Safeguarding Adults Review: Adult P

Overview Report

Independent Report Author: Ian Vinall
A Local Authority Safeguarding Board Commission

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Introduction

1.1 The subject of this review is Adult P. Adult P is the eldest of four siblings. She has described herself as fun, caring and would always help others and that she 'gets on with everyone'.

1.2 Adult P and her children were present in the family home and experienced a significant domestic abuse incident perpetrated by Adult P's ex-husband (known as Adult M for this review). This experience lasted over 11 hours during which time Adult M seriously assaulted Adult P several times leaving her with life threatening injuries. He removed all forms of communication during this period, preventing Adult P and the children calling for help from family or the emergency services. Eventually, when he fell asleep one of the children contacted family members and the emergency services. Adult P sustained significant injuries and was in an induced coma for most of her time in hospital.

1.3 The children and Adult P were subsequently referred to the local multi-agency Rapid Review[1] meeting who confirmed the criteria was met for a Local Child Safeguarding Practice Review (LCSPR) and a Safeguarding Adult Review (SAR) for Adult P.

1.4 The independent author was appointed and facilitated both the LCSPR and SAR.

Methodology and Process

2.1 Under the requirements of Section 44 of the Care Act 2014[2] there is a duty on Adult Safeguarding Adults Boards (SAB's) to arrange a Safeguarding Adults Review (SAR) where it is known that an adult in its area with care and support needs has died or is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.2 The review seeks to understand the circumstances related to the death of the adult in a spirit of learning, without apportioning blame, but to ensure learning is applied to future case to prevent similar situations from happening again.

2.3 A separate SAR Panel was agreed to ensure the focus remained on Adult P and her care and support needs. In addition to the findings outlined in this report, the LCSPR has further informed learning to support necessary improvements.

2.4 The SAR panel confirmed that relevant agencies would provide a chronology of involvement and the independent author would engage in 1:1 conversation with the parents, grandparents and practitioners involved with the family. A practitioner event was held and the SAR Panel met on two occasions.

2.5 The independent author met with both Adult P and Adult M separately. The report author is also grateful for the engagement of family members to assist the understanding of the family story.

2.6 The independent author also reviewed a large number of documents, assessments, plans and reports.

2.7 The SAR Panel agreed that the timeframe for the review should cover a period of two years up until the incident occurred. The independent author also agreed to

[1] Working Together 2018 Chapter 4

[2] Section 44 of The Care Act 2014 requires Safeguarding Adult Boards (SABs) to arrange Safeguarding Adult Reviews (SARs) when the criteria are met, and when they are not met but the SAB believes there is value in doing so.

summarise agency involvement prior to this as there was significant and relevant information regarding Adult P's experience.

Key Lines of Enquiry

2.8 Understand the lived experience of Adult P and whether her care and support needs were adequately met.

2.9 Review and analyse safeguarding agencies understanding of the impact of coercive control and domestic abuse on Adult P.

2.10 Establish the impact on Adult P of illicit drug use and how this was understood by safeguarding agencies in the context domestic abuse.

2.11 Review current arrangements for domestic abuse and support.

2.12 Establish whether there are further lessons to be learnt for safeguarding agencies from the case of Adult P.

Protected Characteristics

3.1 It is against the law to discriminate against anyone because of their age, gender, race, religion or belief and sex.

3.2 The review identified the characteristics and identity of Adult P and her family. Adult P's protected characteristics will be commented upon throughout the review and consideration given as to whether there was any evidence of any direct or indirect discrimination because of those characteristics.

Chronology

4.1 **Childhood**

4.2 Adult P has described her childhood very positively and feels her family life was very close. As a teenager, she 'got in with the wrong crowd' and was 'gobby and mouthy'. This led her to being expelled from school and when she left school and went straight into paid employment. Aged approximately 18 or 19 she was first diagnosed with depression and started taking anti-depressant medication. Adult P was 18 when she met Adult M and they reported that this was their first proper relationship.

4.3 The family have a lengthy Children's Social Care history when living in other areas and Adult P has spoken about suffering with significant depression into adulthood. Adult P has recalled being physically assaulted by Adult M on several occasions, including just after her first child was born. Drugs and alcohol have been a feature in their relationship since the beginning and Adult P received a conviction for drink driving before her first child was born.

4.4 Aged 9 weeks old, their first baby was admitted to hospital with a broken leg and fractured rib and they were placed into foster care. Adult M was arrested and was subsequently convicted of causing the injuries and was sentenced to a term of imprisonment. Adult P resumed care of her children and they became the subject of a child protection plan with the local authority then applying for a Supervision Order. This order was granted and the order concluded after 9 months. It was recorded that the Adult P worked well with Children's Social Care and their case was closed on the conclusion of the Supervision Order. Adult M had moved out of the family home and was living with his mother.

4.5 In March 2011, a referral to Children's Social Care was made via the police following police attendance at the family home because of a serious incident of domestic abuse perpetrated by Adult M. It was reported that he had seriously assaulted her, her parents and her brother. Adult M was arrested, charged, convicted and given a suspended sentence. He was ordered to attend the IDAP[3] and Caring Dad's[4] programme. Adult P and Adult M remained in a relationship and he returned to the family home after several months. There was positive feedback about the couple's work with Children's Social Care and the case was closed in 2012.

