LEARNING FROM SERIOUS INCIDENT REVIEW

ADULT 12 2022

WHAT HAPPENED?

- In 2022 Adult 12 was found deceased in her property.
- At the time of the death, Adult 12 was residing with her partner, Adult 12P who is a recorded perpetrator of domestic abuse against Adult 12 and another family member.
- Adult 12 was a serial victim of domestic abuse, from both her ex-husband, Adult 12X and her partner at the time Adult 12P.
- Adult 12's children live with their father. Adult 12 found this difficult and missed her children.
- Adult 12 had multiple complex needs including alcohol misuse, mental health difficulties, a provisional diagnosis of Emotionally Unstable Personality Disorder (EUPD), Attention Deficit Hyperactivity Disorder (ADHD)and other medical issues.
- Adult 12 was supported by family members through multiple alcohol detoxes in 2020.
- Adult 12 had been heard as a victim of the current partner (12P) at MARAC twice.
- Adult 12 often blamed her own behaviour or withdrew allegations following reported incidents.
- Domestic abuse disclosures made to non-domestic abuse services were not always acted upon by health services.
- In the months leading up to her death, Adult 12 was marked as 'did not attend' across services.
- There was initial concern that Adult 12's death was suspicious but the post-mortem results into cause of death were inconclusive, so no charges were brought forward.

WHAT DID IT TELL US?

- Having multiple-complex needs can make it harder to engage with services and can contribute to unconscious bias in agency responses.
- Agencies can see responding to disclosures of domestic abuse as the responsibility of others.

BEST PRACTICE:

- Alcohol services had a person-centred, non-judgemental approach to engagement, and reached out when she was not in service when made aware of an incident via Probation.
- South Yorkshire police were the only agency to carry out a DASH risk assessment.

LESSONS LEARNT:

- New information around relationship status and dynamics was not always shared between or within agencies, despite the known risk of domestic abuse e.g. when Adult 12P had returned to live with Adult 12.
- Not all enforcement options were utilised to their full potential to reduce the risk of further abuse. For instance, Adult 12's address could have been restricted as part of Adult 12P's enforcement conditions, perhaps due to lack of awareness this did not happen.
- Possibility of post-separation abuse was not explored by children's services.
- Adult 12 received a provisional diagnosis of EUPD, but this was then carried forward throughout her medical record. This also led to her being refused access to Talking Therapies.

WHAT CAN WE DO NOW?

All agencies need to ensure that relevant information about perpetrators and/or victims is shared in a timely manner between and within agencies.	Unconscious bias in relation to complex needs can appear in service responses and to overcome these services should develop plans to ensure they are identified and addressed. For instance, in case supervision and case audits.	All professionals working with victim/survivors of domestic abuse need to remember to use local risk assessment processes and support with safety planning.	All agencies need to consider the suitability of disclosed caring arrangements and the influence of additional known risk factors and refer to the Sheffield Carer's Centre.	To raise awareness that abuse continues post separation, including coercive control, and to be alert to the fact that a perpetrator may be attempting to manipulate agency responses.