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Iechyd Cyhoeddus Cymru
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Learning from Reviews

1 April 2017 to 31 March 2018

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

National Safeguarding Team

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1 Introduction

NHS Wales contribute to a number of review processes in accordance with Part 7 of the Social Services and Wellbeing (Wales) Act 2014.

The purpose of Practice Reviews is to learn lessons, to inform and improve practice. These include Adult Practice Reviews (APRs) and Child Practice Reviews (CPRs) which are commissioned by the Regional Safeguarding Boards as laid down in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. Additionally, Domestic Homicide Reviews are conducted in accordance with the Home Office Domestic Homicide: statutory guidance (2013; 2016).

2 Background

The National Safeguarding Team (NST) through the Safeguarding NHS Network facilitate the 'NHS Wales Learning from Reviews group'.

This group was set up to share learning from reviews in a timely manner across NHS Wales. This learning includes, changes to systems, process or practice within Health Boards and Trusts across Wales in response to the recommendations of Child, Adult and Domestic Homicide Reviews. The group's inaugural meeting was held in February 2017, with terms of reference drawn up and agreed by its members, comprising Heads of Safeguarding from Health Boards and Trusts across NHS Wales. A Designated Professional (NST) chairs the group and a Head of Safeguarding (NHS Trust) was elected as vice chair. An exception report is presented at each NHS Wales Safeguarding Network meeting and various presentations to disseminate further learning with wider professionals across NHS Wales.

3 Purpose

The purpose of this report is to highlight key themes from an analysis of published practice reviews in Wales for the period 1 April 2017 to 31 March 2018.

This work aims to shape best practice and encourage reflection on the lessons and themes identified within local areas and identify similarities from the findings of reviews across different regions in Wales. This information can be used to consider future practice development and innovation and to enhance and deliver improvements in practice both on a local and national level.

4 Methodology

The NST reviewed the current practice of disseminating learning from reviews across Wales through one to one discussion and collaboration with Heads of Safeguarding and Named Professionals.

It became evident that whilst learning from published reviews and early learning was being shared within individual regional safeguarding board areas where the reviews took place; this learning was not consistently shared on a wider basis with colleagues across NHS Wales. This meant that each Health Board and NHS Trust interpreted the recommendations individually and often developed individual policy and procedure, which can lead to inconsistent practice and duplication of work. At the inaugural meeting of the 'Learning from reviews group' in February 2017, the mechanism for sharing lessons learnt, including methodologies used to implement actions from recommendations made were discussed. The methodology for improving the dissemination of learning was then agreed, and the groups 'Terms of Reference' accepted.

From 1 April 2017 to 31 March 2018, group members agreed that they would:

- take responsibility for disseminating any new published reviews conducted within their respective regions with group members
- bring any new policy or procedure developed following a review conducted within their regions for sharing and wider discussion
- bring early learning from unpublished reviews where early changes to practice was felt to be beneficial.

The NST agreed to chair and facilitate the meetings and:

- collate the information shared by members, analyse and disseminate emerging themes and learning
- highlight any Adverse Childhood Experiences (ACEs)
- forward nominations/learning to be included as agenda items for the NHS Wales Safeguarding Network meeting and provide exception reports.

5 Findings

Between the 1 April 2017 and 31 March 2018, there were 12 published reviews in Wales. These comprise 2 Domestic Homicide Reviews, 5 Child Practice Reviews and 5 Adult Practice Reviews.

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

Health Board	APR	CPR	DHR
ABMUHB	1	1	0
ABUHB	0	0	2
BCUHB	2	2	0
C&VUHB	0	1	0
CTUHB	2	0	0
PTHB	0	1	0

Table 2 (below) provides the outcome or contributory factors of the review and age classifications.

Outcome/Contributing Factor	Adult	Child	Young Person (16-25 yrs)
Death	2	1	1
Suicide			2
Sexual Abuse		1	
Self-Neglect/Hoarding	1		
Deliberate Doping of a Child	1		
Substance Misuse	3		2
Domestic Abuse		3	
Medical Neglect		1	
Vascular Problems	1		
Unexplained Injury		1	
Harmful Sexual Behaviour	1		1

Adverse Childhood Experiences (ACEs)

ACEs were identified within all five CPRs conducted and two APRs involving Young People. Tables 3a & 3b below demonstrate the number and distribution of ACEs identified in both children and adults (where capture was possible). There are limitations to the capture of ACEs within the reviews, as not all reviewers give specific categories that are in-line with the 9 categories as used in the Wales ACE Study.

