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Learning from Reviews

1 April 2018 to 31 March 2019

Analysis of Emerging Themes from Child Practice, Adult Practice and Domestic Homicide Reviews in Wales

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1 Introduction

The purpose of conducting Child Practice, Adult Practice and Domestic Homicide Reviews is to establish what lessons are to be learned regarding the way in which local professionals and agencies work individually and collectively to safeguard and protect those who are vulnerable.

The review process brings together multi-agency teams and individuals to share information with one another and to identify what the lessons are both within and between agencies. Close scrutiny and oversight to ensure compliance with action plans and time scales including the implementation of new systems and processes requires strong commitment from front line practitioners and managers alike.

The Regional Safeguarding Boards (RSBs) in Wales have a statutory duty under the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 to commission Child Practice Reviews (CPRs) and Adult Practice Reviews (APRs) in accordance with Part 7 of the Social Services and Wellbeing (Wales) Act 2014 within their regions to learn lessons and facilitate practice improvements. As members of the Boards, NHS Wales work collaboratively with multi agency partners by contributing to Child and Adult Practice Reviews within their regions, and to the Domestic Homicide Reviews (DHRs) process, established on a statutory basis under Section 9 of the Domestic Violence, Crime and Victims Act (2004).

2 Background

The 'NHS Wales Learning from Reviews group' have collaborated and worked together for the last two years (1st April 2017 to 31st March 2019) to establish and develop an efficient and effective means of disseminating learning from reviews in a timely manner across NHS Wales.

Learning has been shared at the NHS Wales Safeguarding Network via 7-minute briefings, presentations and reports and on a multi-agency basis via the Regional Safeguarding Boards.

Changing systems, process and practice in response to recommendations from reviews requires strong leadership and commitment from managers at all levels, to assess their own organisations compliance against recommendations from reviews and to determine what actions are needed, if any. Furthermore, supporting and listening to practitioners concerns through any period of change is fundamental to the successful implementation of any new system, process or practice together with additional training, support and supervision until the new process is firmly established.

Due to the progress made in disseminating learning across NHS Wales over the last two years, members of the Learning from Reviews group have agreed that they would continue to share 7-minute briefings on reviews conducted within their own regions and continue to present findings and learning via the NHS Wales Network. All Health Boards and Trust members remain committed and understand their responsibility for disseminating and implementing changes to policy and practice, and the need to ensure all staff receive the necessary training, support and supervision to successfully implement any changes to practice.

3 Purpose

The purpose of this report is to highlight key themes from an analysis of published Child and Adult Practice reviews and Domestic Homicide Reviews in Wales for the period 1 April 2018 to 31 March 2019.

This work aims to shape best practice and encourage reflection on the lessons and themes identified within local areas. This information should be used to consider and develop improvements required to practice on a local and national level.

4 Methodology

In February 2017, the National Safeguarding Team (NST) collaborated with the Heads of Safeguarding and Named Professionals from Health Boards and Trusts across Wales to ascertain the methods used to share and implement the findings and recommendations from reviews within their own organisation and on a wider basis across Wales.

Following these discussions, it became apparent that learning from reviews was not consistently applied, shared and disseminated within regions and with colleagues across NHS Wales, with each Health Board and Trust interpreting the recommendations individually and often developed individual policy and procedure as opposed to sharing and adopting a once for Wales approach.

It has been two years since the inaugural meeting of the 'Learning from reviews group' in February 2017. The mechanism for sharing lessons learnt, from the recommendations of reviews have been refined and implemented by the Health Boards and Trusts within their own regions and on a National basis via the All Wales Safeguarding Network.

This end of year report is an 'Analysis of Emerging Themes from Child Practice, Adult Practice and Domestic Homicide Reviews in Wales from the 1st April 2018 to 31st March 2019.

5 Findings

Between the 1 April 2018 and 31 March 2019, there were 16 published reviews in Wales. These comprise three Domestic Homicide Reviews, seven Child Practice Reviews and six Adult Practice Reviews.

Table 1 indicates the Health Board involved and type of review conducted

Health Board	APR	CPR	DHR
ABMUHB	1	1	0
ABUHB	0	1	1
BCUHB	3	0	0
C&VUHB	0	4	1
CTUHB	1	0	0
HDUHB	1	1	0
PTUHB	0	0	1

Table 2 (below) provides the outcome from seven CPRs and six APRs, including contributory factors. The detail relating to the three DHRs are included under Section 7.

Outcome	Adult	Child
Death	6	4
Survived	-	3
Physical Abuse	-	2
Sexual Abuse/Exploitation	-	2
Neglect	1	3
Emotional Abuse	-	5
House Fire	-	1
Hanging	-	1
Brain Haemorrhage	-	1
Drug Overdose	-	1
Bronchopneumonia	3	-
Thrombosis/Embolism	1	-
Sepsis/UTI	1	-
Jaundice/Liver disease	1	1

Adverse Childhood Experiences (ACEs)

ACEs were identified within all seven-child practice reviews. These are presented in Tables 3a & 3b below. There were limitations to capturing ACEs within the reviews, as not all reviewers gave specific categories that are in-line with the nine categories as used in the Wales ACE Study.

Table 3a: The table below indicates the distribution of ACE across the seven Child Practice Reviews.