4.6 In March 2013, their child disclosed a further significant domestic abuse incident perpetrated by Adult M and the child sustained a further injury. Both parents denied the incident. The child went to live the maternal grandparents. It was reported by Children's Social Care that the family made 'good progress' and the child returned to the care of Adult P. Adult M was once again out of the family home.

4.7 The family moved to another local authority in 2014 and there is very little information available as the family did not come to the notice of agencies despite the significant history of involvement and the children's father returning home and resuming his relationship with the family. Closing summary documents highlight Adult P's responsibility for ensuring safe 'contact' for their with their father.

4.8 The reports during this period highlight the concerns about Adult M's mental ill health, significant drug and alcohol use.

4.9 **2018 - 2021**

4.10 The family moved to the local authority area in 2018.

4.11 When the health visitor first met Adult P in late December 2018, Adult P denied having any history of alcohol and substance use and no experience of domestic abuse. She reported Adult M to be supportive. When asked about existing or historic child protection concerns in the family, she reported the family had no history of involvement with safeguarding agencies. No health or safeguarding concerns were identified.

4.12 The family initially lived with Adult P's parents at their home address before seeking suitable housing locally.

4.13 In January 2019, Adult P was referred to 'talking therapies[5]' by her GP following reporting low mood and self-reported that the marriage was 'ending soon'. In May 2019, she was prescribed further anti-depressant medication.

4.14 In December 2019, a 14-year-old girl disclosed that Adult M had sexually abused her. The subsequent investigation led to all three children in the family being made the subject of a child protection plan in January 2020.

4.15 At the initial child protection case conference, concerns were raised about the children's history, together with concerns regarding all three children's school attendance, the children reporting that their dad presents as angry, the historic domestic abuse incidents and the sexual abuse allegations against Adult M. Children's Social Care reported that the parents were accepting of their involvement

[3] Integrated Domestic Abuse Programme - IDAP was a cognitive-behavioural programme which challenged convicted offenders' attitudes and beliefs in order to change their behaviour.

[4] The Caring Dad's Programme is a group intervention programme for men who have abused, neglected or exposed their children to domestic abuse.

[5] www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/nhs-talking-therapies/

however, the allegations against Adult M were not evidenced and the police investigation concluded with no further action.

4.16 In February 2020, child P disclosed in a direct work session with the social worker that 'daddy was smacking him'.

4.17 Adult P was charged with drink driving following a car accident in March 2020 and was subsequently banned from driving for 16 months. She sustained a broken ankle and facial injuries. She told police that she had been drinking alcohol the previous evening. Her parents reported that this incident occurred as Adult M had 'chased' her out of the family home and she was escaping violence, however this is not confirmed by other agency information.

4.18 The case was then closed to Children's Social Care at the beginning of September 2020. Adult M did not engage with any elements of the plan. It is of note that these interventions were at the time of the national lockdowns owing to the Covid-19 pandemic.

4.19 In September 2020 Adult M suffered a bereavement in his family and he feels this impacted his mental health and drug use significantly.

4.20 Further reports of domestic abuse were received by Children's Social Care via the police in November 2020. A medium domestic abuse risk flag was placed on the police records management system (Niche). There are no documented attempts to undertake enhanced safety planning with Adult P and the children. Adult M received a caution for 'extreme pornography' in 2020 but this did not feature in multi-agency risk assessments until after the incident in August 2021.

4.21 A further Section 47 investigation was instigated and as part of the child and family assessment, the couple's youngest child disclosed that her mummy hates her and hits her and her daddy hits her mummy and her sister and this makes her feel sad. In December 2020, child Q stated to school staff "My dad always shouts at me, I didn't do nothing wrong. My dad always hurts my sister and my mum and it always make me cry". This information was shared with the children's social worker and there was contact with mother. Adult P reported to school that she 'cannot stop the children from lying'.

4.22 Adult M moved out of the family home and went to live with his mother. He was expected to complete interventions to address his mental ill health, drug and alcohol use to enable him to return to the family home.

4.23 In April 2021, a further Section 47 investigation was instigated following the eldest child's (child O) sexual exploitation online. This led to a Child Sexual Exploitation Risk Assessment and an Initial Child Protection Conference. The three children were placed on a child protection plan under the category of neglect. The child protection plan was largely a repeat of previous plans and interventions which had been unsuccessful in the previous period of child protection planning which the parents did not fully engage in. There were challenges in engaging the family in the plan because of regular Covid-19 presentations of the family members.

4.24 In May 2021, Adult P arrived at school to collect the youngest children intoxicated which led to a further Section 47 investigation and the children were moved to their maternal grandparents.

4.25 Adult M was referred to substance misuse services and was assessed on 30 June 2021. He was offered other services, including a referral to mental health services which he declined. He refused to cooperate following the review child protection case conference but requested a referral to a service that provides a range of substance

misuse services to anyone aged 18 and over who live in the local authority area). This was not actioned as Adult M failed to respond to contact.

