domestic abuse commissioner

Manchester Metropolitan University

Summary Report

Domestic Homicide Oversight Mechanism for Adult Social Care

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Summary of Findings

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Introduction

The intersection between adult safeguarding and domestic abuse is well articulated in policy documents (LGA, 2015), yet simultaneously, there appears to be a gap between policy documents and domestic abuse safeguarding for adults (Mclaughlin et al, 2018; Robbins et al, 2016). The key issue is that those experiencing domestic abuse may not trigger a safeguarding response because they do not meet the eligibility criteria for care and support needs as specified in the Care Act (2014). The purpose of this work is to better understand the types of recommendations made in Domestic Homicide Reviews (DHRs) for Adult Social Care, relating both to intimate partner homicide and adult family homicide, with a particular focus on the over-65s. The study will help to inform the Domestic Abuse Commissioner's[1] Domestic Homicide Oversight Mechanism for Adult Social Care.

Study Methods

Twenty-four DHRs published between 2015-2019 were identified, with an oversampling of those involving adults over 65. Our mixed methods approach comprised a qualitative template to identify examples of good practice, areas for development and learning, and to analyse recommendations made in relation to Adult Social Care and safeguarding. After extraction, a thematic approach was used. A quantitative matrix was developed based on the qualitative themes and subthemes, identifying the most prevalent recommendation types, any specific recommendations related to protected characteristics, carer recommendations, and the targets of those recommendations within the Adult Social Care field. To provide an overview of the sample and its characteristics, we carried out an additional descriptive analysis of quantitative data already collected on the DHRs within the HALT study.

1. This research was commissioned by the Domestic Abuse Commissioner. Funding reference DAC-DHOMOct22-Mar23.
2. One perpetrator was a trans woman.

Key findings

Victim and perpetrator demographics

Sex: Most victims were female (19/24, 79%) and most perpetrators male (23/24, 96%).[2]

Ethnicity: Victims (18/22, 82%) and perpetrators (18/22, 82%) were in the majority White British, with the remainder coming from Minoritised backgrounds (including White Europeans). Two victims and two perpetrators had missing ethnicity data.

Homicide types

- 12 were intimate partner homicides (IPH) (50%)
- 11 were adult family homicides (AFH) (46%)
- 1 was an amicicide (killing of a friend) – in this case a victim killed by the sons of a woman she cohabited with.

IPH relationship details

- Perpetrators were all current male partners (n=12)
- Most dyads had been in their relationship for more than 10 years (7/11, 64%)
- Only one dyad had been together for less than a year.

AFH relationship details

- Most perpetrators were sons (5/11, 45%) or other male family members (4/11, 36%)
- Daughters (one a trans woman) were perpetrators in two cases
- A niece instigated a killing (via her boyfriend) in one case.

Prior domestic abuse

- Prior DVA within the victim-perpetrator relationship was identified in just under half of the DHRs (11/24, 46%)
- In all cases, perpetrators had been abusive to victims
- In three of these cases, victims had been abusive to perpetrators
- Proportions of DVA were similar across IPH and AFH
- However, older adults were less likely to have experienced prior DVA within their relationship (5/15, 33% vs. 6/9, 67%).

Homicide contexts

- Perpetrators were acting as the main carer for the victim in 12 out of the 24 cases (50%) (11 within the over-65 group).
- Most often this was due to poor mobility and cognitive decline (e.g. dementia).
- Coping with care needs and despair for the future were key contextual features.
- In most cases (17/24, 71%), victims and perpetrators were living together at the time of the homicide.

Risk and vulnerability factors

Victims

Under 65s: For younger victims, issues relating to victimisation (7/9, 78%), drug or alcohol use (6/9, 67%), and mental health problems (4/9, 44%) were prevalent factors.

Over 65s were more likely to have experienced physical health problems and other chronic, age-related conditions (13/15, 87%). All those victims identified within the DHRs as having a disability (n=5), were over 65 years, representing 33% (5/15) of that group.

Perpetrators

Under 65s had high levels of socioeconomic disadvantage (13/16, 81%), violence/abuse towards others (13/16, 81%), drug/alcohol use (11/16, 69%), criminality (11/16, 69%), victimisation, trauma, or bereavement (10/16, 63%), and mental ill health (10/16, 63%).

Over 65s rarely experienced these issues, although physical ill health was fairly prevalent (6/8, 75%). Unlike victims, no perpetrators over the age of 65 were recorded in the DHR as having a disability.