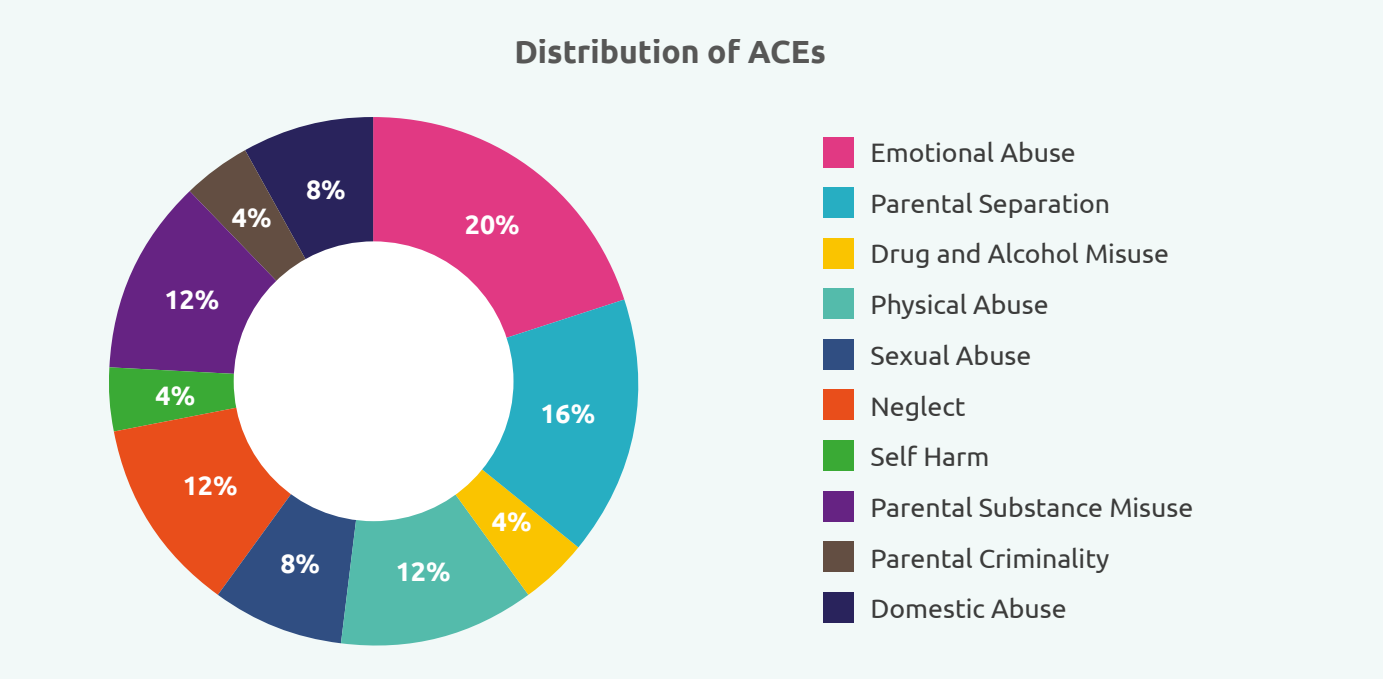
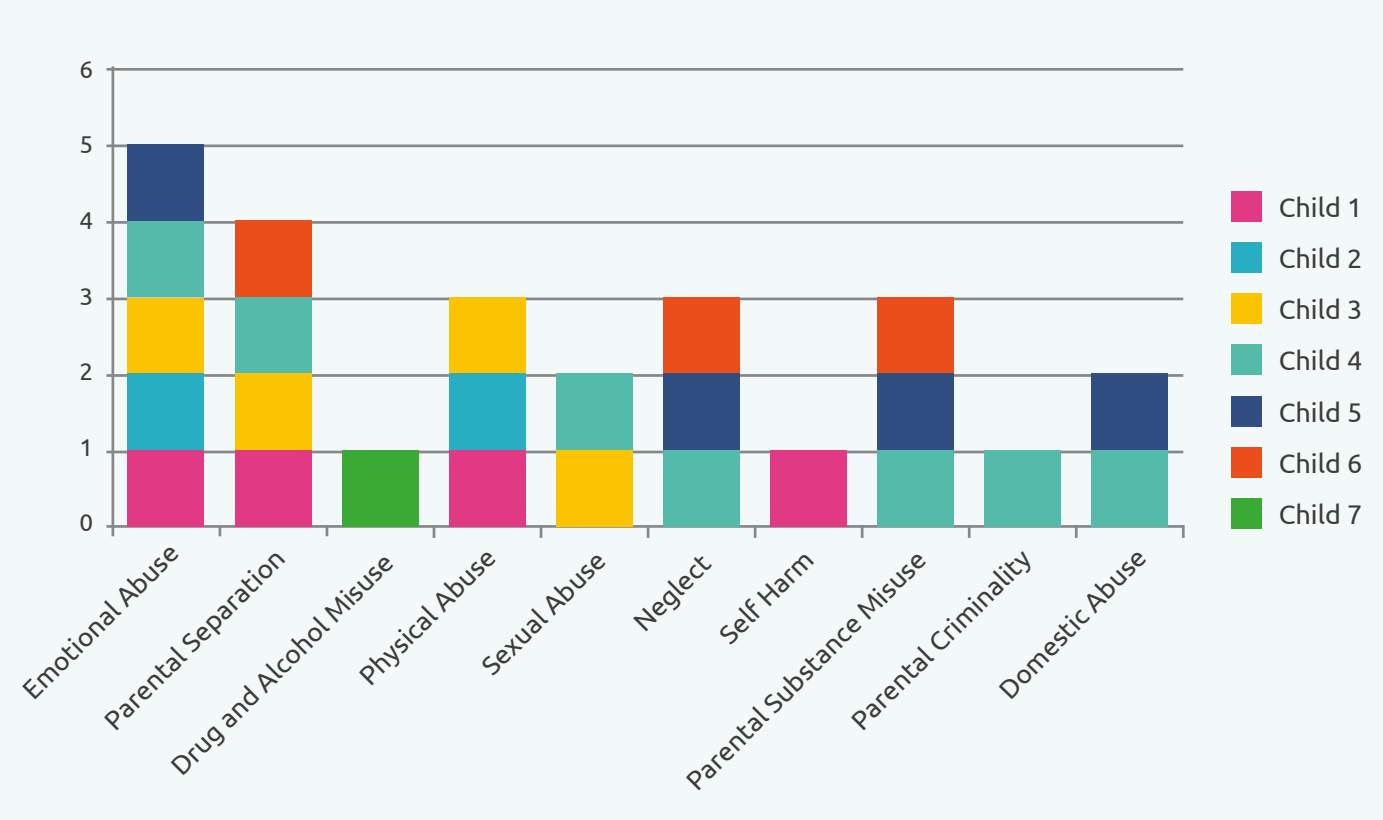


Table 3b: Indicates the number of ACE exposed to by each child.