4.26 Both parents were referred to adult substance misuse services and it was difficult for the parents to engage with the service. This was referred in the Children's Social Care chronology as 'disguised compliance'. Drug testing was instigated as part of the child protection plan and they both tested positive for cocaine on two occasions between July and August 2021.

4.27 On the 8 August 2021, Adult P was the subject of a significant and sustained physical assault by Adult M in which she received life threatening injuries. The incident lasted approximately eleven hours during which time all forms of communication were removed by father and the children were unable to seek help.

Key Practice Themes (addressing the Key Lines of Enquiry)

Care and Support Needs and Safeguarding Adults

5.1 The Care Act 2014[6], gives local authorities a duty to carry out a needs assessment to determine whether an adult has needs for care and support. The local authority must consider other issues as well as the provision of services to support the individual with care and support needs. Individuals are only eligible for assessment if they meet all the following criteria:

- They have care and support needs as a result of a physical or mental condition
- Because of those needs, they cannot achieve two or more of the outcomes specified
- As a result, there is a significant impact on their wellbeing

5.2 Outcomes are specified in the regulations and include individual's day to day outcomes such as dressing, maintaining personal relationships or working.

5.3 When Adult P moved with her family in 2018, they were not known to safeguarding agencies in the local authority. The first notification in December 2019 related to the behaviour of Adult M and this led to a child and family assessment in Children's Social Care. This assessment highlighted the significant history of the family and the domestic abuse experienced by Adult P. The parental history of alcohol and drug use is also considered in this assessment yet at the subsequent child protection conference there was no consideration for further assessment or intervention. The couple were referred to the adult domestic abuse workers in the Family Safeguarding Team who were tasked to provide support and interventions to address the domestic abuse.

5.4 During the review period, Adult P was experiencing domestic abuse, was using drugs and alcohol and was suffering from mental ill health.

5.5 Specific adult safeguarding responsibilities apply to safeguarding agencies where an adult who has care and support needs is experiencing (or is at risk of experiencing) abuse or neglect and is unable to protect themselves because of those needs. Domestic abuse is one of ten categories of abuse described with the Care and Support Statutory Guidance. An adult safeguarding concern should be raised when an adult, who has or appears to have, care and support needs is subject to, or is at

[6] https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

risk of, abuse and neglect. The adult themselves do not need to be in receipt of care and support. The guidance goes on to include 'an adult with care and support needs may be a someone who misuses substances or alcohol to the extent that it affects their ability to manage day to day living'. The Safeguarding Board advocate the 'Making Safeguarding Personal' approach for adults at risk of abuse or harm. Making Safeguarding Personal (MSP) is within the Care and Support Statutory Guidance and underlines the need for the full involvement of the adult concerned. If adults decline support, it should not mean that agencies exit. There should be opportunities to help empower adults to make safe decisions. There is a need to balance the risks between consent and harm and abuse.

5.6 Based on the evidence provided for the review, it was not clear whether Adult P met the three-point test for her care and support needs to be assessed. However, there is sufficient evidence that she met the threshold for a safeguarding enquiry under Section 42 of the Care Act 2014 in that 'she has or appears to have' care and support needs. Those enquiries would determine whether any action needed to be taken to prevent or stop the harm or abuse.

5.7 Whilst statutory processes and procedures were in place to support the children, there was limited evidence to indicate that any agency gave consideration whether Adult P was herself in need of safeguarding.

5.8 The Safeguarding Board multi-agency risk framework has been developed to provide support and guidance on how to manage adults where there is a high level of risk but where the circumstances sit outside the statutory adult safeguarding framework. The risk framework offers a multi-agency method to support the management of these risks in an effective way[7]. There is no evidence to indicate that this was suggested or proposed for Adult P prior to August 2021.

5.9 Given the children were open to Children's Social Care it is assumed that Adult P's risks and needs may have been seen in this context. This approach sadly negates Adult P's specific needs for safety in her own right.

5.10 Systems, structures, workloads, and cultures in safeguarding agencies can influence practitioners ability to explore, ask questions, challenge, listen and understand the life of an adult beyond the immediately obvious. There are professional conditions that allow for deeper enquiry. It requires practitioners to use their communication skills to 'dig deeper' into areas where there is limited information and this approach enhances assessment and intervention. Yet this approach must be supported by strategic leads in safeguarding agencies. There should be explicit guidance that allows time, capacity, working practices, supervision, management support and learning to enable practitioners to be more professionally curious and reflective.

Recommendation 1: Agencies are recommended to review their guidance on professional curiosity and assess its effectiveness with frontline practitioners through a process of open feedback and/or focus groups. This feedback should factor in the development of future guidance to practitioners.

Recommendation 2: The Safeguarding Board should consider a learning audit of how many referrals for Section 42 and/or requests for multi-agency risk framework meetings for adults at risk originate from the Family Safeguarding Teams.

Recommendation 3: Children's Social Care Practitioners in the Family Safeguarding Model need to have specific awareness training on adult safeguarding and the use of Section 42 of the Care Act 2014 and the multi-agency risk assessment framework.

