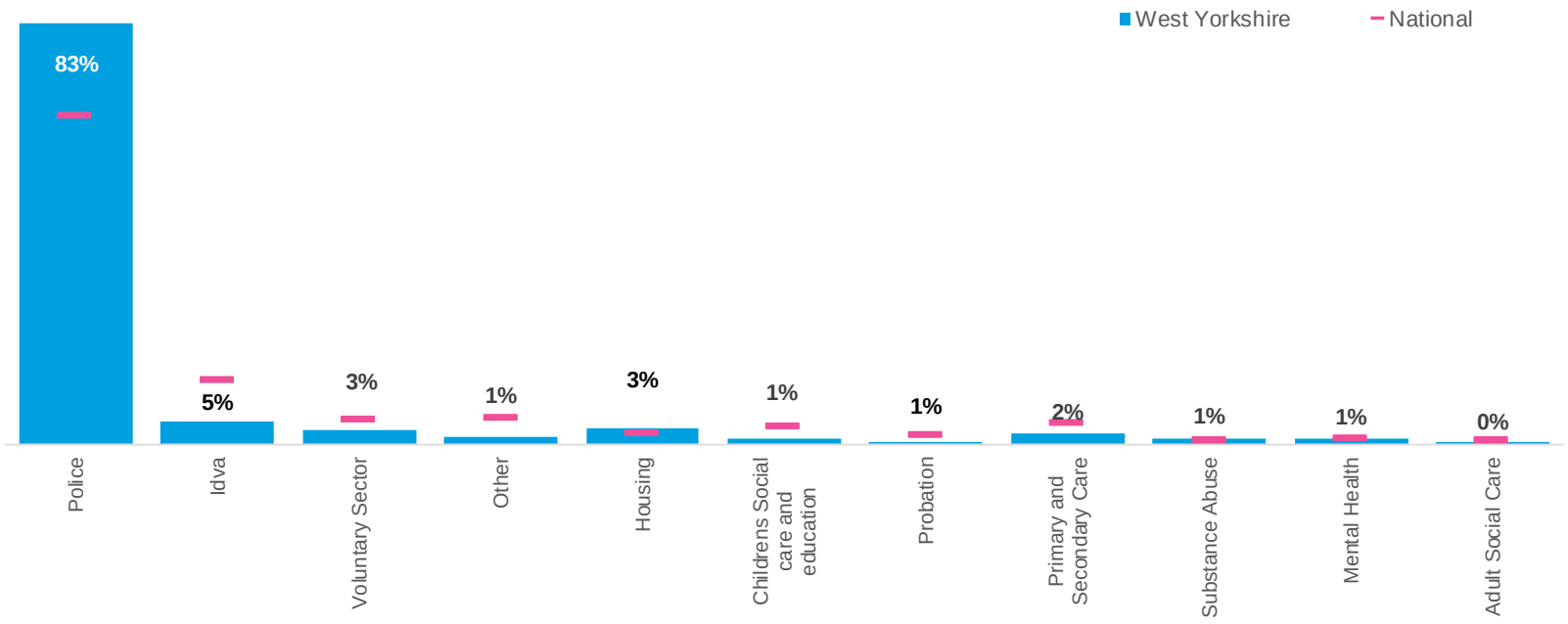


Ending domestic abuse

Marac Diversity Statistics

	West Yorkshire	National
B&ME population	17.9%	18.2%
B&ME cases	14.7%	16.1%
LGBT cases	0.9%	1.0%
Disability cases	2.8%	5.7%
Male cases	5.0%	4.7%
Young victims	1.4%	1.5%