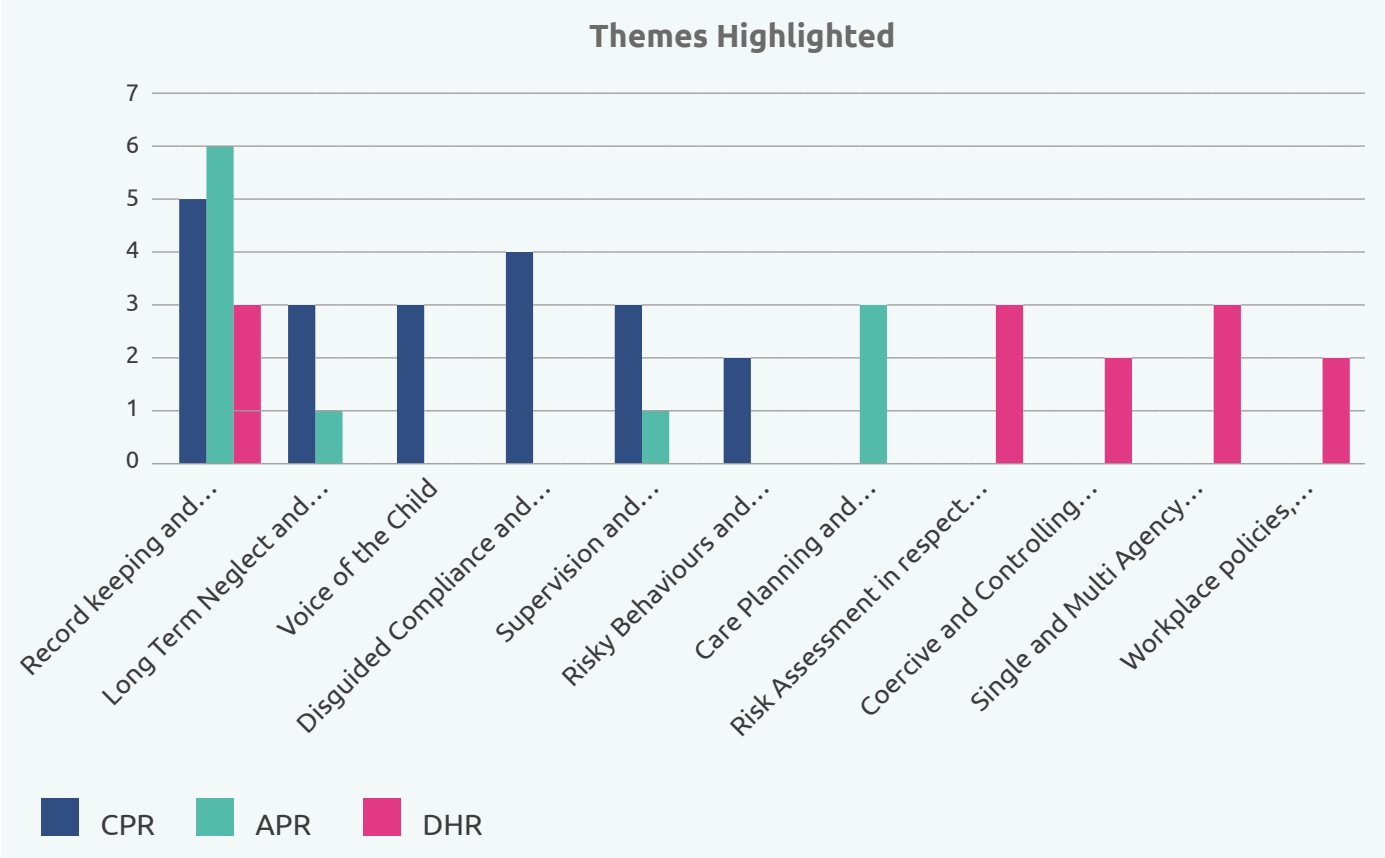
6 Emerging Themes

An analysis of emerging themes from the three DHRs, seven CPRs and six APRs between 1st April 2018 and 31st March 2019 has been undertaken.

The occurrence of each themes frequency throughout the reviews was noted and efforts made to group these together in order to draw conclusions about lessons learnt to inform practice. Whilst themes were identified within individual reviews, which were case and practice specific, many themes presented across numerous reviews and across Health Board areas. These are set out below:

- Record Keeping and Information Sharing
- Long Term Neglect and Complex Cases
- Voice of the Child
- Disguised Compliance and Professional Optimism
- Supervision and Professional Vulnerability
- Risky Behaviours and Holistic Risk Assessments
- Care planning and Supporting Older People
- Risk Assessment in respect of Domestic Abuse
- Coercive and Controlling Behaviour
- Single and Multi-Agency Domestic Abuse Training
- Workplace Policies, Information and Signposting

Table 4 (below) identifies key themes and number of reviews where each category was identified across the 16 reviews.



6.1 Record Keeping and Information Sharing

The most frequently occurring theme across the majority of reviews indicated discrepancies in record keeping and information sharing practice between single and multi-agency partners. Five child practice reviews and all six adult reviews indicated that improvements were required to record keeping and information sharing practice. Concerns related to omissions, lack of clarity and detail, and of failures to share relevant information with others were highlighted.

The use of terminology in records by professionals often lacked clarity and needed to be more descriptive, to paint a picture so that professionals picking up a case not known or familiar to them could understand or imagine the lived experience of the individuals and family living within a home. The type of information and quality of information recorded was inconsistent. Words like good, acceptable or unacceptable were often used, which reviewers felt to be lacking in context and clarity of description. Although more descriptive records were seen, this was not consistent within and across all agencies. In addition, it was felt that descriptions of the children's lived experiences, and of their conversations with professionals needed to be more consistently evidenced within the case records. Professional documentation had a tendency to be more focussed on the adult's participation and parenting capacity, with very little focus placed on recording the children's perspective and situation. Observing and listening to the child's wishes, feelings and perspective in an environment where they feel able to express themselves, is essential for professionals to retain the focus on the child so that they are not blindsided by coercive parents who deflect attention away from the children. The child's welfare is Paramount (Children Act, 1989)

The reviews also highlighted omissions from records, where parents had shared concerns or information with professionals, but the information had not been recorded or communicated with other professionals. One child practice review led the reviewers to question whether the child received enough attention to meet his needs, however practitioners at the learning event explained that the child's extended family had been caring and meeting the child's needs. The reviewers concluded that this fact could have been better documented (WB N 25 2016 CPR).

One review into the death of a young child showed that no one professional held all the information in respect of the child's injuries. The method of recording injuries by both health and social care staff did not facilitate the recognition of a pattern of physical abuse. The lack of a single electronic record hampered effective communication between health professionals resulting in the health visitor, general practitioner and paediatrician having sight of some but not all injuries. Furthermore, there was no evidence to show that the general practitioner or hospital information in respect of the injuries had been shared with social care staff.

> "The observations and recording of a large bruise to the child's forehead both by Children's Services and Health was absent. This resulted in the large bruise becoming 'invisible' to professionals and did not form part of the building an overall picture of what was happening to the child before the final report to the Court prior to the Adoption Order hearing being made" (C&V CPR 04/2016)

Whilst reviewers in another review felt the records to be thorough, professionals attending the learning event, expressed concern about how much more additional information was available concerning the young person, that they had not previously known. They acknowledged that had this information been shared more widely, the risks regarding the young person's situation might have been more accurately understood, which may have resulted in a Multi-Agency Referral being made to Children's Social Services. (CYSUR 2/2017)

> "An asset risk assessment had been completed but this was on a single agency basis at a time when there were an escalating number of concerns being raised with the police and there were concerns about missing reports" (CYSUR 2/2017)

Another review highlighted that

> "Agencies were often working and making decisions without the full information and knowledge of all the dimensions and extent of issues facing this family" (SEWCSB 1/2017)

The maintenance of comprehensive, accurate, up to date records that are legible and written in a clear language are essential practice for all professionals. The use of jargon and failing to update records and share that information with others means that professionals will not have all the necessary information to assess risk. The use of obscure words or phrases further exacerbates this issue as different people can interpret these differently.