Figure 1: Victim risks and vulnerabilities by age group

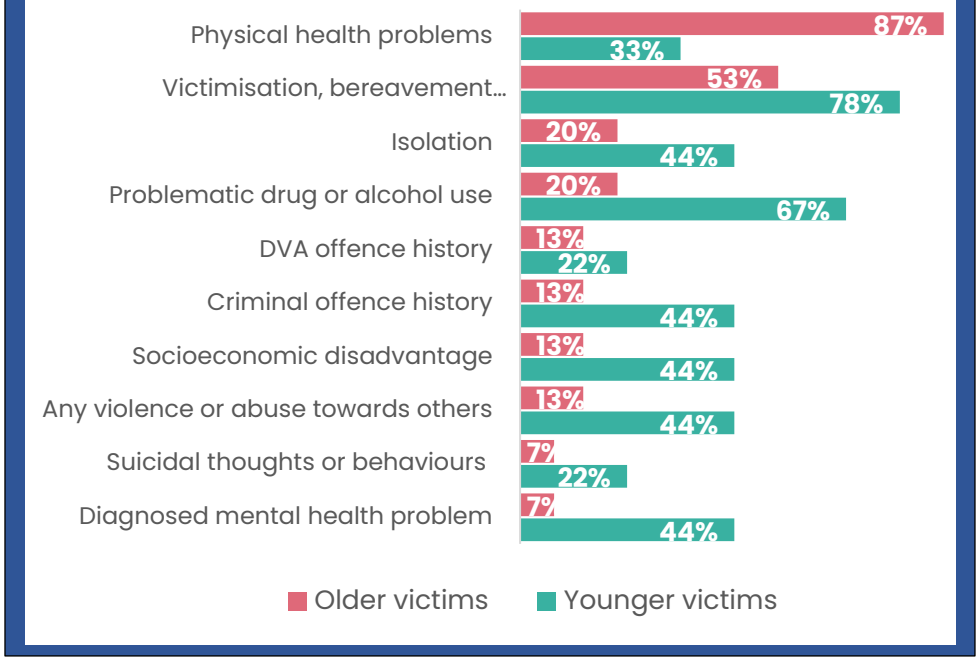
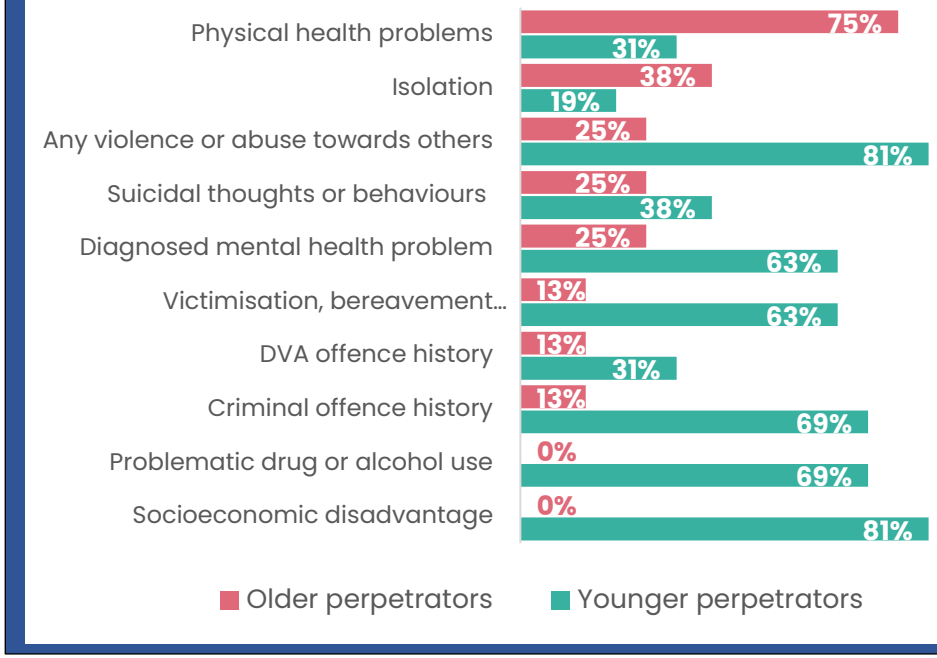


Figure 2: Perpetrator risks and vulnerabilities by age group



Service involvement

Most victims and perpetrators had received support or a service over the period covered by the DHR, most frequently physical health services and Adult Social Care. Service use was often mediated by age. See Figures 3 and 4 below.

Risk assessment and service awareness

In seven cases (7/24, 29%) services were aware of domestic abuse in the relationship between the victim and perpetrator, although in only four cases (4/24, 17%) had a DVA risk assessment been carried out. None of the cases had been referred to a MARAC for review.