Most Common Referral Routes to Marac



Source: SafeLives Marac Dataset - October 2016 - September 2017

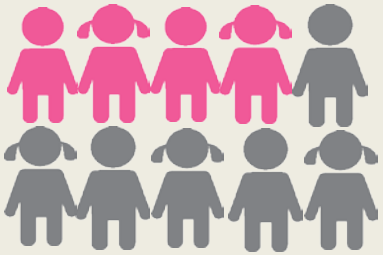
Domestic abuse overview

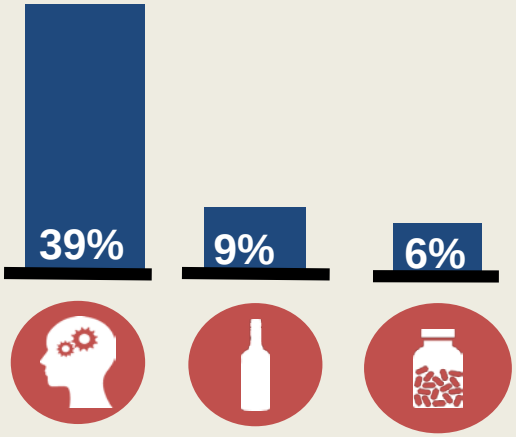
- Around 2.1 million people suffer from domestic abuse in England and Wales – 1.4 million women (8.5% of the population) and 700,000 men (4.5% of the population).
- Two women a week die at the hands of their partner or ex-partner.
- 85% of victims made five attempts on average to get support from professionals in the year before they accessed effective help to stop the abuse.
- ONS doesn't currently collect statistics for over 60s though this will change this year.
- SafeLives estimates that approximately 120,000 individuals aged 65+ have experienced at least one form of abuse (psychological, physical, sexual or financial).
- Only 3% of victims aged 60 or over are accessing Idva services supported by the Marac model

Ending domestic abuse

Data tells us:

Nearly **40% of children** in households where domestic abuse was taking place were **not known to children's services.**





39% of **victims at high or medium risk of domestic abuse** have mental health issues, 9% have substance misuse issues and 6% drug misuse issues.

The overwhelming majority of children exposed to abuse (96%) were **often at home** when the abuse took place, and 88% **witnessed the abuse directly**. In a quarter (26%) of cases the **child tried to intervene** to stop the abuse.

Of those children who were directly harmed by a parent or family member, 89% experienced **emotional abuse**, 25% were **neglected** and 6% were **sexually abused**.

Ending domestic abuse

Multi Agency Risk Assessment Conference (Marac)

At the heart of a Marac is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety.

A victim identified at high risk of serous harm or homicide needs a coordinated, multi-agency response with all agencies sharing relevant information to develop an action plan that is comprehensive, robust and addresses the risk to all parties.