Table 3a

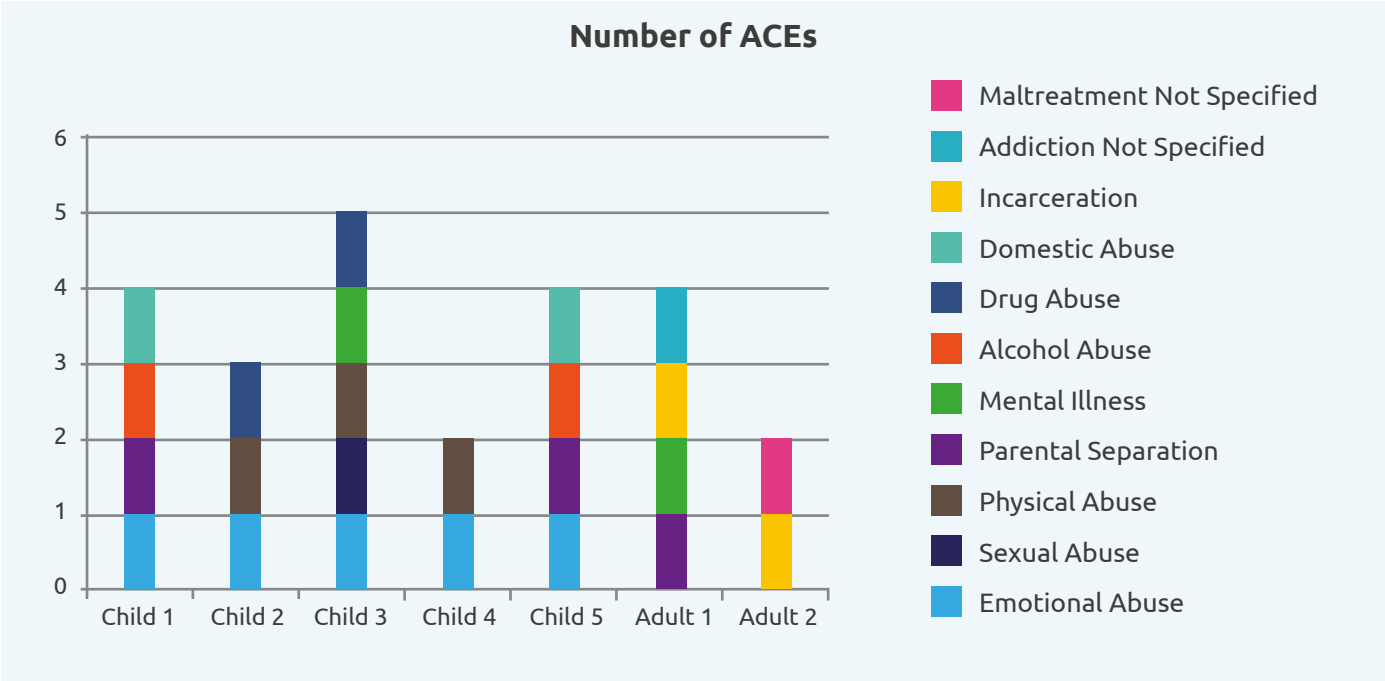
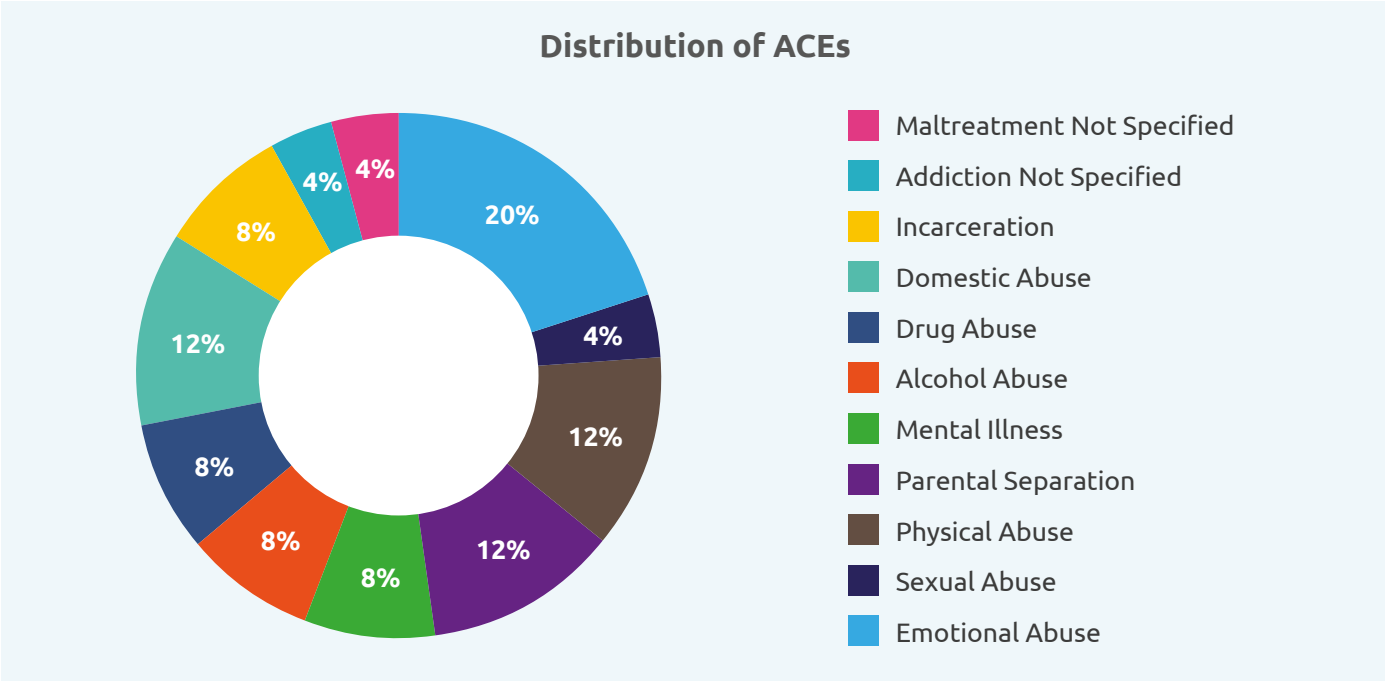


