SAFER SHEFFIELD PARTNERSHIP
Domestic Abuse Serious Incident Reviews 13, 14 & 15

Due to the sensitive nature of SIR13, SIR14 and SIR15, the Safer Sheffield Partnership have decided to only publish the key learnings that came out of each review. The learnings that came out of each review have been summarised together in this document.

SERIOUS INCIDENT REVIEW 13

WHAT DID THE SIR13 REVIEW TELL US?

- A focus on an incident-based way of working meant the cumulative impact of domestic abuse was missed.
- This review showed us that children are harmed by and are victims of adult family violence.
- Accurate data collection was an issue in this case; there were several records for the same individuals and records were not joined up due to different spellings of names.
- Risk of Forced Marriage was not fully explored and opportunities to use professional curiosity were missed.
- The role of men and boys in both families was not fully understood.

SIR 13 - WHAT CAN WE DO NOW?

Recommendations:

1. Promote existing training options on Professional Curiosity and ensure that those using professional curiosity to gather full family histories are doing so in a culturally competent way and gathering the wishes and feelings of the child(ren).
2. Ensure that when recording personal information, such as names and dates of birth, that this is checked for accuracy with the person, with a specific focus on culturally diverse names.
3. Promote the use of the Young person's DASH in the context of both intimate partner abuse and adult family violence across all services and monitor its use and effectiveness.
4. Work with partners to ensure that children are recognised as victims of domestic abuse when adult family violence is happening, and appropriate support is offered.
5. The Partnerships, and individual agencies, to review if processes are adequate for sharing information and escalating concerns about risks in cases where there are frequent recurring issues, that may indicate higher risk.
6. Ensure that a trauma informed approach and response is used across the system when responding to complexity. Promote existing training options.

SERIOUS INCIDENT REVIEW 14

WHAT DID THE SIR14 REVIEW TELL US?

- Improving mental health outcomes for perpetrators, may give an opportunity to reduce the risks for victims and their children.
- The review found inconsistent practices in health settings on recording information about high-risk perpetrators.
- Agencies in Sheffield need to be aware of and follow the Non-Fatal Strangulation (NFS) Pathway.
- Having multiple-complex needs can make it harder to engage with services and can contribute to professionals believing that *'someone else will be dealing with the domestic abuse so I'll focus on the presenting issue.'*
- Due to the limited nature of information shared via Operation Encompass notifications, staff were not fully aware of the risk at home. Similarly, MARAC information was not shared with Designated Safeguarding Leads at the children's schools.
- All agencies need to consider the suitability of disclosed caring arrangements and refer to the Sheffield Carers Centre for assessment.
- Professionals did not consider the impact of post separation abuse on the victim / survivor.

- Consideration was needed for whether the victim / survivor was using violent resistance or acting in self-defence.

SIR 14 - WHAT CAN WE DO NOW?

Recommendations:

1. Promote research that found that the rate of suicide in high-risk high harm perpetrators of domestic abuse is 23 times greater than the highest age-specific suicide rate in the general population.
2. Raise with the Royal College of General Practitioners the issue of how information about high-risk high harm perpetrators is recorded on electronic health systems.
3. Develop a working with perpetrators toolkit so that staff can understand the correlation between mental health, substance misuse and perpetrating domestic abuse and include strategies to deal with this.
4. Promote the Sheffield Non-Fatal Strangulation (NFS) Pathway across agencies in the city.
5. Professionals working with victims/survivors need to take individual responsibility for using local risk assessment processes and offering support with safety planning.
6. Work with schools and Designated Safeguarding Leads to support them to develop a more informed response to domestic abuse incidents, including to Operation Encompass notifications and updates from MARAC.

SERIOUS INCIDENT REVIEW 15

WHAT DID THE SIR15 REVIEW TELL US?

- Online housing applications to Sheffield City Council can take up to 28 days to process, but in this case, there were only a few days between the victim / survivor completing the online form and the incident.
- Due to GDPR, Health Visitors do not access father's records unless the father is a main carer for a child. This highlights a national issue as it means that vital information about perpetrator's behaviours and risk to children may be missed.
- Evidence shows there is a link between children's speech, language and communication and domestic abuse and there were opportunities for professionals to use their curiosity to better understand what was happening in the home.
- Professionals could have explored this post-separation abuse in more detail.
- The perpetrator was often present at appointments which may have limited opportunities to disclose.
- Some cultural factors may have prevented the victim / survivor from disclosing along with an absence of awareness of services that could have supported her.
- Information was not always shared between agencies, so Children's Social Care didn't have the full picture.

SIR 15 - WHAT CAN WE DO NOW?

Recommendations:

1. Review SCC's online housing registration process. Investigate whether functionality can be added so that domestic abuse key words are flagged to enable applications to be reviewed sooner when risk factors are identified.
2. Nationally, raise the issue of Health Visitor protocols about when to access records of fathers who are perpetrators with the Domestic Abuse Commissioner & NHS England, and other appropriate forums.
3. Domestic abuse Routine Enquiry training to include information on the link between children's developmental milestones (including speech, language and communication) and domestic abuse.
4. Using partners/ family/friends/children as interpreters does not allow space for domestic abuse disclosures. We will promote the use of the Interpreter Guidance for cases of domestic abuse.
5. Professionals should be curious about the possibility of post-separation abuse when women do not have contact with children and where a possible victim may not be aware of UK processes and law around DA.
6. Promote domestic abuse services and raise awareness of UK legislation to a range of communities and in a range of languages.