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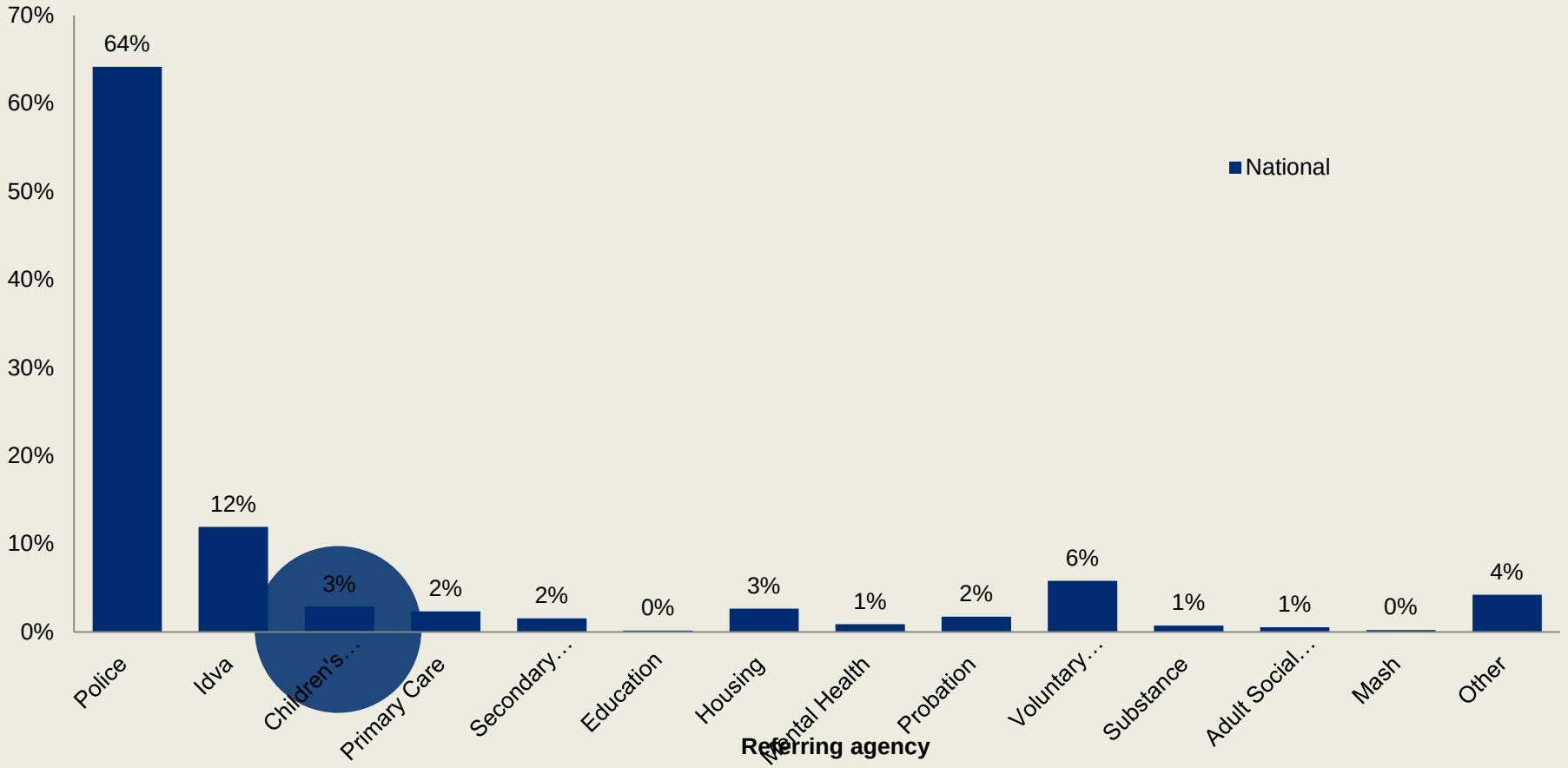
Marac Data: Referring agency data for 2015



This is a very small number, given we know 130,000 children are living in houses with high-risk abuse

Ending domestic abuse

Key Recommendation

Adult Social Care – Core agency at Marac

Duties on Local Authorities

- **The Care Act 2014** states that adult safeguarding "means protecting an adult's right to live in safety, free from abuse and neglect" (s14.7)

- (s14.2) The safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs) and; Is experiencing, or at risk of, abuse or neglect; and; As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect

- Local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria at paragraph 14.2 is, or is at risk of, being abused or neglected." Care Act (2014)

Adult Safeguarding

DL v A Local Authority 2012

"The jurisdiction is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by reason other than mental incapacity because:

a) They are under constraint
b) Subject to coercion or undue influence
c) For some reason deprived of the capacity to make relevant decision
d) Or disabled from making a free choice
e) Or incapacitated or disabled from giving or expressing a real or genuine consent

What our data tells us

80% of older adults are **not visible to services**

Out of those who are visible, ¼ live with abuse for **more than 20 years**

Eight clients aged 60+ (4%) were referred by adult safeguarding. This is an increase from 2% aged 60+ in 2015/16

While the majority of older clients are female there are much higher proportions of older men also experiencing abuse (16%) compared with those under 60 (4%)

What our data tells us

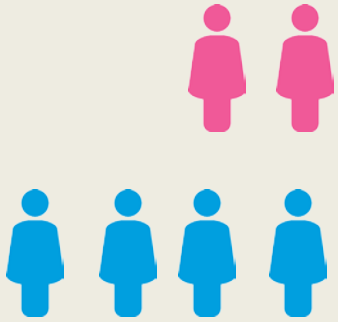
Older clients are much more likely to experience abuse from an adult family member (44% - 6%) and are twice as likely to be living with the perpetrator of their abuse (40% - 28%)

Older clients have a lower level of complex needs in terms of mental health and substance misuse, but are much more likely to have a disability/dependency issue (48% over 61 – 13% under 61) For a third, this disability is physical (34%).

