**Introduction.** Adult L is a male who, in May 2020, was stabbed by his partner Adult M, a female. They had been in a volatile relationship that was detrimental to them both. Adult L sustained potential life-threatening injuries but survived following emergency surgery. Adult M was subsequently charged with section 18 Grievous Bodily Harm (GBH) and perverting the course of justice. The latter offence related to an intention to manipulate Adult L to retract his police statement. Adult M was found guilty at court and was given a substantial prison sentence.

# Adult L SAR: Learning brief

This briefing sheet has been prepared by a local safeguarding board to share the learning from the Adult L SAR in order to support professional practice and development in our commitment to safeguarding an adult at risk. It has combined key messages and lessons learnt from the review to enable you and your teams to reflect and challenge your thinking, with a view to implementing positive change and promoting better outcomes for adults at risk. Full details of the report and all the recommendations can be found here.

**What were Adult L and M's backgrounds?** Adult L was known to Adult Social Care through working with the local drugs and alcohol substance misuse service. Adult M also experienced her own substance misuse difficulties with additional mental health problems. She was also known to Children's Social Care (CSC) as she was approximately seven months pregnant at the time of the assault upon Adult L. Both Adult L and M had children with other partners prior to the time they met, and CSC had intervened because of safeguarding concerns relating to all of the children. Adult M had been subject to a Domestic Violence Protection Order in another previous relationship and similar concerns were mirroring themselves in her relationship with Adult L.

CSC held an Initial Child Protection Conference, where appropriate steps were taken to protect the unborn child against the likelihood of serious neglect being suffered, due to the background history of child protection concerns of both parents, particularly Adult M. The child is now Child Looked After.

**What did the report identify?** There were features of unconscious and gender bias: coercive and manipulative behaviour which emphasises that domestic abuse incidents must be viewed with an open mind and investigated on a case-by-case basis. The SAR confirms the danger of practitioners assuming men are the likely perpetrators of DA when, as in this case, they can also be victims of coercive control and violence. Despite members of the family presenting with extreme and unexplained behaviours, there was a lack of professional curiosity as to the need for specialist advice and support e.g. in respect of determining their mental capacity.

**Summary of conclusions.** It is appreciated that working with adults at risk of domestic abuse can be challenging for professionals. This is particularly so when mental health, substance and alcohol misuse impact upon the people's ability to engage with services, which was a significant feature in this SAR. The review identified the need for a clear domestic abuse pathway that will ensure that practitioners and members of the public know who to contact and the support that is available. It is important that professional communication ensures that the right action is being taken by the right agency. The outcome of risk assessments and rationale for decisions made should be accurately recorded, together with details of the support given to protect adults at risk.

The review also found that assessments were not as rigorous as was required because not all of the safeguarding concerns were reported or shared. In addition, the significant background history of Adult L and M was not fully known by all agencies or researched effectively, which may have impacted on professional judgement. During this review gender bias was identified as a significant barrier and concerns were not fully investigated until Adult L was seriously assaulted. This bias prevented an objective analysis of the information available which indicated evidence of physical abuse and coercive manipulation.

**Are you being curious enough?**

There is a requirement to display enhanced professional curiosity and conduct thorough research into the background history in domestic abuse cases. You must ensure referrals are made in order that the full facts are identified and shared to support assessments, inform decision making and evidence gathering between agencies.

**(SAR Recommendation 2)**

**What do you do when there are concerns for a person's mental health?**

Mental Capacity Assessments and where relevant, advice from an advocate (such as Independent Mental Capacity Advocate (IMCA), Independent Mental Health Advocate (IMHA), Independent Domestic Violence Advocate (IDVA), or Care Act advocate) should be considered in a DA case where there are concerns for the mental health of a person.

**(SAR Recommendation 3)**

**Do you have access to ALL relevant databases?**

Practitioner access to relevant agency safeguarding record keeping systems is crucial. Agencies should develop a system where access is made available to key practitioners, in order that all relevant safeguarding information is accessible from other agency or department record-keeping systems. This will ensure all relevant safeguarding information is known and shared appropriately.

**(SAR Recommendation 5)**

**Do you know the signs and symptoms of unconscious and gender bias, coercive and manipulative control in Domestic Abuse cases?**

It's important that professionals are able to recognise the signs and symptoms of unconscious bias, coercive and manipulative controlling behaviour, intimate partner violence (IPV), intimate terrorism, situational couple violence (bi-lateral abuse) and gender bias in Domestic Abuse cases. To complement this, an understanding of what practical support systems are available should be known.

**(SAR Recommendation 6)**

**Do you conduct risk assessments? Are you aware of the Risk Assessment tool and how to use it?**

* The Bracknell Forest Risk Management Tool can be used to assist in risk assessment in safeguarding cases. If the tool is not used by agencies, they should ensure an effective risk assessment is conducted and the rationale recorded to ensure effective safeguarding practice.
* Ensure that Section 42 Care Act 2014 safeguarding enquiries are conducted when an adult is experiencing or is at risk of abuse or neglect.
* As a level of added protection, consider utilising, through police and magistrate courts, the powers of Domestic Abuse Protection Order (DAPO) and Domestic Abuse Protection Notice (DAPN)s to protect victims when circumstances dictate.

**(SAR Recommendation 7)**

**Do you use databases and websites (such as the BFSB site) to review other recent learning?**

Learning can also be accessed from other trusted sources. For example:

SCIE (adult reviews) - register to access the free SAR library,

NSPCC (children's reviews)

**(SAR Recommendation 8)**