JOINT DOMESTIC HOMICIDE REVIEW & SAFEGUARDING ADULT REVIEW

LEARNING BRIEF - ADULT F

Domestic Homicide Review (DHR)

The Domestic Violence, Crime and Victims Act (2004) defines a Domestic Homicide Review as a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect. DHRs look at the circumstances that led to the death to reduce the risk of something like this happening again.

Background Information - Adult F

Adult F was 80 years old when they were found dead at home in February 2023. Adult F was registered blind with diagnoses of asthma, diabetes, and was cared for in bed. Adult F was a wheelchair user with a live-in carer, who was believed to be their partner during the years they lived together.

Key themes: neglect, carer, disability, domestic abuse.

Safeguarding Adult Reviews (SAR)

The purpose of a Safeguarding Adult Review is to use learning from the case under review to promote and reinforce effective practice and identify where improvements to the system need to be made.

Key Learning

Carer Relationships

The review highlighted a lack of professional curiosity in enquiring into Adult F's relationship with the carer. Agencies record the relationship as 'carer', 'partner' and Adult F's 'adult child' which was not corrected by Adult F or the carer. Professionals didn't seek to clarify the carer's role formally. The review identified that no formal carers assessment was undertaken, and agencies did not proactively gather accurate information about Adult F's care and support arrangements and plan. By being professionally curious, agencies could have explored Adult F's mental capacity to consent to the care. Further enquiry may have also highlighted the risk of carer breakdown linked to carer fatigue.

Age

Age was a theme in the review related to older people who may be experiencing domestic abuse and the barriers faced in accessing support. Research shows the 'often assumed' vulnerability of older people affected can be a limiting factor. Consequently, domestic abuse can be missed or reframed as a health issue which was evidenced in Adult F's case when their biological son referred them to Adult Social Care. The referral was progressed as a request for a service rather than as a safeguarding concern. Unless screened by the professionals they encountered, Adult F's complex health conditions further limited opportunities to report domestic abuse. Also, there was often an overreliance on the information provided by the carer and a lack of consideration as to whether the carer was limiting contact with agencies.

Hoarding and Neglect

A community nurse made the first report concerning hoarding and neglect after attending the home to take Adult F's blood for tests. Records highlighted the cluttered state of the property with only walkways accessible, and Adult F was wearing clothes that were unclean. The clutter rating tool that community nurse practitioners have access to was not used at the time. The community nurse discussed accessing additional support with Adult F and their carer and offered Adult Social Care's contact details which the carer declined. The carer's constant presence may have restricted Adult F's ability to ask for support, in conjunction with, the evidenced neglect and apparent acts of omission could indicate a pattern of coercive control.

Good Practice

Policy and Procedures

The community nurse demonstrated good practice in the application of the 'No Access' policy followed in this case. The policy provides guidance to community nurse practitioners on the risk assessment of a patient they are attempting to access, depending on their co-morbidities, and who they live with.

Information Sharing

Good practice was demonstrated by the community nurse and GP who discussed their concerns with each other, which led to a safeguarding referral being made to Adult Social Care regarding neglect and self-neglect. Learning from this review recommends agencies follow up on referrals as the referral in this instance was not received.

Escalation Processes

The community nurse showed a good understanding of safeguarding, when to make a referral, and when to consult with management appropriately. They demonstrated this through their clear process of escalating concerns when the community nurse was unable to gain access to Adult F. This led to the nurse contacting Adult F's biological son, neighbours, and the senior management team, who subsequently contacted local hospitals to see whether Adult F had been admitted. Finally, a 999 call was made to the police and other emergency services who attended the property to conduct a welfare check on Adult F, where Adult F was sadly found deceased.

Recommendations

- **Recommendation 1:** Agencies should use professional curiosity to ensure that staff who undertake first contacts/assessments are accurately recording details of names and relationships of relevant people within the home environment, including next of kin, family members who have been noted as a point of contact and or informal carer, and any other carer roles and responsibilities.

- **Recommendation 2:** Safeguarding referrals made to the local authority should be followed up by agencies within 48hrs if they have not been contacted by Adult Social Care.

- **Recommendation 3:** Bristol City Council Adult Social Care should promote the use of the safeguarding team 'hotline' to practitioners as a useful resource for case discussion.

- **Recommendation 4:** The Bristol City Council Adult Social Care should ensure appropriate guidance and procedures are in place to ensure staff undertake a carers assessment at the referral stage to ensure carer's details are recorded and roles are understood.

- **Recommendation 5:** Bristol City Council should ensure that feedback is provided to the referrer when a referral does not meet the threshold for a S.42 enquiry. This should be monitored by the Safeguarding Board.

- **Recommendation 6:** Practitioners should follow best practice guidance when screening for domestic abuse in ensuring the conversation is with the person when they are alone.

- **Recommendation 7:** Staff training should include recognition of risks and coercive control, intersectionality and the recognition that perpetrators may have caring responsibilities for their victims. All professionals should be equipped to identify Domestic Abuse and have the appropriate tools such as familiarisation of the older people's Domestic Abuse, Stalking, Harassment, and Honour-Based Abuse risk assessment tool and guidance to do so.

- **Recommendation 8:** The KBSP to improve accessibility to information for families and carers to recognise and articulate concerns around carer fatigue and exploitation or abuse of older victims.

Support

Self-Neglect and Hoarding

Hoarding is one of the most common forms of self-neglect and occurs to various degrees. All hoarding concerns should be referred to Avon Fire and Rescue Service who can carry out a free Home Fire Safety Visit.

Domestic Abuse

The Next Link Plus service offers specialist domestic abuse support for women, men and children and young people from all communities (including LGBTQ+ and black and minority ethnic). They will support with any additional needs (for example substance misuse, mental health, hearing difficulties, learning disabilities, etc.). Call 0117 925 0680, text 07407 895620, email enquiries@nextlinkhousing.co.uk or online chat via the Next Link website.

Domestic Abuse and Older Persons

Following a recommendation from this review, the KBSP have developed a resource which includes advice and support services for older persons who may be experiencing Domestic Abuse. Please click here for the KBSP resource on Domestic Abuse and Older Persons. The KBSP website also has other professional resources on how to support those who may be experiencing domestic abuse.

Where to find us:

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www.bristolsafeguarding.org