Learning from a Joint Safeguarding Adult Review (SAR) and Domestic Homicide Review (DHR)

Caroline was in her 50s when she died in 2018. She had a history of alcohol dependence, self-neglect and abusive relationships and was known to have a mild learning disability. Caroline lived with her partner who cared for her. There was a history of domestic abuse incidents between Caroline and her partner.

In the years before her death, multiple agencies submitted safeguarding referrals for Caroline with regards to self-neglect, physical injuries and concerns of domestic abuse and the state of their home environment.

Assessments were undertaken but Caroline did not meet agency acceptance thresholds and was also deemed to have capacity for the decisions and choices she made.

A year before she died, Caroline was admitted to hospital to recover from the effects of self-neglect. Following this, Caroline moved to a supported living scheme where it was said that she 'thrived' but ultimately chose to return to her partners' house where old patterns were re-established.

Caroline sadly died as a result of fatal injuries that appear to be linked to self-neglect.

The partnership commissioned this review using a methodology that fulfilled the statutory obligations of both SARs and DHRs. The purpose of both types of reviews are largely compatible, both focus on learning lessons for future improvements to practice.

Find out more about the requirements of SARs and DHRs on the KBSP website

- Safeguarding adult reviews
- Domestic homicide reviews

11 different agencies contributed to the review which was led by a reviewer independent from services in Bristol.

FINDINGS: Guidance and Assessments

Caroline was recognised as an adult at risk by the agencies and organisations involved, which reflected the needs she clearly demonstrated

The GPs, police and ambulance services showed a **good understanding of safeguarding** and when to make a referral. They demonstrated this through their clear decision-making and referrals made. They responded to their concerns about Caroline appropriately and sought to identify and highlight the risks as they saw them using the framework and process laid out within the safeguarding requirements.

The initial assessment of Caroline by the Community Learning Disability Team was a **good example of a thorough and detailed assessment.** Given the borderline nature of the presentation, **the professionals involved showed good judgment in revisiting the assessment** with taking their assessment back to the wider team for discussion which aided their decision making. **It provided a clear record of their actions and demonstrated a wish to ensure a thorough and fair process.**

Overall, there was **good knowledge about the use of the Mental Capacity Act** and of the **Deprivation of Liberty Safeguards.** Because Caroline was assessed to have mental capacity, the various legal provisions available to agencies could not be utilised. There may have been other options, including the use of 'inherent jurisdiction', which can be applied to a situation where the person is putting themselves at risk due to self-neglect but has mental capacity.

FINDINGS: Domestic abuse

A multi-agency approach whereby agencies work together **to gain a full overview of a person's situation and co-ordinated response to support** would have been beneficial **especially when addressing risks in the context where professionals have been unable to engage.** An increased **understanding of the MARAC** process would have assisted agencies to come together to discuss, agree next steps and escalate concerns.

Better consideration of the **impact of controlling relationships** and how this can affect an individual's decision making is needed. Also required is **increased recognition of patterns of behaviour** and consideration of the potential causes, such as incidents related to situational violence (i.e., arguments related to a combination of vulnerabilities, stressors or poor coping skills that could escalate).

The GP surgery was an IRIS registered practice and had **received training and information on the recognition and approach** to take where there are **concerns about domestic violence.**

Whilst the GP practice demonstrated good insight into her multitude of problems, it was felt that as there was a clear history of domestic abuse, **further opportunistic enquiries would have been useful.**

FINDINGS: Recognising vulnerability

Since the review, Avon and Somerset Police have developed a **BRAG (Blue, Red, Amber, Green) risk assessment process** and all officers have completed the relevant training with regard to vulnerable people.

Practitioners must remember that many vulnerable people still struggle with basic literacy and as such may not be able to access the help they need; we must remain alert to this problem. This may mean **adapting verbal communication and offering easy read literature.**

Another consistent theme is the **difficulty of linking individuals who live in the same household** so that risks associated with the relationship can be appropriately considered.

A **greater awareness of the interplay between alcohol use, self-neglect and domestic abuse** and how this can **increase an individual's level of risk is required.**

RECOMMENDATIONS

1. **To audit routine enquiry in a sample of Bristol GP surgeries**. Bristol GPs should review the learning from this DHR as part of best practice.
2. **Review information sharing protocols** to ensure that historical factors are considered.
3. **Update self-neglect policy** to reflect the dynamic nature of interfacing risks such as substance and alcohol misuse, coercive control, communication difficulties.
4. Where service users have complex needs (including instances where domestic abuse may be an issue) **a multi-agency / multi professional case management conference** should be considered as the starting point for a housing resolution and throughout the re-housing process.
5. **Ensure there is a strategy in place for people who experience domestic abuse in cases that do not trigger a MARAC referral** but are escalating in frequency or nature. Staff from all agencies should be trained to recognise this risk.

RESOURCES

Self-neglect

- Support for adults Welcome to the Keeping Bristol Safe Partnership website. (bristolsafeguarding.org)
- Self-Neglect Resources
- KBSP Multi-agency Guidance: Self-Neglect

Carers

- Support for carers (bristol.gov.uk)
- Care and support for adults in Bristol
- KBSP Information Sharing protocol kbsp-information-sharing-protocol-june-21-final.pdf (bristolsafeguarding.org)
- KBSP Adults Escalation Procedure

Domestic Abuse

- Information about where you can access support if you are experiencing domestic abuse Support for Bristol Residents - Domestic Abuse
- Information about the MARAC Process , including referral form and guidance.
- Safe Lives DASH Risk Assessment tool safe-lives-dash-ric.doc
- What is IRIS – information about the IRIS programme.

Training

The KBSP offer a wide range of training courses including:

- Mental Capacity Act Training
- Domestic Abuse and Safeguarding Training

Additional courses rolled out between April 2023-March 2024 include:

- Problematic substance use and safeguarding
- Disability and safeguarding
- Core safeguarding adults' course

Further information can be found here: KBSP Training

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www.bristolsafeguarding.org/contact-us