> "Professionals should ensure that when completing assessments and recordings that clear descriptive language is used. This is extremely important in cases of neglect" (WB N 25 2016 CPR)

> "The importance of individual agencies maintaining a live chronology on case files. This would be useful when professionals are asked to cover cases" (WB N 25 2016 CPR)

The reviews emphasised the importance of sharing information with health and social care professionals regarding young people and adults being placed in out of county placements or care homes. One of these reviews emphasised the importance of alerting the Looked after Children nursing teams in advance of a young person being placed out of county to ensure their across the border health colleagues were fully informed about the child's placement and their health needs. (C&V LSCB 02/2014).

Another review into the death of an elderly woman transferred to an out of county specialist dementia residential unit highlighted numerous concerns relating to record keeping and information sharing practices within and between agencies on a multi-agency basis. Care Home records were said to be limited and lacking in detail, particularly in relation to the accurate recording of falls. The records comprised short statements such as "found on floor", which lacked information concerning the circumstances of a fall, the location, witnesses, those present and injuries suffered. There were also concerns about the recording of strategy meeting minutes, which did not accurately reflect the discussions that took place, with reviewers recommending that

> "a clear Action Plan (Including roles, responsibilities and timescales) be completed and recorded within the Strategy Meeting minutes and that this Action Plan is reviewed in subsequent meetings and the outcomes recorded" (APR3/2016/Conwy)

Additionally the recording of verbal communications between professionals and the family lacked clarity about who participated in the conversations, what issues were discussed and what actions were agreed with the family.

> "Valid concerns regarding Adult A's care were raised by the family, but these were not always given the prevalence and may have been dismissed when the relationship between the family and professionals was proving difficult" (APR3/2016/Conwy)

Furthermore, two reviews highlighted the impact of modern technology and the need to consider how agencies and professionals record text messaging and other forms of new technological information, because this information is increasingly becoming an important source of information. Agencies therefore need to determine how professionals and systems capture text messages to ensure they are included in case records.

> "Information gained at one learning event confirmed that the child's parent used text messaging as a form of communication between themselves, extended family and professionals" (WB N 25 2016 CPR)

6.2 Long Term Neglect and Complex Cases

Three child practice reviews highlighted the difficulties of working with long-term neglect cases and families with complex needs. At times however the reviewers found that unrealistic expectations were sometimes placed upon families to comply with child protection plans, or other support plans, when the lack of co-ordination by professionals and joined up health services made it impossible for families to comply with those plans. One particular review showed that multiple health appointments for siblings and other family members had been arranged on the same days and at different locations, which meant the family was unable to comply with the plan as it was unachievable, and further exacerbated the complex needs of the family.

> "Although many strategies were employed by professionals in both health and social care to assist the family to meet their needs, this did not prevent multiple children being expected to attend various health appointments on the same day in different locations, prompting the reviewers to remind agencies to 'Think Family'"(WBN 25/2016)

Reviewers also emphasised the need for professionals to communicate with families in a way that families understand and to explain the rationale for decisions made, especially when their needs, requests, or expectations cannot be met. Professionals also need to be supported to further develop and enhance their skills and confidence to effectively manage families with complex needs and effectively secure their engagement.

> "Skills training should be put in place for professionals to further develop person centred communication in order to improve engagement" (CYSUR 02/2016)

One of the learning events highlighted

> "that working with a family in the context of long term neglect had left professionals feeling overwhelmed. The reviewers highlighted that when cases have been open to child protection for over 2 years, with no positive change being made, there should be consideration of the threshold for care proceedings" (WB N 25/2016)

Another review featured 'dental neglect' amongst other types of abuse as the child's health needs went unmet. The review highlighted pre-existing extensive dental decay, which sadly resulted in the child having ten teeth extracted under general anaesthesia. The reviewers highlighted the extensive pain and suffering that the child must have experienced because of the decay and poor oral health. However, the child was not invisible to agencies. Three child protection referrals had been submitted, the first one being raised by neonatal staff when the child was first born. However, the timescale for completing core assessments fell outside of the 35 working days (AWCPP, 2004) and almost six months had elapsed before an initial child protection conference was convened. This meant the child continued to suffer from ongoing long-term neglect and harm, despite numerous child protection referrals being made by professionals because of

> "concern around poor home conditions, substance misuse and frequent callers to the home address, with the child said to be often left alone in the front garden with only bags of crisps to eat" (CPR 03/2016)

The reviews emphasise that a child-focused assessment must be carried out concerning the needs, safety and welfare of every child, particularly where parents are known to misuse drugs or alcohol, and where the children are exposed to domestic abuse within the home. Assessments must look at parenting capacity and must analyse the impact of parental behaviours on the children within their care.

Allowing cases to drift as in long-term neglect cases, with a lack of management oversight or clear action plans and time scales, which are adhered to, means that agencies fail to protect children and young people from further ongoing harm as evidenced within these reviews. Information gathering to inform decision making to assess and determine what is happening or has been achieved is essential to ensure professionals do not lose objective sight of what is happening. Child protection plans or other safety plans need to be realistic and achievable, but at the same time closely monitored to ensure there is no risk of drift. Parental assertions that they will change or excuses about why they failed to do something for a child should not be acceptable unless there is a valid reason for not doing so or the expectation was unrealistic in the first instance (WB N 25 2016).

6.3 Voice of the Child

Previous well-publicised reviews have highlighted the importance of seeing, hearing and observing the child (Laming, 2003).This recurring theme was reflected in three of the seven child practice reviews undertaken within the last year.

The reviews highlight the importance of hearing the voices of children and of the need to clearly record what is seen and heard as a fundamental part of the assessment process and developing safe care plans. In some instances, the child's voice was reported by reviewers to be 'lost' or 'overlooked', because of the complexities involved in managing the parent's personal needs which deflected attention away from the children . One review highlighted that core group meeting discussions tended to revolve around the mother and her relationships, with little evidence of the child's wishes and feelings being considered. The review emphasises the need for practitioners across all agencies to be mindful of the need to be more alert to the vulnerability of abused children to ensure opportunities for intervention are not lost. The reviewers emphasise that it was only when the child had been removed and placed in foster care that the child felt safe to disclose the abuse they had suffered (C&V CPR 03/2016).