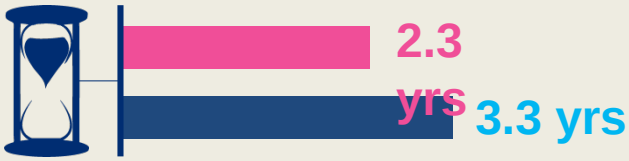
Perpetrators of abuse on those over the age of 61 were less likely to have a criminal record compared to those in the national dataset.

What our data tells us

Disabled women are twice as likely to experience domestic abuse than non-disabled women

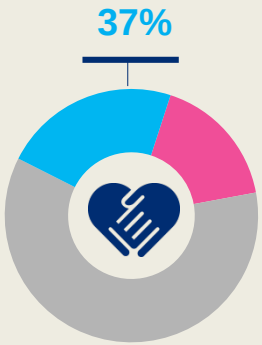


Disabled women experience **more frequent and severe abuse over longer periods of time.**

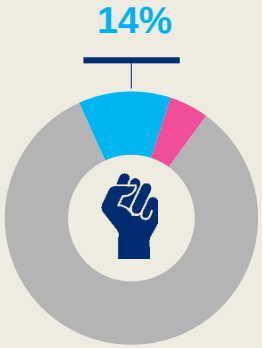


What our data tells us

Disabled victims are more likely to be suffering abuse from a **current partner** (**37%**) than non-disabled victims (**28%**).



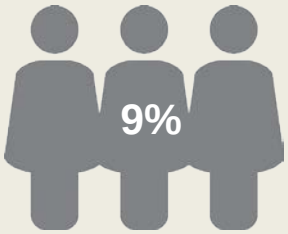
Disabled victims are more than **twice as likely** to be experiencing abuse from an **adult family member** (**14%**) than a non disabled client (**6%**)



What our data tells us

Number of high risk victims of DV that are **not being identified**

Of the **925** referrals into domestic abuse services**, 0 were from Adult Social Care**



Only 9% of disabled victims **accessed** adult safeguarding services, despite experiencing high risk abuse even after receiving domestic abuse support.

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What have the Spotlight experts highlighted further

Specialist DV Services, Disability Experts and Academics:

(Public Health England, DeafHope, Talking Mats, Dr. Ravi K Thiara, Stay Safe East, Standing Together Against Domestic Abuse, Dr Michelle McCarthy)

- Perpetrator's use their positions as carers to **coerce and control** disabled victims and others.
- Disabled victims experience **the same forms of domestic violence**, but their **disabilities are also** used as a means of **coercion and control**.
- **Society ignores that disabled people experience domestic violence** and does not target DV education towards disabled people-especially regarding sexual violence and abuse.
- Learning disabilities go particularly **unidentified** as a vulnerability and domestic violence services do not know how to meet the needs of disabled victims, particularly those with learning disabilities.

The Reality…….

Professional Involvement is not the same as engagement. Just because another professional is involved with a child's case does not mean that they are proactively engaged with protecting the child. The danger is that we assume that if a child has a social worker, they are being protected; or if a police officer visited the house after a domestic violence incident, the child is safe. Always check information out – children are best protected when information is clearly shared across the professionals involved and action is coordinated. Never assume that someone else is doing something when you have a cause for concern – two professionals taking action is better than no one taking action at all. [SCR Daniel Pelka 2014]

A theme in this review is the extent to which Hamzah was unknown and invisible to services throughout his short life.