Table 3b



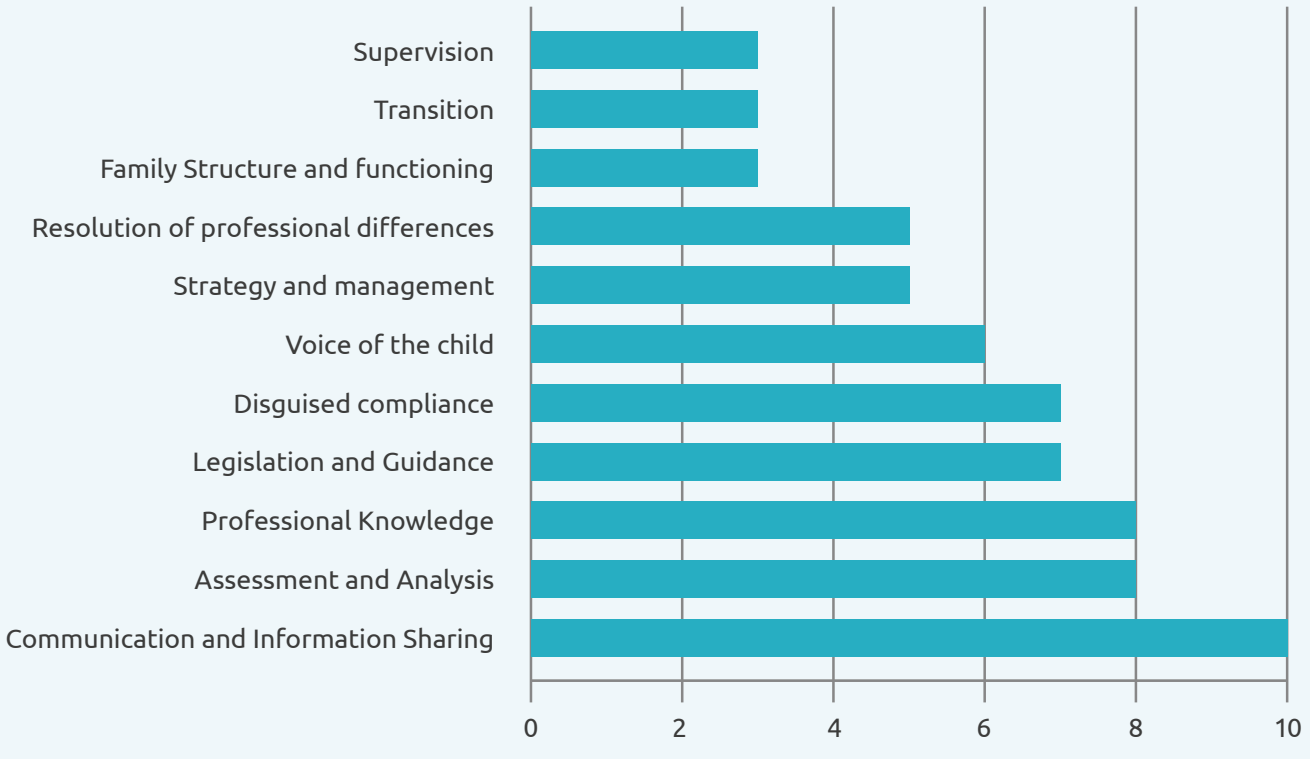
6 Emerging Themes

An analysis of emerging themes from the five CPRs and five APRs between 1 April 2017 and 31 March 2018 has been undertaken.

The frequency of each themes occurrence through 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 other enduring themes featured across reviews and Health Board areas. These are set out below:

- Communication and information sharing
- Assessment and analysis of risk
- Strategic planning
- Management oversight
- Professional knowledge/skills
- The voice of the child
- Policy issues and compliance
- Understanding family structure and functioning
- Disguised Compliance / Challenging Behaviour
- Supervision
- Resolution of professional differences
- Transition arrangements

Table 4 (below) identifies key themes and number of reviews where each category was identified either as a main or secondary theme.