Figure 3: Victim service involvement by age group

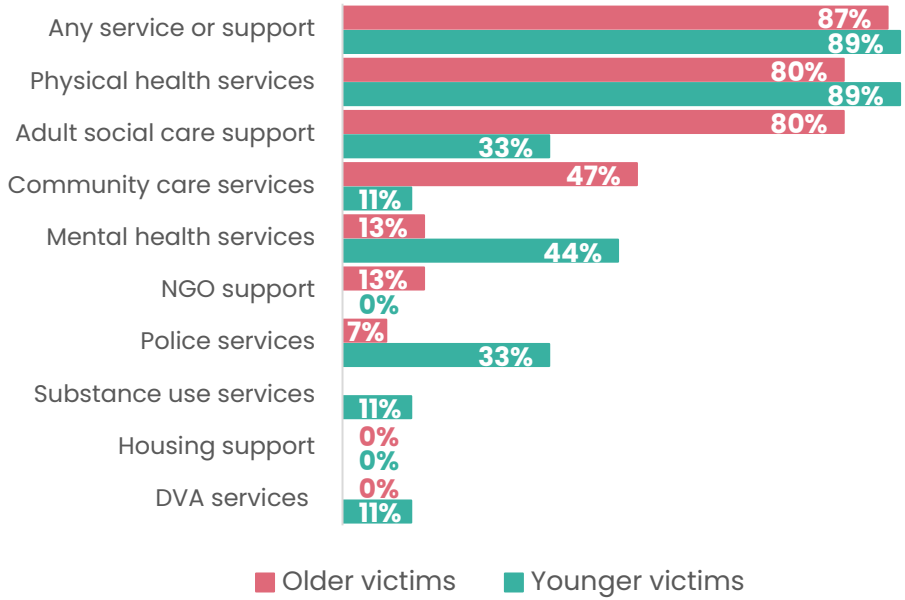
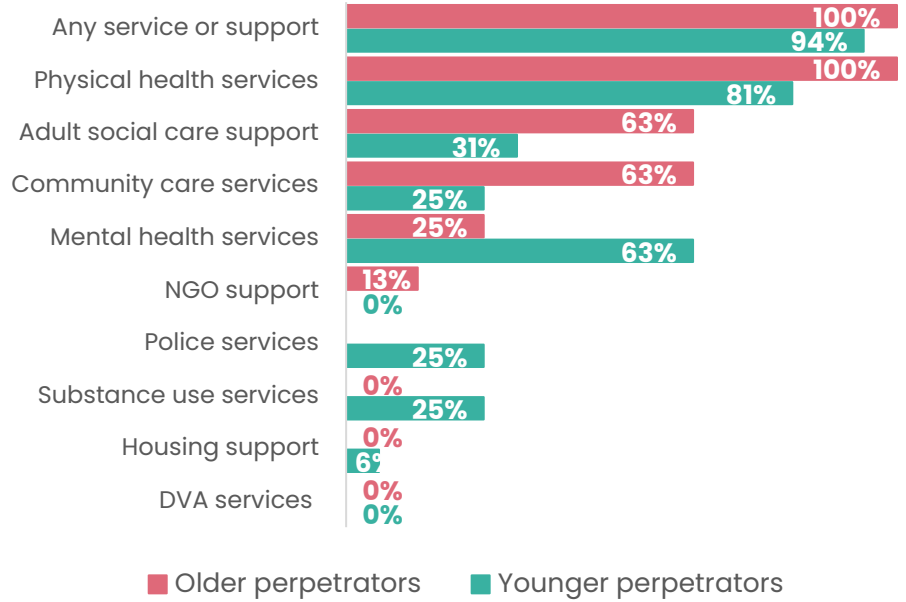


Figure 4: Perpetrator service involvement by age group



Thematic Analysis of Recommendations

Many of the themes identified through our analysis overlap. For example, training regarding domestic abuse will hopefully enhance professional curiosity, risk assessment, improve record keeping and generate a multi-agency response. These recommendations are also made in other forms of review across time, demonstrating the need to ensure that they become embedded in policy and practice.

Lack of multi-agency working and information management

Analysis of recommendations relating to Adult Social Care and safeguarding identified a lack of multi-agency working and poor information management in 20 of the 24 DHRs (83%). Specifically, recommendations highlighted the need for: improved gathering, reporting and sharing of information to and from partner agencies, as well as better intra-agency

communication and co-ordination (12 DHRs); improved recording of information (9 DHRs); improved referral into other agencies (including adult social services) (5 DHRs); and the importance of clearly advertising the DVA support pathways at a local authority level (1 DHR).

Improving Assessments

Recommendations calling for improvements to assessment processes were present in 12 DHRs (50%). Specifically, recommendations highlighted the importance of: carrying out carer's assessments to identify the needs of carers and the cared-for (9 DHRs); carrying out domestic abuse assessments, or other assessments of relational risk, and taking a nuanced/wider understanding of victimhood and perpetratorhood (6 DHRs); improving the co-ordination and sharing of assessments (including domestic abuse risk assessments, carers assessments, mental health assessments, capacity assessments, and adult safeguarding assessments) (5 DHRs); and ensuring assessments take a holistic/systemic approach.