Men remain largely invisible to services that work with vulnerable children even when their behaviour as in this case is one of the sources of concern and risk for children;

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SafeLives

Child J's **needs and vulnerabilities as an adolescent** were at times poorly understood, and agencies were often unable to help her access their services. The numbers of professionals involved with her was sometimes actively unhelpful and there was inadequate thought given to her relationship with key professionals and how this could be developed, or how those key professionals could be better supported.
Too often **Child J** was viewed as a difficult young person and not recognised as a **child in need of safeguarding.**

DHR/SCR Child J (Oxfordshire 2016)

The most important message from them was that the police and Children's Social Care should **focus less on the victim as just the mother of the children but see the picture as a whole** and focus their work on controlling the perpetrators of violence and abuse. The victim was a young woman in a relationship where the family had had concerns about her welfare all along yet they felt that their concerns had been minimised and they had not been listened to.

DHR: BDHR2012/13-04

Coercive and Controlling Behaviour

Perpetrator repeatedly or continuously engages in behaviour that is controlling and coercive **AND**

At the time of behaviour the perpetrator and victim are:

In an intimate personal relationship **OR**

They live together and are either members of the same family OR

They live together having been in an intimate personal relationship with each other **AND**

The behaviour has a “serious effect” on the victim and

The perpetrator knows or ought to know that the behaviour will have a serious effect on the victim.

Two ways to commit the offence

If it causes the victim to fear on at least 2 occasions, that violence will be used against them **OR**

If it causes the victim serious alarm or distress which has a substantial adverse effect on their day to day activities

Defence and Penalties

We need:

To understand the whole picture for an individual and family, to give an effective response

People with lived experience tell us:

> No one understands what's happening for us as a family. We have 8 different workers in our house but each one cares about something different.

> I'm a person. I don't fit in to one of your categories.