6.1 Communication and Information Sharing

The most frequently occurring theme within 10 reviews, both adult and children, related to communication failures, comprising of multi-agency and single agency information sharing processes, and those between agencies and families. Difficulties ranged from not providing feedback on the status of referrals, to more complex issues in respect of clarification and understanding of explicit risk. There were instances where a lack of a common language or understanding was seen to impede effective risk assessment. This was evident from learning events where practitioners described open channels of communication between partners however expressed frustration at the lack of understanding of risk once information had been shared.

This lack of professional understanding had far-reaching impact affecting not only the quality of risk assessment and planning but in some instances stifling the voice of the Child.

> "In summary there was some confusion within the agencies as to what constituted a "referral" where concerns were being expressed about the child. There was also some frustration that there was no explanation or feedback from CS around what action was taken, or planned to be taken following telephone calls and letters concerning the child's wellbeing" (C&VRSCB 09/2014)

There was recognition within the reviews of the importance of specific professional's attendance and contribution at strategy meetings and at child protection conference, to communicate risk and contextualise the information being shared. The Paediatricians attendance at strategy meetings and initial child protection conferences where child protection medicals had been undertaken for example and the attendance of a medical professional in cases where chronic health conditions had been diagnosed. Two CPRs identified instances when a lack of medical representation at such meetings hampered the multi-agency partners understanding of risk.

> "We recommend that where a child on the child protection register is known to have a specific chronic illness or complex health need, a medical practitioner must attend all initial case conferences and reviews". (DENBIGHSHIRE 2 ECPR)

Adult reviews indicate the need for the early identification of a key professional who has the best understanding of the vulnerable person's circumstance in order to maintain continuity and ensure that context of risk to the adult is not lost in multi-agency discussions.

Issues in respect of communication with families related to the relaying of information pertaining to explicit risk, which appeared to be lacking from the dialogue along with the need to check families understanding of the information given to them.

> "Family did not believe that they had been informed of the outcome of the investigations into the incident whereas practitioners confirmed that meetings had occurred where this information was offered". (APR WBSB 2016)

6.2 Assessment, Analysis and Strategic Planning

Assessment, analysis and strategic planning were seen as a key issue in respect to identification and escalation of risk in eight reviews comprising both Adult and Child Practice reviews. When combined with strategic planning which featured within a further five it was the most frequently cited theme and out ranked communication. A lack of management oversight and failure to re-evaluate plans was identified by both child and adult reviewers as being a significant issue.

Within Adult Practice Reviews, the need for ownership, accountability and maintenance of safeguarding plans was seen as a priority area for improvement. Furthermore, recognising the need to assign a named individual for the purpose of coordination was vital.

"The reviewers did not see evidence that the action plan was being given strategic importance. The reviewers were unable to establish how it was being implemented and who was responsible for its implementation" (APR2/2016/Conwy).

One Child Practice Review highlighted concerns about insufficient information provided at the point of referral, which made it difficult to establish accurate risk and this in turn influenced the effectiveness of the subsequent assessment. Furthermore, decision making in respect of safeguarding actions was on occasion, influenced by non-engagement and age, rather that evidence of reduced risk. The need for a robust multi-agency approach to assessment and planning was a key issue, as was the need to improve the way in which the views of agencies or professionals are given proportionate weight in assessments and subsequent decision making.

"Practitioners need to be mindful of the role and scope of each agency's involvement with the family, and the value of such information. At the learning event practitioners from one agency perceived that the validity of their information was not seen as important and was not informing decision making" (C&VRSCB 09/2014).

The importance of incorporating points of escalation into multi-agency plans was identified as a key component to effective risk management along with a clear line of referral once such escalation points had been reached.

"The Adult Protection Plan agreed by all agencies was not sufficiently robust to identify trigger points at which organisations should have met within a multidisciplinary team context. Similarly, there is no detail of individual organisations responsibilities. A detailed protection plan may have indicated the trigger points in this case". (NWSB APR 3215)

Both adult and child reviews identified times where strategy meetings should have been convened in order to ascertain a clear picture of risk and to co-ordinate an appropriate safeguarding response, failure to do so resulted in lack clear understanding of the individual's circumstance and risk management.

"In this case there was no strategy meeting coordinated under the Sexually Harmful Behaviour Protocol to support the multi-agency practice in managing risk and coordinating responses to the subject's needs. This was a missed opportunity for coordinating services and assessment in relation to the young person's well-being" (CTSB 2/2016).

6.3 Professional Knowledge and Skill

A lack of professional knowledge or skill was identified as a theme in eight of the reviews, resulting in delayed action. This ranged from an inability to recognise behaviours associated with abuse to identification of injury such as bruising to the ear of a child, and a lack of training and expertise to manage harmful sexual behaviours in adults with learning difficulties.