Drug and alcohol misuse

5.11 Initially, the extent and impact of the parents alcohol and drug misuse was not fully evaluated, particularly the drug use of Adult M.

5.12 Both parents confirmed their use of drugs and alcohol and were open about the impact this had on them individually and as a couple. There was a level of acceptance of the impact their behaviour had on the children. Adult M's cocaine use significantly increased following the death of a close family member and he was in significant drug debts. Adult P reported that the family did not have any money and she would take out money from accounts so the family could buy food. Practitioners working with the family gave no indication that the family were deprived of money, goods, or food.

5.13 Expectations were placed on Adult M to proactively take action himself to address his drug use and self-refer for support. He never attended any treatment programme.

5.14 Adult P reported that Adult M was drinking and using cocaine throughout their time together but this increased when he was arrested for the alleged sexual assault in December 2019. She reported that he would come home each evening after work after 10pm and would drink and take cocaine before bed avoiding the meals Adult P had prepared. She stated that she developed a routine where all the children were in bed by 9/10pm to avoid any confrontation that they could witness. She stated that he would line up several lines of cocaine on the mantlepiece and snort those throughout the late evening. Adult P reported that the following morning she would be up at 5am to bleach and clean the house so that the children had no visual signs of his drug and alcohol use. This was confirmed via webcam footage located by the police.

5.15 Adult P has reported that she used cocaine rarely and could only recall using about six times. She explained that she took cocaine to 'try to be supportive to Adult M', yet it is not clear why this was the case. Substance misuse workers believe Adult P's cocaine use to be far higher than she reported. Adult P did use alcohol and would drink with Adult M in the evenings and she reported that the children would always be in bed when the couple used drink or drugs. Adult P described having concerns about the marriage and how it could continue in this way. She described her increased use of alcohol as a 'coping strategy'. This was confirmed by the substance misuse worker. Adult M reports that Adult P's alcohol use was significant and that she would excessively drink at all times of the day.

5.16 Women frequently do not believe their drinking is their main problem but instead perceive alcohol as a coping mechanism to a specific crisis or social situation[8]. It is argued that there is a greater social stigma associated with women who misuse alcohol alongside feelings of guilt or shame and their perceived failure to succeed as a parent or wife and this may cause women to deny or minimise their alcohol use and its impact. Positive approaches or ways of working with women with substance use problems include providing services that are gender-responsive, trauma informed, strengths-based, relationship-based, collaborative and family-centred[9].

Recommendation 4: Drug and Alcohol Services should consider the implementation of 'women sensitive' services that address gender specific treatment issues and that consider women's wider social contexts, particularly their experiences of domestic abuse and coercive control.

5.17 Adult P's own alcohol use increased from May 2021 and has been a consistent feature in assessments up to the incident in August. Her increasing alcohol use and drug use became the subject of regular testing. The evidence available indicated that Adult P tested positive for cocaine on three occasions between May and July 2021. The last test before the incident in August took place in mid-July. This was negative. There was a failed visit recorded on the same day as the incident in August but there is no record as to the reasons for this.

5.18 As part of the Family Safeguarding Model in the local authority, Children's Social Care worked alongside colleagues from Adult Services who provided drug testing and support for Adult P from May 2021 following the incident where Adult P arrived at school under the influence of drugs and alcohol. The substance misuse worker began an assessment of Adult P and this concluded in July 2021 with a proposed support and reduction plan. This support was only put in place following the school incident and it is not clear why substance misuse workers were not involved previously with the parents given the history.

5.19 The school described Adult P has 'incredibly embarrassed' about her presentation at the school and regularly apologised to school staff for her behaviour.

5.20 There was regular liaison between the adult and children's practitioners and joint supervision was in place. There were joint visits made to the family home by the social worker and the substance misuse worker. The adult substance misuse worker was of the view that Adult P was using cocaine much more than she admitted and whilst she was amenable to drug testing initially, Adult P became more 'oppositional' over time. Substance misuse workers attempted to engage Adult P in alcohol safety planning and a reduction plan. It was felt that Adult P was not being honest with professionals and they did question whether she was not able to talk 'freely'. This did not result in any more investigative questions about her relationship and her experiences of domestic abuse. Adult M did not engage with any ongoing drug testing despite requests for doing so.

5.21 Alongside this, Adult P was referred through the Family Safeguarding Model, to qualified mental health practitioners who are seconded from health into the multi-

[8] Developing women-sensitive drug dependence treatment services (Reed BG) *Journal of Psychoactive Drugs.* 1987
[9] Mothers who use substances and implications for the care system: desk-based literature review, SCIE 2022

agency teams. All the contact with Adult P was virtual and she was not able to engage with this support and her case was closed.

5.22 This presents a challenge to joint working between adults and children's services as threshold, policy and practice remains different for adults and children. Adult P was closed to the substance misuse service on the 18 August 2021 due to her hospital admission. The legal and procedural arrangements differ in adult's and children's services and non-engagement can be a precursor to case closure which might contradict the approach and risks highlighted by children's services.