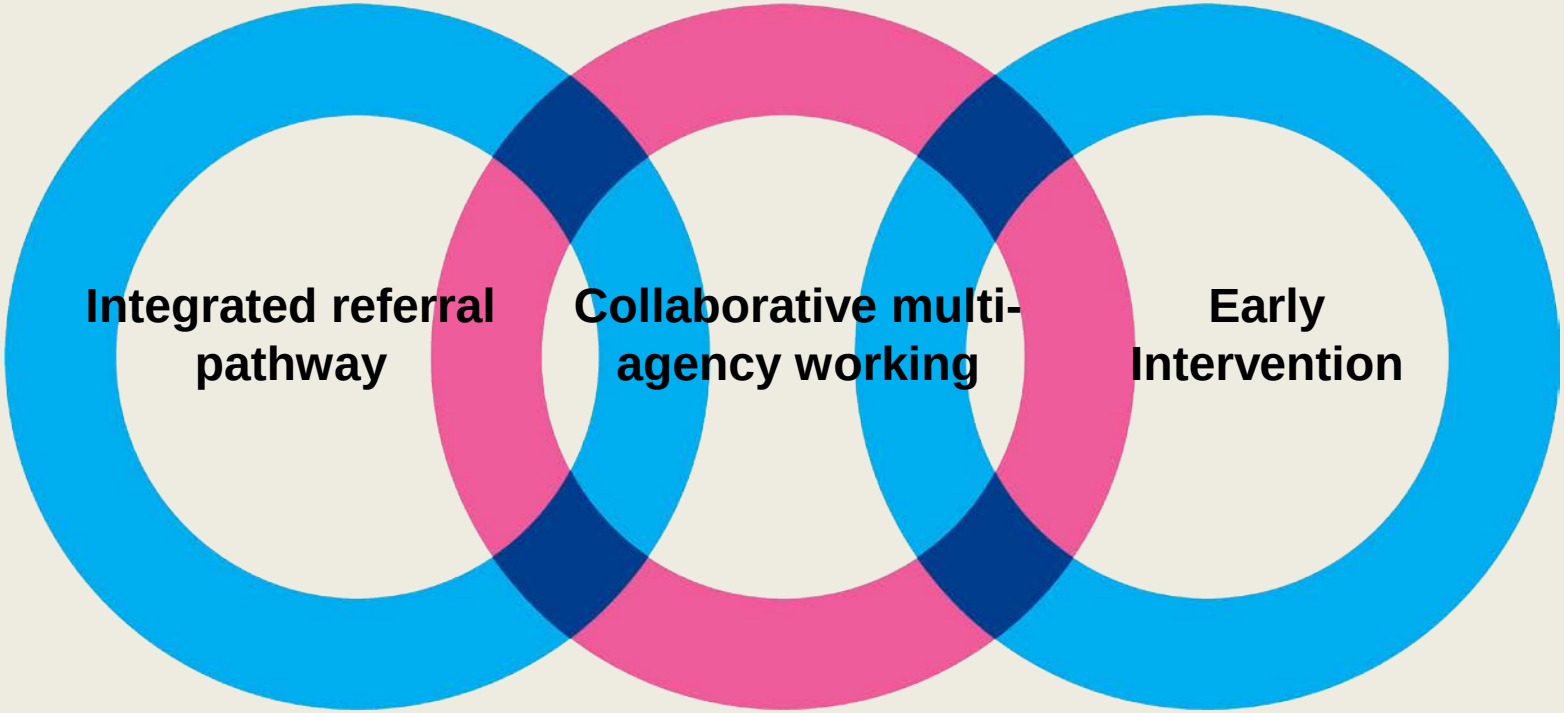
Ending domestic abuse

What about Multi-Agency Safeguarding Hubs (Mash)?

What's different:

- The One Front Door is a whole family response
- The full model will see a single point of access for all vulnerabilities
- The OFD will share information AND expertise
- Look at associated people who may pose a risk including ASG

One Front Door



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One Front Door - the pathway

1 **A safeguarding concern** is identified for any family member

2 They are referred to the **One Front Door** team to research, who check relevant information on them and their family

3 Each family member is assessed and assigned a **BRAG rating**

- High risk
- Medium risk
- Standard risk
- Low or no risk

4 Any action taken follows the timescale of the **highest risk** identified

- Multi-agency or strategy meeting
- Statutory or voluntary agencies
- Advice and information