Another review suggested that social workers should visit school age children who are in adoptive placements outside of the placement to strengthen opportunities to see the child alone (C&V LSCB 02/2014). The importance of capturing the child's voice and perspectives on their lived experiences is fundamental to ensure the child safety. This includes capturing the 'voice' of very young children, including those who have a speech and language delay, who may not be able to express their feelings in words.

Professionals may therefore need to consider using alternative approaches such as direct work using playful activities to obtain the child's views. Following this particular review one local authority has since introduced the 'signs of safety model' of working to ensure the voice of the child is clearly heard and documented.

The caseworker described one child's behaviour as

> "boisterous and erratic with incidents of head-butting the sofa and hitting out at siblings, attempts to pull down curtains and playing dead on the floor being observed frequently" (C&V 02/2016)

Reviewers emphasise the need to consider non-verbal communication cues and to remind practitioners that this type of behaviour can be indicative of domestic violence within the home, and that given the practitioner's observations and child's behaviour in this case, reviewers viewed this to be a missed opportunity to talk with the child about personal feelings.

6.4 Disguised Compliance and Professional Optimism

Four child practice reviews exhibited some form of disguised compliance by parents and professional optimism, which had negatively affected children subject to the reviews. Reviewers highlighted a range of skilful strategies were used by parents to keep professionals at 'arm's length' or of giving the appearance of cooperating with agencies to avoid raising suspicions, to allay professional concerns and ultimately to diffuse professional intervention.

Babies and very young children are at particular risk from a lack of timely intervention, particularly when professionals are over optimistic about families. Working with families who appear to be engaging well, with no previous history of concern, can easily give professionals a false sense of security. This false sense of security can result in professionals dismissing or downgrading a concern, or failing to make further enquiries that would enable them to initiate timely interventions to protect the child.

A review into the death of a young child recently adopted highlighted a sense of professional optimism in respect to the adoption that may have contributed to the lack of professional curiosity in respect to a pattern of injuries sustained by the child in the months preceding the child's death. Reviewers noted that previous fractures, bruising to the head and a unilateral squint were seen as isolated incidents, with a lack of recognition of a pattern of injury. Furthermore, some of these

incidents had not been documented or shared with other professionals. The review emphasises that professionals should be mindful not to accept presenting behaviour or assurances from parents that they have alerted another professional or sought medical attention regarding an injury to a young child. They should speak to other professionals themselves to clarify and discuss the presenting issue and weigh up the risks together to determine whether further intervention is required. The reviewers in this case remarked that the parents had presented as appropriate, caring professionals who had previously successfully adopted a child, which gave professionals a false sense of optimism about the family.

> "The Professionals involved with the child viewed the adoptive placement as being very successful; the events in the child's life were viewed through a 'positive lens'. This is the case for the majority of children placed for adoption" (CPR04/2016)

Another review highlighted a prevailing sense of optimism amongst professionals, which resulted in a clear consensus amongst agencies to removing the children's names from the protection register, only to reinstate their names onto the register just six months later. Reviewers questioned how embedded those improvements had been due to the short timescale between de registration and re registration with practitioners reporting that in hindsight that there had been some level of disguised compliance by both mother and extended family members.

The reviews clearly indicate that where disguised compliance was a feature, this affected the professional's ability to effectively implement changes or timely improvements for the benefit of the child and family.

6.5 Supervision and Professional Vulnerability

Child and Adult Practice reviews highlighted the importance of supervision to support and enable professionals to objectively assess risk and manage difficult situations and behaviours. This was felt to be particularly important for newly qualified professionals and those managing complex cases such as long-term neglect cases and young people who exhibited risky behaviours and difficult to engage. One review found that a student social worker had been allocated a particularly complex case but had not received any formal handover of the case from the previous case holder. The case was later closed despite numerous new referrals being submitted to adult social care, with no recording to indicate that formal supervision took place regarding case closure. (C&VRSCB 02/2016).

Poor management oversight, high caseloads and a lack of adequate supervision were highlighted within a number of reviews. There was also concern amongst professionals about feeling ill equipped and unprepared when required to cover for colleagues. This was because there was no formal handover and there was insufficient documented information for them to effectively undertake the tasks required of them in an informed way. This highlights the previously raised concerns about record keeping practice and the importance of management oversight and supervision for staff.

The review highlighted

> "the need to ensure particularly during times of disruption and change that staff receive adequate support. Professionals who have taken cases for periods of cover should be given sufficient time to acquaint themselves with the detail of the case and handover briefing sessions should be undertaken for the same" (WB N 25 2016)

Another review highlighted a missed opportunity for early intervention and identified that clearer case management advice, giving specific timescales and instructions regarding intervention, would have been helpful. Reviewers note that had this been available to practitioners it may have triggered more child protection inquiries and the seeking of legal advice and subsequently prevented further incidents. The availability of supervision for social care practitioners was deemed essential to support effective risk management and planning and as a means to challenge over optimism. Where supervision was lacking from casework this created an environment where practitioners lost focus on the child.

One review emphasised the need to implement a model of supervision for social care professionals that ensures all adoption cases are discussed in the same way as child protection cases. This will ensure consistent oversight and robustness around information sharing and decision making.

> "Supervision should include discussion about potential safeguarding concerns/ welfare matters/ significant events in respect of the child placed, and that direct questions are asked of Professionals as to whether there have been any issues/incidents of concern" (C&V CPR 04/2016)

Professional vulnerability was also a feature within the reviews, with concerns raised about the vulnerability of professionals who lived in the same communities as the families they were supporting. The potential conflict of interest for professionals and their vulnerability in such instances may not be conducive to objective thinking and action. It was recommended that

> "Managers and supervisors consider the implications for practice and provide appropriate support in these circumstances" (WB N 25 CPR)

One adult practice review highlighted the vulnerabilities of professionals who needed to attend a home visit accompanied by another professional because of escalating concerns about an adult son who was the main carer for his elderly mother. District nursing teams and other professionals became increasingly concerned about his degrading manner and behaviour towards mother. District nursing teams and multi-agency partners appeared to have exhausted their approaches to diffuse the son's hostile and challenging behaviour and acknowledged that in trying to appease the son, the voice of the adult subject to the review had been lost. Because of the complexities and difficulties experienced by professionals in this case, reviewers felt concerned that some staff members may still be traumatised by the case. The review recommended that the health board develop

> "a clear process for formal management and clinical supervision of their staff, ensuring that they are supported in escalating concerns and reduce risk of burnout with complex cases" (NWSAB1/2017/FCC)

6.6 Risky Behaviour and Holistic Risk Assessments

Two child practice reviews highlighted the challenges for agencies and professionals working with young people where there are escalating concerns about risky behaviours. A feature in both reviews was the tendency to go missing, and exclusion from mainstream education, because of escalating concerns where the school felt unable to manage the risky behaviour.