5.23 Children's Social Care request drug tests or breathalysers as a way of monitoring adult behaviour. It is not normal practice in the substance misuse service and these are normally more 'random'. These tests often mean adults can be reluctant to engage as they do feel 'judged' about their drug or alcohol use.

5.24 There was an overt focus on testing Adult P for cocaine and alcohol and despite agencies knowing of Adult M's own drug use, it is not clear why the safeguarding partners did not feel it necessary to understand more about Adult M's substance misuse, which was by far more serious at the time. As Adult P was the main carer she became the focus of the drug and alcohol testing. Adult M's role, influence and behaviour did not seem to be considered as a risk factor and potentially a pre-cursor to Adult P's increased use of alcohol.

5.25 Adult P has been emotionally and physically abused for over 12 years and this has impacted upon her emotional wellbeing. She has tended to rely on alcohol and possibly drugs as a way of escaping those experiences. This does not absolve Adult P of responsibility but places her alcohol and drug use in context.

5.26 Family Drug and Alcohol Courts (FDACs)[10] which have the aim of helping parents address their substance use problems, improve family functioning and reduce the need for children to enter care have a strong emerging evidence base. Research indicates that FDACs significantly increase safe, stable family reunification and have a significant effect on parental substance misuse and decrease the likelihood of future child neglect and abuse. These positive outcomes are due to the intensive, holistic approach and the supportive culture it creates around families.

5.27 In 2022, the Berkshire East Combatting Drugs Partnership was established with the purpose of improving the lives of people with alcohol and drug issues and are currently undertaking a needs assessment. This partnership may want to explore the efficacy and need for an FDAC for their local authority areas and may wish to review the Local Child Safeguarding Practice Review and this SAR to assist in their needs assessment.

Domestic Abuse

5.28 Records indicate that there were serious incidents of domestic abuse perpetrated by Adult M dating back to 2008. He was convicted in 2008 and in 2009 for assaults on a female and in 2011 was convicted of 4 counts of battery and criminal damage on Adult P's parents and brother. He caused injuries to his youngest child (child Q) on at least 2 occasions. There were 3rd party disclosures of domestic abuse but not an extensive history of reported incidents by Adult P. It was recorded on file that she never supported police action against Adult M.

[10] The Family Drug and Alcohol Court [FDAC] is an alternative family court for care proceedings. It is specially designed to work with parents who struggle with drug and alcohol misuse.

5.29 Adult P was never assessed as high risk of domestic abuse and therefore was not referred to the Independent Domestic Abuse Advocate (IDVA) or the Multi Agency Risk Assessment Conference (MARAC). There is no evidence that a discussion took place with Adult P regarding support from Berkshire Women's' Aid.

5.30 Both parents do report periods of stability and limited physical violence at times in their relationship and there is a period between 2015 and 2018 where there are no reported incidents of violence. This is surprising given the history and experiences of the family and Adult P may have been experiencing ongoing domestic abuse under the radar of safeguarding agencies.

5.31 There was a pattern of Adult M leaving the family home following domestic abuse incidents, sometimes at the request of safeguarding agencies and the court and returning to his birth parents address. This was considered an effective safety plan but there was ongoing evidence that he returned to the family address and this was with agency knowledge. The relationship between Adult P and Adult M continued and despite this significant history, Adult P's vulnerability to domestic abuse was not risk assessed. There is indicative evidence that agencies knew tacitly that Adult M was living in the family home, yet there were no subsequent risk assessments evidenced and no sense of professional concern that he had returned to the family home. The level of acceptance of this arrangement without risk assessment raises concerns about the weight given to the domestic abuse perpetrated by Adult M and the impact this had on Adult P.

5.32 It was reported by Adult P's parents that Adult P was fleeing domestic abuse perpetrated by Adult M on the 6 March 2020, when she had driven her car under the influence of alcohol. The police report states that Adult P had been 'celebrating' the night before following Adult M's 'release from the investigation for which he was falsely accused'. The two domestic abuse incidents in November 2020 did prompt the completion of a DASH risk assessment[11] and Adult P was 'graded at standard risk for domestic abuse' in the first and medium risk in the second. Adult M was arrested but the investigation concluded with no further action.

5.33 A 'risk management occurrence' (RMO) was generated automatically via the self-populating computer systems in the Multi-Agency Safeguarding Hub (MASH) indicating the need for ongoing risk management and victim safety planning. This information was shared with Children's Social Care yet there is no documented evidence that enhanced safety planning was undertaken with Adult P.

5.34 The commissioned service providing enhanced safety planning with domestic abuse survivors were struggling to provide the service at the time. They have since been decommissioned.

5.35 Thames Valley Police (TVP) have since identified that medium risk domestic abuse RMO's are not owned by individual officers and therefore no on-going risk management takes place. The work regarding all RMOs (not just domestic abuse) is being undertaken by the TVP Policing Strategy Unit (PSU). The PSU are proposing that the current RMO system for Medium Risk Domestic Abuse will be replaced with a standardised use of each Local Police Area's (LPA) Multi-Agency Tasking and Coordination (MATAC) function. A coordinator in each county will review and

[11] The Domestic Abuse, Stalking and Honour Based Violence (DASH 2009) Risk Identification, Assessment and Management Model was implemented across all police services in the UK from March 2009.

manage cases with more problematic risk according to a Recency, Frequency, Gravity and Serial matrix. This change would represent a more focused, risk-based approach to Medium Risk Domestic Abuse cases.