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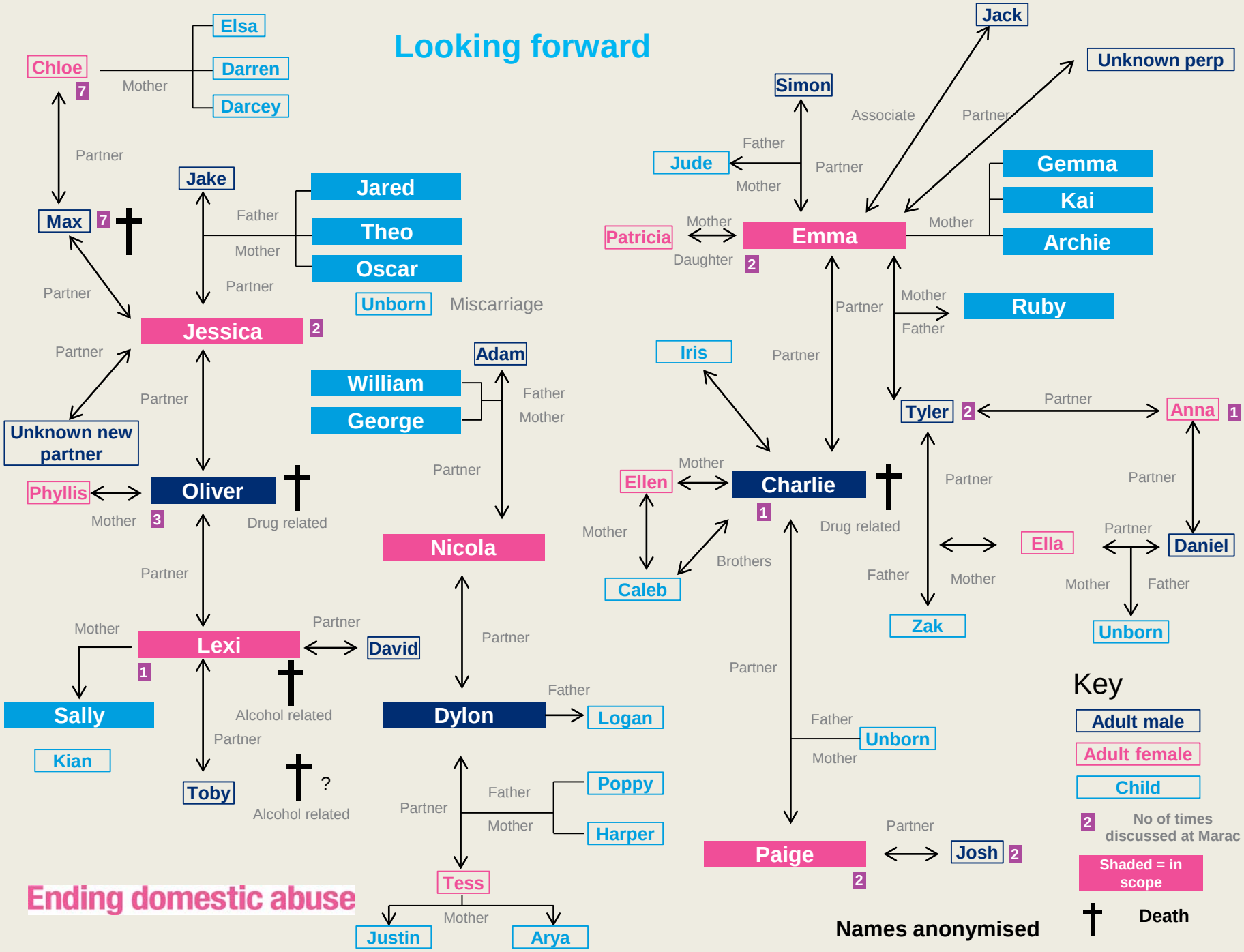
Looking forward



3. Why we need a new approach

Summary of agency involvement: Findings from a death review of two domestic violence perpetrators	
5	Deaths – we found 3 connected deaths (2 suicides) in addition to the 2 who were subject to the review
14	Children placed on child protection plans
3	Children adopted
2	Looked after children
14	Children living with family members other than mum (either grandparents, aunt or father)
15	Referrals to Marac
25	Ambulance call outs (based on information from other agencies and Marac only)
30	Police incidents (based on information from other agencies and Marac only, so generally domestic abuse or child protection incidents)
2	Sections under the Mental Health Act
1	Hospital detox for 7 days
24	Children identified as being linked with the 4 main adults
26	Adults identified as being linked with the 4 main adults
188	**Total number of known interactions/referrals with agencies**

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[1] Based on information gathered from those individuals who were in scope of the review

SafeLives is listening

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Facebook.com/safelives.uk
lucy.giles@safelives.org.uk

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Serious Case Review and Domestic Homicide Review

Gill Poole

Nurse, Health Visitor, Senior NHS manager, Senior Nurse Child Protection, Chair Safeguarding Adult Board

Hull

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Background

- Brain injury 2008 / 2009
- Moved in with brother and partner – no contact for previous 20 years
- West Yorkshire Police and Kirklees Children's Services records
- Social care and carers assessment 2014
- Safeguarding alerts February 2015
- Death March 2015

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Lessons Learned

- Need for timely, adequate and proportional assessment
- Understanding of Mental Capacity Assessment and Best Interests
- Importance of robust management oversight
- Reflective supervision evidencing challenge and effective practice
- Validation of information provided on behalf of service users
- Safeguarding adults at risk is everyone's business
- Links between children and adults services

Conclusions

- Ensure Mental Capacity awareness is embedded in practice
- Person Led Assessment linked to assessment of Mental Capacity
- Evidence of registered Enduring Power of Attorney, Lasting Power of Attorney or Deputyship is established and recorded appropriately
- Review information sharing protocols
- Safeguarding adults training includes response to domestic violence and interpersonal abuse

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Key Learning

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Sharing The Learning.