Lack of visibility in self-funded care

In DHRs where care was self-funded there was no oversight of the context of care or the changing nature of care needs. However, the principles and concepts inherent in the Care Act 2014 should be adhered to, regardless of how care is financed:

Developing Practice

Thirteen DHRs (54%) made recommendations relating to developing frontline practice including: increasing professional curiosity and assertiveness (enquiring and asking questions); ensuring service users are spoken to/responded to separately from family members or partners who may pose a hidden risk; thinking holistically and systemically, ensuring family needs and risks are considered, as well as patterns of behaviours over time; rebalancing professional priorities – ensuring a focus on care over funding and safeguarding above all else; and lastly, ensuring methods of sharing good practice are identified and implemented.

Training and development for staff

Recommendations relating to staff training and development appeared in 16 DHRs (67%). They called for: an increase in or development of domestic abuse training, including expanding the definition to encompass adult family abuse and non-physical forms of abuse, approaches to discussing DVA with clients, utilising tools such as the DASH, and understanding agency remits and responsibilities (12 DHRs); an increase in or development of adult safeguarding training, including training on mental capacity, self-neglect, and power of attorney (8 DHRs); improvements in supervision, including arrangements for supervising locum practitioners (4 DHRs); increased training in risk assessment (3 DHRs) and record keeping (2 DHRs); and training on carer's needs, rights and services (2 DHRs). Importantly, two DHRs called for the implementation of plans to monitor the effectiveness of any changes to training and supervision, to establish their effectiveness.

Policy and Process: develop, amend or follow

Recommendations to implement, revise, update or expand organisational policies, practice and process appeared in 16 DHRs (67%). Most frequently, recommendations were targeted at reviewing/complying with adult safeguarding procedures.

Good Practices

There were few examples of good practices (6 DHRs). Most examples related to making appropriate referrals, proactive practice and raising safeguarding concerns. Other good practice by Adult Social Care staff included responding in a timely way to referrals and offering a range of services/support, good communication with other agencies, awareness of carer vulnerabilities and maintaining good records. There was also a regional initiative which should potentially help support individuals who may not reach the threshold for safeguarding but nevertheless require support (see main report).

National Recommendations

National recommendations were made in only two of the 24 DHRs (8%). An important recommendation was for there to be new statutory processes to protect vulnerable adults from abuse which parallel those processes and arrangements within Children's Services. A further recommendation was made regarding policies and processes for dealing with historic abuse allegations.

Table 1 Theme frequency by agency

	Target Agency (= DHR)			
Theme	**Adult Social Care**	**Community Safety Partnership**	**Adult Safeguarding Boards**	**Residential Care Homes**
				
				
				
				
				
				

Key Messages

- Domestic abuse and domestic homicide experienced by older people includes intimate partner and adult family abuse and homicide. The latter is more poorly recognised than intimate partner abuse.

- The lack of a statutory requirement to institute a multi-agency safeguarding hub (MASH) for adults is potentially a barrier to safeguarding adults from domestic abuse, particularly for those without additional needs.

- Specific domestic abuse training for Adult Social Care professionals is required which includes different types of abuse (e.g. adult family abuse, 'mate' abuse, coercive control) as well as their intersections with disability, mental capacity, consent and how this relates to specific long-term, debilitating and life-changing diseases. Training should also explore the intersections between other protected characteristics and domestic abuse.

- Recognising and acting upon carer stress is vital as this can support the carer but also shed light on the cared for. Assessing whether a nominated carer is capable to provide care should ideally be undertaken to identify potential likelihood of domestic abuse.

- There is a gap in responding to those who are self-funding care despite the Care Act making clear that safeguarding applies regardless of funding arrangements.

- Private sector care agencies are missing from multi-agency arrangements, and they also appear to be less likely to have domestic abuse policy or training.

- More assertive and enquiring practice is called for with adequate and probing supervision of practice to ensure that best practice is in place. Understanding an individual within their context and 'think family' was also recommended in several DHRs.

- DHRs pertaining to Black and Minoritised victims stressed the need to challenge supposed cultural

norms and ensure communication with the victim (including with interpreters).

- Equality and diversity are scarcely considered within the DHRs, partly due to poor information from agencies. Understanding the impact of ethnicity, gender, or disability on the lives of the people involved is key. For the DHRs included in this report, physical disability was a factor in most cases, with severe mental illness also featuring frequently. At the very least an understanding of these disabilities and their impacts is crucial.

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