"The following week the child was reported to have hit herself with a toy which had caused bruising to her legs and had "aggravated a bruise to her ear". These explanations were accepted. (At the Learning Event it was identified that practitioners lacked knowledge in relation to the significance of bruising to the ears, especially in young children – such injuries can be indicative of abuse and should be referred for a child protection medical opinion" (WBSB 20/2015)

The reviews highlighted the responsibility placed on health boards to ensure their staff are trained to recognise abuse indicators as well as identifying concerning behaviours or presentations at the earliest opportunity.

6.4 Legislation and Guidance

Practitioners understanding and interpretation of legislation and guidance featured in four reviews. Two of these identified issues with professionals' interpretation of the Social Services and Well-Being (Wales) Act 2014.

Case 1, highlighted professional's reluctance to share or receive information when concerns raised despite being significant did not reach the threshold for a Section 47 Child Protection Investigation. Practitioners felt that information sharing was prevented under the "Act" without explicit consent. There appeared to be confusion between consent and the need to inform. The reviewers highlighted the importance of working together and the need for professionals to have clear and consistent guidelines to support decision-making with regard to consent.

> "During the learning event it became clear that practitioners had differing views and understanding on the need for consent to share information with other agencies if a child protection threshold has not been met. They were anxious that the Social Services and Well Being (Wales) Act 2014 would suggest this is not allowed" (WBSB 20/2015)

Case 2 identified confusion amongst professionals in respect of transition planning post 18years of age, particularly relating to "When I am ready". The review identified the role of the Independent Reviewing Officers (IRO) in assisting professional partnerships to "get it right for children in care" and recommending multi-agency staff training pertaining to SMART pathway planning in line with the SSWB Wales Act 2014 "When I am Ready" Good Practice Guide.

> "Across the multi-agency partnership and within the Local Authority there appeared confusion about the underpinning principles of the newly launched Social Services and Well-being (Wales) Act 2014 and the importance for young people in Child A's situation to be considered eligible to remain in their foster placement post 18 years". (CYSUR 4/2017)

Two reviews identified discrepancies in implementing internal policy and multi-agency guidance. Case 1 identified conflict between the opt-in appointment system and the 'Was not brought policy'. The reviewers highlighted the need for health professionals to be mindful that there may be safeguarding concerns for children who are repeatedly not brought to appointments for chronic conditions. This is particularly pertinent when children are on the CP register.

> "BCUHB Standard Operational Procedure for monitoring children who were not brought (WNB) procedure was not followed, which led to a re-occurring pattern of referral, discharge and re-referral with no individual practitioner taking overall responsibility in monitoring the child's well- being." (ECPR DENGBIGSHIRE2)

Case 2 highlighted discrepancies in implementing the pre-birth assessment process between health and social care. Professionals were not always clear as to when these should be instigated or applied. The reviewers recommend that the process of sharing assessments should be reviewed with the view of promoting synergy across the region.

> "During the individual interviews with professionals it was evident that Social Service professionals were not consistently clear about when a Pre-Birth Assessment should be instigated". (ECPR GWYNEDD 1 2015)

In a further three reviews the need for multi-agency protocols to facilitate effective partnership working between agencies was deemed necessary.

6.5 Disguised Compliance and Challenging Behaviour

Three Child Practice Reviews identified disguised compliance as having an impact on professional's ability either to recognise the needs of the child or to effectively implement change or improvements for the child. Disguised compliance when unchallenged was viewed to have an impact on any attempts to reduce risk. It was noted within the reviews that disguised compliance is not only a way in which parents can affect the way professionals view situations but also the accuracy of any risk assessments undertaken. Behaviours noted to have a negative impact were: Intermittent compliance with programmes aimed to help and support families to make positive change, engagement that fails to achieve positive improvement in the situation for the child or family, parental distraction from issues relating to the child and providing rationale for children's behaviours, which, whilst lacking in evidence were taken on face value.

Disguised compliance was seen as an effective way in some cases for parents to not only confabulate but also to "groom" professionals and ultimately resulted in "over optimism" on behalf of workers. Whilst it was noted that there was evidence of professional challenge to such behaviours, challenge was not consistent across all agencies and amongst all professionals. In addition, the reviews highlighted that some policies in respect to appointment systems and automatic discharge following fail to attend actually contributed to the impact on the child when disguised compliance was an issue.

> "It is the opinion of the Reviewers that the mother used what could be described as disguised compliance by attending a number of parenting programmes and appearing to engage with services, however this did not improve her relationship with the child or her ability to manage and supervise her child" (C&VRSCB 09/2014)

Challenging behaviour was a key theme in both child and adult reviews. Similar to disguised compliance, challenging behaviour and non-engagement was seen to have a significant impact on the way professionals assessed and risk managed individual cases. Challenging behaviour influenced the efficacy of safeguarding plans in respect to both adults and children and in some instances impacted on how decisions were made in respect to child protection registration. For both challenging behaviour and disguised compliance, high quality supervision and management support was seen as an effective mechanism to challenge situations that impede the safeguarding process. Both behaviours had a considerable impact on practitioner's ability to influence positive change and even when there was good evidence that practitioners were working to the best of their ability, the lack of supervision, strategy and escalation protocol impeded the success of this work.