One young person was described as being subject to special educational needs and exhibited unpredictable, challenging and often uncooperative behaviour. There was a tendency to go missing from placements even though she did not appear to have close relationships with her peers. Whilst the other review described the young person as a loving, loyal, articulate person who was popular with their peers, but who was unable to say 'no' or to walk away from situations.

One review highlighted concerns about relationships formed with young people at a residential care home, which led to the young person being vulnerable to sexual abuse and exploitation. After being subjected to two separate sexual attacks with the latter resulting in the young person being hospitalised. Social services undertook a risk assessment and subsequently obtained a three-month 'secure order' to place the child in secure accommodation for her own safety. This young person is reported within the review to be safe and well and when asked to contribute to the review expressed that

> "she was annoyed at the number of times she was moved although she understood it was to keep her safe and she didn't mind being so far away from home. She was happy that she was now in a placement with her sister, as when she was placed elsewhere she missed her sister and was not allowed to see her or phone her Nan" (C&V LSCB 02/2014)

This young person also demonstrated an understanding of her inappropriate behaviour and told reviewers that

> "she was annoyed when she was placed out of area that her Social worker was never available to talk to and she was never visited by her, and that she wanted to see her family more" (C&V LSCB 02/2014)

Furthermore, this young person's grandmother told reviewers that

> "she was upset that once her granddaughter was placed out of area she never saw her, she didn't know what was going on, professionals never contacted her and it wasn't until the child ran away that the family were first made aware of the 'sexual exploitation issues" (C&V LSCB 02/2014)

The other review showed escalating risks around substance misuse issues, poor school attendance, challenging behaviour and increasing episodes of going missing from home. There were also frequent contacts with the police with reviewers noting that the young person could be

> "Stubborn, hedonistic and ambivalent, and despite being academically capable demonstrated increasing challenging behaviours and high levels of absenteeism" (CYSUR 2/2017)

Reviewers also noted that the young person had become increasingly aggressive at home and the family had felt unable to cope or manage the situation. The inquest into the young person's death indicated the excessive use of cannabis and MDMA prior to her death.

Both reviews highlighted increasing concerns by both agencies and family members as they tried to engage with the young people in an attempt to manage and diffuse the escalating concerns. Both reviews also indicated that there was a general mistrust of agencies by the families and young people concerned. Family members were reported to be unclear as to what support was being offered and which agency was responsible for providing that support, with reviewers also noting that

> "The young person may have benefited from a more holistic, co-ordinated person centred planning approach based on their daily situation, particularly when signs of risky behaviour escalated" (CYSUR 2/17)

And that

> "Such meetings may have afforded further opportunities for holistic working with the young person to analyse, inform and risk assess the emerging picture. Situations arising with the young person were dealt with based on a reactive approach, as opposed to considering a longer-term outcome/plan; at the time of their death, there was no multi-agency plan in existence to manage the escalating risky behaviour" (CYSUR 2/17)

6.7 Care Planning and Supporting Older People

Four Adult Practice Reviews highlighted concern about the lack of care-coordination packages to meet the care and support needs of adults.

One review showed anecdotal concerns raised by a specialist dementia residential home who escalated their concerns to the Local Authority, as there was no care and support plan in place for the adult for the whole time she had been placed with them and they could no longer meet the adult's needs. The adult subject to the review sustained three falls whilst at the residential unit, and following the last incident was admitted to hospital, where she never recovered from her injuries. Despite the residential home asking the local authority to consider placing the adult in a nursing home there was no documented evidence to indicate that the care homes concern had been acknowledged or explored further by the placing authority(APR 3/2016/Conwy).

Whilst another review highlighted concerns about an elderly woman who was said to have no capacity, was bedbound, with limited speech and totally dependent on others to meet her care and support needs. Numerous safeguarding reports had been raised in relation to the domiciliary set up and the ability of agencies to access the property. Four adult at risk reports were submitted to the local authority's safeguarding team by the District Nursing staff which highlighted anecdotal concerns in relation to the suitability of the son to care for his mother. Multi Agency communication in relation to assessing the care and support needs of the individual were not robust, resulting in no care-co-ordination or review of a rapidly declining individual. The

reviewers noted that there was no evidence of a best interest meeting to review the care package and safeguards in line with the Mental Capacity Act (2005).

The review showed that

> "This case has been simmering along and on the radar for a few years with no clear nomination of a care co-ordinator" and an admission that "they may have been lax in their approach to monitoring" (NWSAB1/2017/FCC)

Another adult review highlighted the lack of joined up health services and co-ordination. Two vascular surgeons together with specialist nurses working in different regions but for the same health board were seen to be working independently of one another, yet no one coordinated the clinical care package. This was despite both consultants knowing of one another's involvement. One of the doctors at the learning event confirmed that

> "The patient 'fell off the radar' because no one came back to him" (APR2/2016/Conwy)

7 Domestic Homicide Reviews

Three known Domestic Homicide Reviews (DHRs) were published between 1st April 2018 to 31st March 2019. These have been considered together outside the CPR and APR analysis, to ensure the themes identified are carefully and fairly represented despite the different processes of conducting both types of reviews.

7.1 Findings from Domestic Homicide Reviews

Similarities were found across the three Domestic Homicide Reviews. All three victims were female and the perpetrators were male. All three perpetrators had previously been reported to the police for various types of crime and domestic related incidents. Two of the perpetrators had a history of petty theft and violent crime, domestic abuse and had been previously incarcerated. There was no evidence to indicate that these relationships had been escalated to either Multi-Agency Risk Assessment Conference(MARAC) or Multi Agency Public Protection Arrangements (MAPPA).

It is important to note that the names referred to in the analysis below are and not the victim's real names.

The first review considers the circumstances surrounding the death of 'Belle' a thirty five year old woman, who was murdered by her husband, caused by fatal knife injuries. Her husband the perpetrator later killed himself.