5.36 TVP are proposing that the DOM5/DASH model for assessing risk in domestic abuse cases, be replaced with a new model, the Domestic Abuse Risk Assessment (DARA) which is seen to be more effective than the existing models in identifying coercive control. The DARA is recommended by The College of Policing and the National Police Chief's Council.

5.37 TVP are to move towards the use of the 'Victim's First Hub' to provide information and support for Medium Risk Domestic Abuse victims. It is proposed that by March 2024 Victim's First will be contacting all victims of domestic abuse regardless of consent, effectively making the service an 'opt out' service rather than one requiring consent.

5.38 In late November 2020, following the two recorded incidents of domestic abuse, Adult P asked Adult M to leave the family home. The couple self-reported that they would both comply with the plan for him to live with his mother and would abide by contact arrangements with the children. The child and family assessment undertaken by Children's Social Care following these incidents concludes that 'without Adult M in the house, the children are safe and appear to feel secure, their basic needs are met and their well-being is maintained'. Adult P presented at school with facial injuries and was open about who caused them, however, Adult P reiterated that Adult M needed help. The school offered support to Adult P but no referral took place regarding the risks to Adult P.

5.39 For many women and children, abuse and violence continues or intensifies after separation[12] and it is recognised that children living with post-separation violence maybe the most distressed in the population[13]. Social workers need guidance, support and effective supervision to ensure that enforced separation does not exacerbate the risks to women and their children.

5.40 Adult P explained to the report author that Adult M would call her names on a daily basis but would become more physically aggressive after a 'come down' from cocaine use. She described having to 'walk on eggshells' when he returned home after work and she would make a point of ensuring all of the children were in bed to avoid confrontation. She reported wanting to protect the children from his violence. Adult P clearly outlined, which was supported by other information, how she effectively 'self-safety planned' when Adult M returned home each evening.

5.41 Adult P indicated that she had intended to leave Adult M and this, in her view, prompted his violence on the evening in August 2021 that led to this review. He believes Adult P was having another relationship which prompted his violence.

5.42 Regardless of the reasons, Adult P suffered significant injuries that evening in a prolonged and sustained assault. Adult M's behaviour that evening cannot be explained by a 'come down' from cocaine. He was lucid enough to remove all communication methods to enable no contact with emergency services and at times reportedly tended to her injuries. His level of violence that evening and overnight

[12] Routes to Safety: Protection Issues Facing Abused Women and Children and the Role of Outreach Services, Bristol, Women's Aid. Humphreys & Thiara (2002)

[13] Buchanan, A., Hunt, J., Bretherton, H. and Bream, V. (2001) Families in Conflict: Perspectives of Children and Parents in the Family Court Welfare Service, Bristol, Policy Press

suggests his intention to seriously harm or kill Adult P. The fact that their eldest child was able to call for help the following morning may have prevented Adult P's death.

5.43 There was a chronology available to professionals highlighting the domestic abuse in the family home and this appeared to carry less weight in terms of risk than the drug and alcohol use and the sexual abuse concerns raised. The fact that Adult M had not completed any work to address his behaviour was 'skirted over' in assessments and whilst not commented upon in the analysis of chronologies, some elements of 'victim blaming' was evident regarding the expectations placed upon Adult P. Whilst Adult P continued to have significant issues herself with regard to alcohol and some drug misuse, it is difficult to evidence how her situation was understood in the context of a violent and abusive relationship and what methods she chose to manage her situation. With no expectations placed upon Adult M to address his behaviour, Adult P has had to consistently 'prove' herself to safeguarding agencies. This has impacted on her emotionally and mentally.

5.44 This does not deny how much of Adult P's own parenting behaviour has impacted on the children but it goes some way to explain how challenging she found everyday life and there was not a great deal of professional empathy evidenced for this. There was evidence that Adult P was complicit in telling untruths to professional agencies and she hid the fact that Adult M had returned to the family home yet this had to be seen in context.

5.45 Adult M did not engage in any interventions proposed. Adult P did cooperate with some of the interventions yet the family found it hard to engage with support services. Covid-19 did impact on the services and interventions proposed and the virtual nature of visiting and support arrangements presented their own challenges. Adult P would maintain that she was the parent that had to 'prove herself' to agencies and Adult M was given no responsibility.

5.46 Coercive control is an underlying feature of domestic abuse yet this has not been considered in the assessments of the children or in Adult P's circumstances. Whilst she did not disclose this information at the time, all professionals should be cognisant of the high likelihood of this if physical abuse allegations are present. Professionals should ask questions about this issue. The climate of fear in the family home that emerged following the incident in August suggests that questions were not asked or professional hypotheses made about what life could have been like for Adult P in the household. Controlling or Coercive Behaviour is now a Criminal offence under Serious Crime Act 2015 Section 76. Coercive control is now recognised as the most prominent behaviour that underpins the majority of domestic abuse cases. It is a pattern of behaviour which seeks to take away the victim's sense of self, minimising their freedom of action and violating their human rights.