> "Key professionals have had to seek to engage and form a professional relationship with very challenging parents, whilst maintaining the ability to appropriately challenge non-compliance and recognise 'disguised compliance'. (ECPR Gwynedd 1 2015)

One Regional Safeguarding Board (RSB) identified good practice from the reviews in the form of professional guidance and the development of a 'Challenging Cases Protocol' in response.

6.6 The Voice of the Child

The Laming Inquiry (2003) emphasised the need for children to be included in care planning and assessments so that professionals hear the child's voice and their lived experiences. Five Child Practice reviews identified further improvements were required to include the child when conducting assessments, care planning and in the case conference process. In some instances, the child's voice was lost or overlooked, because of parental behaviours, which distracted professionals from the child's needs. These behaviours had the potential to groom professionals and had an impact on multi–agency assessment planning.

Aggressive and violent parents were also cited as a cause for concern amongst professionals. One child practice review expressed that professionals felt, a father was too aggressive for them to visit the child at home, however they failed to translate this into an understanding of what life was like for a child living in this environment. The reviewer emphasised the need for agencies to consider practitioners or family members that

have pertinent information that would provide them with greater insight into the child's lived experiences and that there was a need to give proportionate weight to all information held. This is particularly pertinent for non-verbal children. Reviews involving young people also identified the need to understand presenting behaviours in the context of the child's experience and highlight the impact of ACEs on engagement and the young person's ability to express themselves. There was evidence within the reviews that professionals saw children alone, although the quality of the information gained during this interaction was often insufficient to determine what life was really like for the child.

There were examples of good practice in relation to advocacy services within adult reviews. One APR demonstrated the effectiveness of using an advocate in respect to an Adult with learning difficulties. Appropriate use of the "My voice service" meant professionals were able to hear their views and involve the adult in decisions that affected them, such as placement planning.

> "In this case, the voice of the child and their siblings is represented in the social worker's record keeping and within the conference process, but it has been difficult to see the full extent of this and how their views were used in relation to care planning. The child was articulate and talked about experiences at home, but there is no record within the social work files of any follow up to any of the concerns the child had expressed and no indication as to whether things had changed for the child and their siblings".
> (ECPR DENBIGSHIRE 2 2016)

6.7 Resolution of Professional Differences

Five reviews recognised the need for more robust professional challenge when there was disagreement in respect to risk. Reviewers noted that whilst there was recognition of risk by some agencies, this was not always perceived or easily understood by other agencies, and interagency challenge to decision making was not always felt to be strong enough. It was noted within both adult and child reviews that despite the existence of a multi-agency resolution of professional differences protocol there was evidence to suggest that professionals failed to evoke the protocol, despite there being evidence of interagency disagreement. This area was highlighted for improvement within the reviews. It was felt that management oversight and supervision was key to ensure robust professional challenge, and that agencies should ensure that staff are aware of the protocol and that it is fit for purpose.

> "It appeared that all agencies outside the local Authority looked to each other to find answers but crucially overlooked the need to resolve professional differences with the Local Authority to hold them to account" (CYSUR4/2017).

> "The management of the case was challenged on a number of occasions by the lead Paediatrician. The school made a number of telephone calls to CS, which appeared to result in no action. At the learning event these agencies highlighted their frustration at the lack of feedback or action to safeguard the child however neither agency invoked the "Resolving Professional Differences" guidance to challenge how the case was being managed". (C&VRSCB 09/2014).

6.8 Family Structure and Functioning

The need to have a clear understanding of the impact of family members on the lived experiences of the vulnerable adult or child was evident within five reviews. They emphasised the need for professionals conducting assessments to satisfy themselves that they are clear in respect to family relationships, structure and functioning. Child Practice Review findings indicate that information pertaining to family functioning can be hindered when staff working with adult service users fail to consider the wider family including children living within the home. The importance of robust exploration of the subject's situation and impact of family members must be considered and fully recorded in assessments.

> At the time of the child's injuries mother was in a new relationship. There was a history of domestic abuse in her partner's previous relationships. However, the status of his relationship with mother and whether they were living together is unclear" (WBSB2/2015)

> The focus of the work appears to have been entirely on Adult A's needs and situation, although there is evidence to suggest that his wife displayed hoarding behaviours, which we can reasonably assume, contributed to the overall situation. Evidence suggests that Adult A's circumstances were considered in isolation of his family and relationships". (APR3/2015CONWY)

There is a need for views of all professionals and when appropriate other family members to be conveyed and received by agencies so that information pertaining to the family functioning can be assessed and managed according to risk.