The reviewers noted

> "Why didn't she just leave?"("Belle" Community Safety Partnership of Monmouthshire Public Service Board, 2018)

The reviewer's highlight that the answer to this question is not simple because

> "the reasons are many, subtle and varied according to the victim's circumstances" ("Belle" Community Safety Partnership of Monmouthshire Public Service Board, 2018)

The second review considers the circumstances surrounding the death of 'Lesley' aged 51 years who was strangled, by her partner, who later killed himself. 'Lesley' was a much-loved mother of four and grandmother to seven children from a previous marriage ("Lesley" Powys Community Safety Partnership, 2018).

The third review was into the death of 'Janet' aged 54 years who had sustaining significant burns to her body, inflicted on her by her ex-partner. Despite medical intervention, Janet died 10 days later of multiple organ failure and probable sepsis. ("Janet" The Vale of Glamorgan Community Safety Partnership, 2019).

7.2 Risk Assessment in Respect of Domestic Violence

The recording, gathering and sharing of both current and historical information about those who pose a risk to others is essential to protect and safeguard victims of domestic abuse and other forms of abuse.

Two of the three perpetrators within the DHRs had a previous history of domestic violence within previous relationships, yet this information was either not known by professionals or was not deemed significant because of the way the information had been classified and recorded at that time. There was also evidence of previous theft, burglary, crime, and previous incarceration in two of the reviews, with one of these perpetrators incarcerated for a previous murder that had taken place during a robbery. However, most of this information was not apparent or considered as a risk to these victims. The reviews do however acknowledge the difficulties faced by police officers when alerted or called to a disturbance or incident where couples are embroiled in an argument, and where verbal or physical abuse has taken place, yet the victims

refuse to give statements testifying these facts. The victims within these reviews downplayed the incidents when asked to provide statements to police officers which emphasises the difficulties police officers have when required to classify, assess risk and record this information.

The reviews also highlight the importance of recording and assessing the information gained not only from professionals but also from concerned family members, friends, community and workplace, as they will have a much better insight into the circumstances from conversations they have with the victims. They emphasise the role of employers and colleagues in the workplace in supporting victims of domestic abuse as two of the reviews indicated that the victims had disclosed difficulties within the relationships to co-workers, who had offered support and advice about leaving and suggested a safe refuge where they could stay. The perpetrator in one of the reviews ('Belle') would often turn up at her workplace and 'stalked her'. The reviewers therefore highlighted the importance of workplace policy, guidance and training to raise awareness of domestic abuse and coercive control to enable staff members to support victims of abuse and to support staff members themselves.

The setting up of flagging systems is referred to in both 'Belle' and 'Janet' as both perpetrators had previous histories of domestic abuse, which could in future be included as a marker onto the perpetrators health records. A number of other systems are highlighted within the reviews that indicate the various systems used by professionals in different regions to assess risk e.g. The IRIS project is referred to in one review as a means of assisting General Practitioners (GPs) with the risk assessment process; the Wales Applied Risk Research Network (WARRN) system used for all people accessing the Community Mental Health Teams (CMHT). However, agencies need to be mindful that systems and processes themselves only work if professionals consider all the information available and to consider each case holistically, taking into account the circumstances and issues of concern.

> "The Wales Applied Risk Research Network (WARRN) risk assessment was not carried out at the initial appointment with mental health services. Consideration to complete this assessment at the first appointment would usually be if there were any presenting immediate risks otherwise the assessment may be best completed over a couple of sessions" ("Belle" Monmouthshire Community Partnership of Monmouthshire Public Service Board, 2018)

A theme that featured throughout the review into the homicide of 'Belle' was the perpetrator's lack of engagement, which had hindered professionals from carrying out a WARRN assessment.

The review also highlighted that interventions tended to be aimed at 'Belle' as the victim, rather than the perpetrator as being a risk; and if greater concentration had been placed on the perpetrator, and professionals had made further enquiries, this may have altered the course of intervention. Although reviewers note that no-one could have predicted what would have happened, the risks of leaving are well known and that the escalated danger point of leaving should be made very clear and explicit in domestic abuse literature and to those advising women in abusive relationships.

The reviewers noted that

> "Domestic Abuse is commonplace, and many men and women assault each other without there being ongoing coercive control and abuse. This is the area in which we find most bi-lateral violence, which is sometimes confused with domestic abuse. It is when the violence is used as a means of control that is domestic abuse" ("Belle" Community Safety Partnership of Monmouthshire Public Service Board, 2018)

None of the victims were known to MARAC however, the review into the homicide of 'Janet' showed that MARACs might have taken place which police may not have a record for, due to issues relating to the police information and crime recording systems for retaining minutes. Agencies are reminded of the need to have systems and processes in place to capture and store all relevant information in order to

assist professional decision making, assess risk and to alert others of those risks. None of the perpetrators were known to MAPPA, despite the perpetrator relating to 'Lesley' receiving a custodial sentence for a previous manslaughter charge relating to a burglary where someone died. Reviewers in this case felt that this information had been handled appropriately by agencies at the time according to existing policies. MAPPA was introduced around the time of his release from prison, with meant there was no prior record to indicate that the perpetrator had ever being included in the MAPPA process.

The reviews emphasise the need for a thorough risk assessment, using all the available information not only from professionals, but also information received from the victims, their families, friends, neighbours and wider community who express concern. The need for multi-agency training is also deemed essential to improve, monitor and extend the use of such information systems and the means of sharing and using them is essential to improve future risk assessments.

7.3 Coercive and Controlling Behaviour

Two reviews highlighted numerous examples of a pattern of coercive and controlling behaviour that had not been recognised by professionals as being indicative of any risk. However, there was evidence of family members, friends, co-workers and neighbours identifying concerns, relating to 'Belle', particularly the controlling nature of the relationship as the perpetrator controlled all the finances, payed the bills and organised transport, paid from his bank account despite the victim being the breadwinner and the perpetrator being unemployed and claiming benefits.

The extent of this coercive control was further evidenced when the victim set a date to marry another man, but due to the perpetrator's ongoing pursuit of 'Belle', the wedding was called off. The perpetrator was said to be…

> "haunting her throughout her relationship with the other man" ("Belle" Community Safety Partnership of Monmouthshire Public Service Board, 2018)

'Belle' married the perpetrator instead on the same day, time and venue that had been intended for marrying the other man. The victim's family and friends were unhappy about this union, and 'Belle' had also been warned by the perpetrators former wife about his previous history of violence and controlling behaviour.

> "Controlling men are identified as presenting the highest risk for killing their intimate partner or former intimate partner, irrespective of whether they are also habitually violent. In fact, Stark, (2013) reports that coercive control is a higher risk than violence alone by a factor of 9:1." "("Belle" Community Safety Partnership of Monmouthshire Public Service Board)

The reviewers note that more close probing is required from health, police and other professionals to highlight the indicators of a pattern of behaviours, including coercive control, and that training for professionals is essential.