Recommendation 5: The Safeguarding Board should assure themselves that all relevant frontline practitioners have (as a minimum) awareness training specifically on coercive control.

Mental Health

5.47 Adult P has described suffering from depression and anxiety since the age of 18. There have been periods where her mental health has improved and she stopped

taking medication. In 2020, her mental health deteriorated again and she was prescribed Sertraline to help manage her depression, anxiety, low mood and self-esteem. Talking Therapies provided by Berkshire Healthcare has helped Adult P in using techniques and strategies to help her manage her anxious feelings. Adult P has however a tendency to rely on alcohol as a way of managing her feelings and emotions.

5.48 Adult P was not referred to the Community Mental Health Team prior to the incident in August 2021. Her mental health symptoms were being managed via her GP. Adult P was referred to the practitioners in the Family Safeguarding Team who are adult mental health qualified staff on the 6 February 2020 and closed on the 29 May 2020 after minimal involvement. She struggled to engage with this work and declined involvement. There is no statutory expectation placed upon her to engage in this work but it might conflict with the expectations placed upon her by the Family Safeguarding Model in Children's Social Care.

Focusing on the parenting of mothers

5.49 Adult P was referred to in discussions and reports as occasionally very hostile and challenging to professionals. Agencies who struggled to engage her would refer to her 'disguised compliance'. This unhelpful terminology gives no consideration to Adult P's context. Her ongoing defence of Adult P was misunderstood and the more agencies focused on her parenting, the more she felt under pressure and potentially became hostile.

5.50 There was evidence that Adult P struggled in her parenting role and behaved in ways that would have placed the children at risk of harm. This was balanced against evidence that she was actively protecting the children from harm. Adult P was parenting from a place of trauma herself and had developed ways of safeguarding herself and the children. Adult P had often presented to practitioners as angry and aggressive but she did cooperate occasionally with the interventions and support offered. This presentation was challenging to practitioners and there was evidence that Adult P was judged for that behaviour, without fully considering her context. The focus clearly shifted to the behaviour and parenting of Adult P and this was reinforced following the incident at school in May 2021.

5.51 The practice in this case reflected the invisibility of Adult M and the accountability of Adult P. There was a sense that Adult P oversaw the safety of the children and when she 'failed' to do so, there was proactive intervention to place the children elsewhere. It is likely that practice was focused on the parent who could engage and was more accessible. One professional noted that 'Adult M was out of sight and out of mind'. Despite this, Adult M maintained his relationship with Adult P and was visiting and staying at the family home with the knowledge of professionals. This approach had worked before for Adult M and was effective again. Slowly he began returning to the family without question or risk assessment. No doubt Adult P colluded with Adult M to ensure agencies were not aware of their circumstances, yet this behaviour must be placed into the context of living in an abusive and coercively controlling relationship for many years.

5.52 Information shared by the children subsequently reveals the climate of fear in the household. Whilst interventions were focused on effective drug treatments and support, increasing knowledge, enhancing parenting skills and supporting Adult P

overcome personal challenges, these were attempted in the context of ongoing harm and abuse. Her ability to engage in such work was not considered in that context.

5.53 The level of self-reporting from the parents, particularly Adult P, was not triangulated with other evidence and was accepted by the professional network. The crucial aspect of following up and following through on actions was lost.

5.54 Farmer and Owen's study[14] into child protection clearly showed that in two parent families the focus of the intervention tended to switch from the abusing father to the mother. The process is also evidenced in the Dartington Social Research Unit (1995) 'Messages from Research'. As Adult M was also not allegedly in the family home at times, Adult P became the focus of care, protection and support for her children.

5.55 Adult P's parents have played a significant role in supporting Adult P during this period, despite their frustrations regarding Adult P's ability to change. It highlights the need to appropriately involve the wider family and friends network in the safety planning and support.

Working with adults who struggle to engage

5.56 This has been a consistent theme in this case and there has been overt non-compliance at times from both parents. This compliance has not been disguised and agencies were fully aware of it. It has been quoted many times in discussions and reports. The challenge for practitioners was whether this non-compliance was 'significant enough' to use legal powers to address the risks. There was a level of 'acceptance' at this level of engagement, particularly with Adult M. Likewise, it is it is crucial to shift the language relating to a lack of engagement. The focus needs to be on how agencies proactively reach out to the adults to ensure that their approaches are accessible and that any potential barriers to support are well understood. the concept of "overt non-compliance" as well as disguised compliance needs to be embedded into future training for safeguarding professionals.

5.57 Eileen Munro's 2011 review[15] into child protection emphasises the importance on the building of relationships with parents and the benefit for those parents in feeling better understood. The parents have experienced safeguarding professionals in their lives since 2007. They would have experienced the power and authority of those professionals for many years and developed ways of avoiding professional scrutiny. Relationships are a crucial part of effecting change and relationship-based practice recognises that people want to be understood and be treated as an individual in their own right rather than parents simply being seen as "a means to the end of protecting their children from harm" (Turney 2012)[16].