> "SMS identified a Health and Safety risk to staff and made a decision based on the aggression of father not to visit alone. Despite this decision, the children remained in the household. In the reviewers' opinion when a situation is deemed too risky for professionals to attend alone, this must give rise to significant concerns of the risks posed to the children in the household, and should trigger a review of the level of risk presented to the children". (ECPR GWYNEDD 2015)

6.9 Transitional Arrangements

Within three reviews involving young people, two Adult Practice Reviews and one Child Practice Review, transitional arrangements were found to be an emerging theme. It was evident within the reviews that there were significant challenges in commissioning suitable placements for children with specific needs within Wales. Transition also created additional stressors for the young person and is associated with additional risk. There was evidence that multi-agency decisions in respect to young people were possibly influenced by their age rather than evidence of reduction of risk, and that challenging behaviour and disengagement was often a barrier to ongoing work.

> "The transition process must be acknowledged as a critical period of heightened risk and must not focus on one organisation relinquishing responsibility of a young person." (CTSB/1/2016)

> "The multiagency decision to remove the subject's name from the Child Protection Register was based upon the challenges associated with implementing a plan and the age of the subject who was nearly 16 at the time, rather than evidence of reduced risk". (CTSB/2/2016)

The reviews highlighted the need for robust transitional arrangements, developed from clear and timely multi-agency planning. Professionals are reminded that the views of the young person are paramount, not only in verbal declarations but also in respect to their behaviours and involvement with services. There is a need to fully consider the young person's challenging behaviours and why they fail to engage so that they can be contextualised in risk assessment. Disengagement should not be seen as a reason to end support but should be viewed in the context of the young person's life history. Consideration should also be given to ACEs experienced by the young person.

> "Despite concerns about the subject's emotional well-being, behaviour and circumstances, the case was closed to children's services once an offer of a preventative service was made and declined". (CTSB/2/2016)

Agencies are asked to consider how to best support vulnerable people as they transition from child to adult service, and there is a need for a common threshold and approach to supporting vulnerable young people through this process as their vulnerabilities do not cease to exist just because they turn 18 years. The reviews noted that robust management, strategic oversight and professional understanding of legislation in respect to post 18 planning for children who are or have previously been a Looked After Child (LAC) is of paramount importance.

> "The Reviewers recognised that professionals gave considerable thought to protecting the young person and considered a variety of options available to them. However, towards the end of childhood there were occasions where agencies appeared to lose sight of the fact that the young person was still a child. Also, there was little evidence that when the young person became an adult that consideration was given to the use of adult safeguarding procedures". (CTSB 1- APR2016)

6.10 Supervision

Three child practice reviews identified supervision as a key theme highlighting the importance of high quality supervision to assisting professionals assess risk and challenge disguised compliance. Supervision was viewed to be important for effective risk management and planning and as a means to challenge over optimism amongst professionals. Where supervision was seen to be lacking from casework it was identified that this had created an environment where practitioners lost focus on the child. Factors that inhibited supervision included high caseloads and a lack of protected time set aside to adequately supervise staff experiencing highly challenging complex cases. One child practice review highlighted the need for health professionals working within adult services whose clients have parental responsibility to access corporate safeguarding supervision in respect to recognising risk to children in the care of the adults they were supporting.

> "The use of safeguarding supervision for partner agencies could have resulted in a better corporate parenting and professional escalation of risk. Good supervision practice and effective management oversight avoids drift and delay in care planning, keeps children safe and promotes good professional practice". (CYSUR4/2017)

7 Domestic Homicide Reviews

Due to the Domestic Homicide review process differing significantly from APR and CPR reporting, it is difficult to draw themes and to analyse the context in a comparable way. This is compounded by the fact that during the reporting period there were only two known published DHRs. The DHRs have therefore been considered together outside the APR and CPR analysis. The findings are presented below.

7.1 Findings from Domestic Homicide

Similarities were found within both DHRs. Both victims were female and both perpetrators were male. The MAPPA or MARAC process had known neither victim nor perpetrator in either case prior to the incidents that led to the death of the victims. Both Homicides took place in Gwent. Neither victim had extensive history with the Police. It was felt by the reviewers that neither of the incidents could have been predicted or prevented.

The circumstances of both Homicides were however very different. DHR 1 (Karen) was shot by her estranged husband and DHR 2 (Adult A) was a victim of strangulation and stabbing by her boyfriend following what was described as a trivial argument. The victim of DHR 1 was a married mother of two who was in the process of separating from her husband. The victim of DHR 2 was a young woman with learning disabilities and no children.

7.2 Risk assessment in Respect to Domestic Violence

Both reviews highlighted a lack of adequate risk assessment pertaining to domestic abuse, which affected the professional's ability to recognise abusive behaviours. In DHR 1 despite the victim contacting police and reporting stalking, escalation of aggression and her fear that her ex-husband kept firearms. This was not assessed in context of Domestic Abuse. However, the reviewers reported that this was a failure on behalf of individual officers and not systemic within the Police processes. It was reported that there were systems in place to recognise and assess abuse indicators however, these had not been applied appropriately in this case. The perpetrator in this case had also contacted the victims General Practitioner to enquire about the victim's health and to gain insight into her behaviours. He also disclosed that he was suffering from depression as the couple had recently separated. There was no record in the GP notes of any domestic abuse being reported.