March 2018

Peter Ward

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Case Overview

- Only child;
- Parents;
- Planned pregnancy;
- After death the child was found to have had numerous significant injuries.

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Services Involved

- Midwifery Services
- Family Nurse Partnership
- Leaving Care Worker for father
- Police
- Hospital
- Children's Social Care Duty Team

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Professionals' View of Parents

- Settled Relationship;
- Excited about becoming parents;
- Mother was quiet and passive;
- Father dominant;
- At no stage did agencies have concerns that the child was at risk.

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Engagement with Services

- Good through pregnancy and first two months of child's life;
- Less good after this;
- Cancelled appointments;
- Child not seen by family nurse during last nine weeks of life.

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Domestic Abuse

- Under reported;
- Reactive & Pro-Active opportunities missed;
- Recognition, reporting and sharing;
- Asking mother about domestic abuse;
- Not prioritised because not concerned.

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Engagement with Father

- Positive;
- Presents Challenges;
- Why? – Possible Coercion & Control;
- Father's role;
- Addressing concerns.

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Professional Curiosity

- Why was father always present?
- How did baby sustain a mark to face?
- Why did level of engagement reduce?
- Why was child not available to be seen on some visits?

Why?

- Rule of Optimism;
- Failure to Reassess;
- Fear of Further Disengagement;
- Organisational changes.

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Summing Up

- Identification and sharing of Domestic Abuse;
- Asking mothers about domestic abuse;
- Injuries to non-mobile infants;
- Professional Curiosity & respectful uncertainty;
- Be prepared to change your mind;
- ngage r tha

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Domestic Homicide Review

‘Corrinne’

DAVID HUNTER

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Family Structure

Corrine	Victim
Mark	Perpetrator
George	Ex-husband of Corrine
Edwina	Ex-partner of Mark
Child 1	Child of Corrine and George
Child 2	Child of Corrine and George
Child 3	Child of Mark and Edwina
Child 4	Child of Corrine and Mark

Domestic Abuse History between Corrinne and Mark

Incident One-Mid December 2013

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Medium Risk

There are identifiable indicators of serious harm. The offender has the potential to cause such harm, but is unlikely to do so unless there is a change in circumstances, for example failure to take medication, loss of accommodation, relationship breakdown, drug or alcohol misuse.

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Domestic Abuse History between Corrinne and Mark

Incident Two-Late December 2013

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Lessons

- There is a need for all forms of domestic abuse to be recognised and acted on in accordance with agency policies.
- There is a need to recognise when it is necessary to make a referral to agencies so that victims can be supported
- Not recognising the links between domestic abuse and child protection could leave children vulnerable of further exposure to domestic abuse.

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Lessons

- Supervisors who allow inappropriate actions by officers to go unchecked perpetuate their mistakes and miss development opportunities.
- Many victims of domestic violence are in partnerships where alcohol and drug dependency together with mental health needs exist.
- Victims may present, on face value, as being calm and in control. This might lead to incorrect assumptions, that the victim is capable of managing the situation and does ot requir

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KEY FINDINGS FROM ANALYSIS OF DOMESTIC HOMICIDE REVIEWS

Home Office December 2016

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Themes mentioned in intimate partner homicide reviews

Theme	National	Corrine	13 DHRs
Risk factors and assessment	✓	✓	✓
Information sharing between agencies	✓	✓	✓
Identifying and understanding abuse	✓	✓	✓
Organisation policy	✓	✓	✓
Competence, knowledge and skills	✓	✓	✓
Referrals	✓	✓	✓
Public awareness	✓	✓	✓
Drugs, mental health and alcohol	✓	✓	✓

The Big Three Are:

- Competence, knowledge and skills
- Communication
- Risk assessment
- What risk is missing?

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Coercion and Control

Age Groups	Offenders in Group	Victims in Group
11-20	1	1
21-30	7	7
31-40	6	7
41-50	6	6
51-60	8	6
61-70	3	2