5.58 Motivational interviewing is a method used as part of the Family Safeguarding Model and is described as a collaborative conversation style for strengthening a person's own motivation and commitment to change. There is limited evidence that this approach was used in supporting Adult P in making changes to safeguard herself and the children. It is again based on the relationship approach to practice and seeks to engage the parent first rather than action to address risk and need.

[14] Farmer, E., & Owen, M. (1995). Child protection practice: Private risk and public remedies—Decision making, intervention and outcomes. London: Protection Work HMSO.
[15] Munro, E (2011) *Munro review of child protection: Final report, a child-centred system*. England: The Stationary Office
[16] Turney D (2012) 'A relationship-based approach to engaging involuntary clients: The contribution of recognition theory'. *Child & Family Social Work,* 17(2), 149-159

5.59 The available information provides enduring evidence of drug and alcohol misuse, conflict, violence and verbal aggression in the family home over many years. This was primarily hidden from professionals and Adult P's parents. Adult P was complicit in minimising the concerns regarding Adult M's behaviour and her own responses to this. It was felt by professionals that Adult P was not always able to engage openly and honestly and this presented further risks to her and her children. However, this professional opinion has tipped practitioners into blaming Adult P for not being able to protect herself and the children. Whilst it is accepted that some of Adult P's behaviour led to further harm and abuse, it is naïve to suggest that she behaved in this way without significant influence, coercion and threat of ongoing violence from Adult M. This suggests a lack of understanding of the dynamics of domestic abuse and in particular coercive control.

5.60 There was no evidence in the records that independent advocacy was offered to Adult P in the period of the review. Whilst Adult P's parents have advocated for their daughter strongly, they are in an unenviable position of conflict regarding the future care of their grandchildren and their daughter. It seems that independent advocacy for Adult P under the Care Act 2014 duty could have been considered so that her wishes and feelings were better represented at significant periods during this review.

Recommendation 6: The Safeguarding Board should seek assurance that the commissioned advocacy services in the local authority are well understood by frontline practitioners.

Conclusion

6.1 Adult P has experienced domestic abuse and coercive control for most of her adulthood. Her mechanisms for coping with this adversity have placed her and her children at further risk of harm yet have not been well understood by the professional network. The domestic abuse she experienced whilst mostly hidden by her and the family, did not prompt further enquiry or understanding of her lived experience. She was given little opportunity to tell professionals how life was really like without considering the implications for her and her children by doing so. By telling professionals about her life at home, she knew from experience, what the likely response was going to be. Alongside the ongoing threats from her ex-husband. Adult P's responses to trauma and adversity have placed her at risk of further harm and abuse. There is sufficient evidence to suggest that she could have been the subject of a safeguarding adult enquiry which may have given agencies the opportunity to review her safety in her own right. The focus, rightly, on the children's welfare has led to a lack of consideration to Adult P's own needs for safety. Adult P did not appear to meet the threshold for her care and support needs to be assessed but there is evidence that she may have met the criteria for an adult safeguarding enquiry.

6.2 Adult P's significant alcohol use, which has increased over time, has not been the subject of agency concern despite this being a risk factor since the involvement of safeguarding agencies. The opportunities to address those needs could have been considered sooner and not purely as a result of a trigger incident in May 2021. Her use of cocaine, which was by far less than her ex-husband, became the subject of testing and evidence of her inability to safeguard the children and herself. This focus

may have diverted attention unhelpfully on an issue which was not as significant as Adult P's problematic alcohol use.

6.3 Whilst Adult P found engagement with agencies challenging, there was no real understanding of her context and what influenced and impacted upon her decision making. She was not given the opportunity to have independent advocacy and this may have supported her ongoing engagement in services. The more expectations were placed upon Adult P to safeguard herself and her children, the more difficult this became which resulted in her increased use of alcohol as a coping mechanism. The reports seen do not offer much empathy towards Adult P.

6.4 Adult P experienced a significant physical assault perpetrated by her ex-husband which has impacted upon her life forever. Her circumstances have significantly changed since the incident in August 2021and her responses to this further trauma have pushed her further into depression, anxiety, low self-esteem and increased alcohol use. Adult P remains at risk of harm.

6.5 There is an inherent gender bias in the expectations placed upon Adult P to meet the expectations of safeguarding agencies. Adult M was able, without challenge, to not participate in any assessments, interventions or support which placed the responsibilities solely on Adult P. This placed additional pressure and burden onto Adult P which increased her vulnerability to alcohol.

6.6 There is an ongoing need to assess and support Adult P as there is a high likelihood that her mental health and significant alcohol use will impact on her ability to keep herself safe. Independent advocacy should be considered to ensure she understands and engages in the support available to her.

6.7 This is a sad and upsetting story, yet there are opportunities to change and enhance practice as a result with the learning and recommendations from this review alongside the children's local child safeguarding practice review.