In DHR 2, the assessment of risk in respect to Domestic Abuse appeared to have been hampered by the Protection of Vulnerable Adults process, which was in place at the time of the review (subsequently changed to Adult at Risk under the Social Services and Wellbeing (Wales) Act 2014).

The learning disability nurse working with the victim had made a Vulnerable Adult Referral following a report of abusive behaviour perpetrated by the victim's boyfriend. However, an opportunity to explore disclosures of domestic abuse effectively, particularly the disclosure of attempted strangulation by her boyfriend, a crime for which there is a statutory duty to report was missed. The review found that the disclosure was not discussed with the police at the time of the Vulnerable Adult Referral and the decision not to instigate adult protection procedures was based on the victim having capacity and not wanting support. In view of the fact that a disclosure of attempted strangulation had been made, and the victim being viewed as vulnerable, the application of the interim Adult Protection Procedures was not effectively applied in this instance. Reviewers highlighted the fact that consent or co-operation was inappropriately interpreted. Furthermore, there was a failure to recognise the perpetrators behaviour in the context of Domestic Abuse, and a referral to MARAC should have been discussed with the police and considered.

7.3 Communication

The communication of risk was hampered in the case of DHR 2 due to the way information pertaining to abusive behaviours was managed. This was exacerbated by the lack of information gathered by professionals. Whilst it recognised that, the victim in this case was in a new relationship with a partner who had displayed abusive behaviours, the health professional did not share this information, and therefore this case was not risk assessed in the context of domestic abuse and subsequently not shared with Police.

In respect to the victim in DHR 1, the only agency aware of her disclosure was the police. No disclosures were made to other agencies. It is recognised that currently there is no formal consistent system to share information in respect to domestic abuse with General Practitioners, which means that any police report generated would not have routinely been passed onto her GP, and they would therefore be unaware that domestic abuse was a feature in her relationship.

7.4 Perpetrator Behaviour and Its Effect on Victims

Both the reviews note the impact of Domestic Abuse on victims in the context of coercive control. The reviews highlight that both victims had reported abuse. With regards to DHR1, the reviewers felt that the victim had been subjected to coercive control throughout her marriage, and that this had gone unreported until the events highlighted within the review. Both reviews highlight that the behaviour of perpetrators influences the victim's ability to recognise or report abuse and there is a need to develop relationships when possible to allow for disclosure. This was particularly pertinent in DHR 2, as she had reported the abusive behaviours but these were never revisited during subsequent contact.

7.5 Firearms in Domestic Abuse

DHR 1 highlights the increased risk associated with firearms in the context of Domestic Abuse. The reviewers note that when firearms are present at a time that Domestic Abuse is suspected there should be consideration of seizure and recognition of their potential for serious harm. DHR 1 recognised that the victim was fearful that her husband's possession of firearms put her at risk in the context of his escalating behaviours. Despite the fact that her husband had always maintained his firearms in line with legislation his escalating behaviours were indicative of domestic abuse and as such should have prompted scrutiny in respect to his ownership and the additional risk of significant harm.

7.6 Partners Information

DHR 2 highlighted the need for professionals to gain information in respect to family members and partners. In this case, the victim had informed her nurse that she was in a new relationship and experiencing abuse, despite this, her new partners details were not ascertained during visits. This is pertinent because the victim's boyfriend was known to the police from his involvement with a previous partner, and had this information been known and shared with the Police a more accurate assessment of risk could have been made.

7.7 Third Sector Support

The value of third sector support was recognised within the reviews. Unfortunately, the victim in DHR 1 whilst aware of support available, she had not accessed any. It was felt the opportunity of accessing effective third sector support was a missed opportunity for the victim in DHR 2, due to the lack of exploration of abusive behaviours and details about the victim's relationship once an Adult Protection referral had been made. Furthermore, DHR 2 highlights the wider issue in respect to services for adults with learning disabilities in the context of domestic abuse.

8 Summary

The key themes identified within this review are set out below. They are consistent with previous findings from systematic analysis of serious case reviews such as "Pathways to Harm, Pathways to Protection" (2016).

- There is a need to strengthen practices that facilitate listening to the voice of the child/ vulnerable person and allowing time to hear and observe what they do and say to better understand their lived experience.
- There is a need to enhance the culture of communication and to develop respect for the views of all agencies, professionals and family members.
- Multi-agency practice should include the views of all appropriate and suitably qualified professionals in meetings and assessments.
- Assessments should be holistic, up to date and demonstrate points of escalation.
- 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.
- The time of transition for young people involved with child and adult services presents additional challenge and possible risk that should be understood in the context of assessment and planning.
- In cases of domestic abuse, identification should be based on accurate risk assessment and acted on accordingly. Referrals to Domestic Abuse Support Agencies should be considered at the earliest possible opportunity. Professionals should be able to recognise the markers of coercive control and understand its impact on victim behaviour.

9 Acknowledgements

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10 References

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