The homicide into the death of 'Lesley' noted that both she and her partner had lived together for many years, with no evidence of any domestic abuse until the relationship deteriorated sharply within one calendar month before her death. However, during the review process it became evident that despite no agencies being involved previously, contact with friends, family and colleagues revealed behaviours that fit with the definition of coercion and control. They also recognised that the perpetrator's behaviour seemed to transition from such behaviour to the point where he killed 'Lesley' in the space of 4 weeks. This meant there was no clear evidence relating to 'Lesley' or to the perpetrators previous relationship until the point of breakdown. However, there were indications corroborated from the accounts of others, to suggest perpetrator behaviour that would fit under the new definition of domestic abuse as coercion or control.

> "With the review indicating that the violence has escalated from coercion or control directly to the point of unlawful killing in the space of one calendar month" ("Lesley" Powys Community Safety Partnership, 2018)

7.4 Workplace Policies, Information and Sign Posting

The reviews highlight the importance of community and workplace based support for victims, which includes friends, family and employers. One of the reviews highlighted the support and protection provided by work colleagues and the community to a victim, without any formal policy, guidance or training. The Welsh Government Right to be Safe Strategy (10, 000 Safer Lives Project 2012) has placed specific duties on public bodies to develop work place policies for staff members who are experiencing domestic abuse. The introduction of work place policies and associated guidance for employers shows that many victims of domestic abuse are targeted at work (75%). However, work is known to also provide victims with a safety net where they can safely access support away from the perpetrator. The reviews also highlight the need private business sectors to have guidance in place, for example solicitors firms. One of the reviews highlighted the need for solicitors to have protocols and information following advice given to one of the victims to "leave immediately" without fully considering the implications and consequences of leaving. Information, flyers and notices displayed in public places and at hospitals and health centres are promoted as a means of raising public awareness of domestic abuse and what to do if they have concerns.

'Janet' had presented to health services on twenty-four occasions during the scoping of the review, and on two of those occasions, she mentioned being a victim of domestic abuse at the hands of her partner. She was taken by ambulance to hospital and released to the care of her son, however there is nothing to indicate that further questioning about the incidence of domestic violence had been explored further or that she had been given information or offered any other means of support. The second time 'Janet' mentioned domestic abuse was during a visit to see her General Practitioner, whom she had seen on numerous occasions due to issues relating to her alcohol dependency and blackouts. The reviewers noted

> "She told her GP that her physically abusive former partner had recently been released from prison and that she was 'terrified' he would 'come onto her', despite there being a restraining order in existence. She was not sleeping well and there was some discussion about sleeping tablets and alcohol being only short-term solutions" ("Janet" The Vale of Glamorgan Community Safety Partnership, 2019)

There was nothing to indicate that the victim's concerns had been acknowledged, or any discussion about her safety or a referral to MARAC or appropriate support agency.

Police officers had however attempted to engage with 'Janet' the victim on several occasions to take a statement from her following an incident where she had dialled 999 from a neighbour's house to alert them that the perpetrator had grabbed her by her throat, and where she had been able to break-free. However, 'Janet' declined to make a statement telling them that she and the perpetrator had been drinking together all day and that they were both drunk.

Reviewers noted that

> "Manual strangulation is a recurring theme in domestic abuse and it often indicates either an ongoing pattern of abuse or it foreshadows escalating violence. The act sends a message to the victim that the perpetrator holds the power to take the victim's life, with little effort, in a short period, and in a way that may leave little evidence of an altercation" ("Janet" The Vale of Glamorgan Community Safety Partnership, 2019)

7.5 Single Agency and Multi Agency Domestic Abuse Training

All three Domestic Homicide Reviews made recommendations for further training to raise awareness of domestic abuse and coercive and controlling behaviours. All three reviews recommended the following:

> " all organisations contracted by the Council for the provision of care services on their behalf, to offer training to their staff that accords with the requirements on relevant authorities of the National Training Framework under VAWDASV" ("Lesley" Powys Community Safety Partnership, 2018)

> " all health staff/GPs to undertake the Mandatory Domestic Abuse (Group2) training to ensure that victims of domestic abuse are identified and that health are meeting the needs of the victims particular in EU and at the GP surgeries" ("Janet" The Vale of Glamorgan Community Safety Partnership, 2019)

> "it is clearly important that Ask and Act training is rolled out to general practitioners and also to Accident and Emergency staff as promptly as possible, and the importance of questions designed to uncover coercive and controlling behaviour cannot be underestimated" ("Belle" Community Safety Partnership of Monmouthshire Public Service Board, 2018)

With the advent of the new offence of controlling or coercive behaviour in an intimate or family relationship (S76, Serious Crime Act 2015), the review highlights the need for all police operational frontline staff to receive training in this area. The training aims to assist officers in the identification and understanding of behaviours and tactics used by perpetrators and the actions officers should consider, including the ability to hold safe enquiries with victims. Following one of the reviews, a video training package was developed to share with staff. This training package has since been extended and enhanced to include stalking and harassment offences.

8 Summary

The key themes identified within this review are set out below.

- The maintenance of comprehensive, accurate, up to date records that are legible and written in a clear language is essential practice for all professionals. The use of jargon and failing to update records and share that information with others is unacceptable as it means that professionals will not have all the necessary information to assess risk.
- Clear Action Plans should be developed following strategy meetings and these should be reviewed at subsequent meetings to indicate progress or completion.
- Looked after Children nursing teams should be informed in advance of a young person being placed out of county in order for them to share pertinent health information to health colleagues across the border.
- There is a need to strengthen practices that facilitate listening to the voice of the child / vulnerable person to better understand their lived experience.
- There is a need to enhance communication practices with service users and their families to ensure they are involved in decisions and feel able to express any concerns. These conversations should be accurately recorded and any actions agreed should be identifiable within case notes.
- Care Plans and Assessments should be holistic, up to date and demonstrate points of escalation.
- There is a need to strengthen Multi Agency work to share and gather information, to ensure Holistic Risk Assessments are undertaken.
- Risk should be assessed in the wider context of the vulnerable person's experiences and not on episodic events.
- Strategic planning and management oversight should be evident through all work with vulnerable clients.
- Front line workers require support in the form of high quality supervision, guidance and training when working with complex challenging cases.
- Professionals have a duty to ensure that they are up to date with guidance and legislation and best practice standards. Mechanisms of support should be in place to assist this process.
- Single and Multi-Agency training should be made available to all staff to raise awareness of Domestic Abuse and Coercive Control.

9 Acknowledgements

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10 References

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