SETDAB Southend, Essex & Thurrock Domestic Abuse Board

Southend Community Safety Partnership

Southend Safeguarding Partnership

Safer Leeds Working in partnership to keep communities safe

BACKGROUND

A Domestic Homicide Review and Safeguarding Adult Review was commissioned to identify how agencies worked together and to learn from any lessons to improve multiagency responses to domestic abuse.

This DHR/SAR was not published but the learning has been shared across the partnership.

AGENCY INVOLVEMENT

- Leeds Teaching Hospital NHS Trust
- Leeds Adult Social Care
- Leeds Integrated Care Board
- Leeds Children's Services
- Leeds Council Housing Department
- Leeds Multi-Agency Risk Assessment Conference
- National Probation Services (NPS)
- Southwest Yorkshire Partnership NHS Foundation Trust
- West Yorkshire Police
- Sugarman Health & Wellbeing
- Essex Partnership University NHS Foundation Trust
- Department for Work and Pensions
- East of England Ambulance Service NHS Trust
- Leeds and York Partnership NHS Foundation Trust
- Yorkshire Ambulance Service
- South Essex Homes
- Essex Police

Chloe 2021

RECOMMENDATIONS

There was significant single agency learning in this review. Key multi-agency recommendations include:

- DAC office promotes research to better understand the reoccurrence of persistent and systemic themes in reviews and escalate learning to governmental departments.
- Learning around risk of 'place' relating to 'high-rise' accommodation is shared with the College of Policing to inform future risk assessments, with MHCLG to ensure that the risks to victims of DA accommodated in such provision is understood, and with DAHA to enable housing providers seeking accreditation to be aware of the risks identified.
- Learning is shared with DWP to enable better understanding of risk arising from patterns of applications for benefits.
- SafeLives amend current MARAC practice guidance to ensure that 'flags' for repeat MARAC victims are kept on agency records for 24 months, and where appropriate, DWP should be engaged when financial abuse is known.
- HMPPS explore and secure appropriate interventions for those perpetrators of domestic abuse who are neurodivergent.
- Learning from this review is shared with commissioners in Leeds to ensure that commissioned services are enabled to facilitate full cooperation with future Reviews.
- Agencies in Leeds and Southend to ensure that assessment and associated practitioner guidance are responsive to potential risks related to frequent pregnancies / claims of pregnancies from vulnerable women.
- Leeds Adult Safeguarding Board ensure that all agencies are aware of pathways to specialist domestic abuse services.

KEY THEMES

- Risks were known by agencies in Leeds but there were practice gaps in relation to agency risk assessment, risk management, information-sharing, practitioner knowledge / skills, record keeping, and professional curiosity.
- Patterns of abuse were not recognised and the impacts of trauma not understood by Leeds agencies.
- Chloe was perceived as a protective factor for the perpetrator whose behaviour was often 'medicalised' by agencies and there were no concerted efforts to address his use of violence and abuse against her when she was at a high risk of harm from him throughout their relationship.
- Statutory multi-agency safeguarding arrangements in place but those agencies supporting him did not know how best to address the perpetrators complex needs.
- Risks around the Chloe's frequent pregnancies / claims to be pregnant were not recognised by agencies.
- Relevant checks and information not shared by Leeds ASC when aware they were moving areas and when a referral was made, this was incomplete.
- Agencies in Southend missed opportunities to show professional curiosity in their interventions with Chloe.