Wolverhampton Safeguarding Together (WST) Learning Lessons Briefing - SAR PAT.

The Review

This Learning Lessons briefing has been written as a result of the Safeguarding Adult Review (SAR) which was undertaken to review the experiences of Pat, a 79-year-old woman who was abused by her son.

The Safeguarding Adult Review considered the findings and key learning themes arising from the information provided by agencies who had been supporting Pat.

Information was provided by Pat's family, the Care Agency, Police, Health Providers, Adult Social Care, all of whom had contact or involvement with Pat between 2016 and 2019.

Scrutiny of actions taken by professionals and agencies including areas of good practice and key learning themes were considered and reviewed by the SAR panel.

The purpose of this briefing is to share the learning that arose from the SAR.

How can you make a difference?

Key messages from the learning to ask yourself for your practice are: -

- *Can I make changes to improve my own practice?*
- *Do I need to seek further support, training, or supervision?*

Background Summary

Pat was a 79-year-old woman who lived with her adult son. Due to Pat's physical disabilities, she had been cared for by her partner Keith, until he died in 2019. Following Keith's death, Pat was then cared for by her son and received daily support from a care agency.

Following Keith's death, Pat experienced domestic abuse perpetrated by her son. The Care Agency raised three separate safeguarding referrals due to concerns the carers had about the behaviour of Pat's son, including unexplained bruising seen on Pat's body.

The SAR panel considered there may have been missed opportunities to safeguard Pat if the safeguarding referrals had been responded to differently. The SAR panel

also questioned whether escalation processes were followed or effective, these issues are reflected in the SAR findings and recommendations.

Following a serious assault that led to her son's arrest, Pat was admitted to hospital where she was treated and safeguarded. Following the hospital admission Pat was discharged home to a Residential Care Home.

Pat's son was arrested and charged with Grievous Bodily Harm and criminal damage that occurred within the family home. He was convicted and received a custodial sentence at Court.

Key findings and recommendations arising for WST Safeguarding Partners and Voluntary Organisations to the SAR. They outline the learning which needs to be considered for effective change?

Finding 1. Developing a Domestic Abuse, Adult at Risk Pathway with a Single Point of Contact and implement a Media Strategy. Although ASC have a SPOC for safeguarding (MASH), this is not specific to DA and was not generally known to those that attended the practitioner's event or spoken to during the review process. This raised the need for a DA pathway to be developed.

- *Agencies should develop a Domestic Abuse pathway and recognise the role of a 'Champion' or a Single Point of Contact to ensure all cases of domestic abuse are referred, monitored, supervised, and directed to the right professional and agency in order that effective action is appropriately taken, ensuring information is shared expeditiously and enacted upon.*
- *Develop an adult at risk toolkit and flowchart to assist the DA pathway or SPOC to support safeguarding professionals in the function of their roles and responsibilities. Review whether current thresholds and role responsibilities in domestic abuse cases are up to date, comprehensive and reflects Local and National Safeguarding Adult guidance.*
- *Conduct a media strategy to make available contact and helpful numbers where members of the public can report cases of domestic abuse and are able to receive advice and assistance* (***SAR Recommendation 1***).

Finding 2. Domestic Violence Protection Notices, Orders (Domestic Abuse Protection Notices and Orders from 2023) and Victimless Prosecutions. There were initiatives that were available and could have used to protecting Pat, an extremely vulnerable, adult at risk.

- *Police and other agencies to effectively utilise Domestic Abuse Protection Notices and Orders (DAPN and DAPO) that consolidates existing protection orders and non-molestation orders under the Domestic Abuse Act 2021.*
- *Police in persistent DA cases, where the victim does not support a criminal prosecution, through the CPS, a request should be made to conduct a victimless prosecution* (***SAR Recommendation 2***).

Finding 3. Recognising Coercive, Emotional and Manipulative Control. There was clear evidence provided to the review which supports this finding which was not identified or recognised in Pat's case.

- *How to recognise and act upon the signs and symptoms of coercive, emotional, and manipulative controlling behaviour of an adult at risk in conjunction with the Domestic Abuse Act 2021.*

- *Ensure the criminal offence under Section 76 of the Serious Crime Act 2015, if suspected will be referred for safeguarding action to be taken to protect the subject* **(*SAR Recommendation 3*).**

Finding 4. Supervision, Professional Curiosity and Risk Assessments. Agency submissions to the review outlined the requirement for more effective action required which supports this finding to enhance professional practice.

- *A high-risk domestic abuse case or any safeguarding referral should not be closed without supervision oversight, to ensure that all available action, risk assessments, safeguarding plans are completed with the rationale recorded that is subject to scrutiny.*
- *More professional curiosity must be displayed to ensure that practitioners are aware and take into account all aspects of domestic abuse of an adult at risk, in order to protect their health and well-being and utilise the supportive services of an IDVA where necessary.*
- *A review must be conducted as to the suitability of the role of a sole carer where safeguarding concerns of domestic abuse and other serious concerns have been raised, to ensure the continued protection of the person* **(*SAR Recommendation 4*).**

Finding 5. Consideration of Mental Capacity Assessments for 'Best Interest' decisions. The SAR process and practitioners' event identified an MCA should have been considered and more thoroughly. If in doubt, advice should always be sought from a professional, as mental capacity should never assumed without considering the full facts.

- *Where there is a possible concern of mental capacity, they must ensure that a Mental Capacity Assessment is always considered to be carried out or seek the advice from a Mental Health/Capacity professional or Independent Mental Capacity Advocate, to ensure the 'best interest' decision, to protect the welfare of the adult at risk, is assessed.* **(*SAR Recommendation 5*).**

Finding 6. Communication, record keeping, escalation and sharing information. Agency submissions to the SAR identified and evidenced this finding and recommendations.

- *The requirement for enhanced professional curiosity to fully investigate and record on the correct database, details of their enquiries and decision making for any case of domestic abuse, in order to protect an adult at risk. The information should be expediently shared to the relevant safeguarding agencies in compliance with Local and National Domestic Abuse Policies and Guidance.*
- *Professionals should be encouraged to challenge the decisions or actions taken in a safeguarding enquiry which are not agreed. Practitioners should raise the concerns to their line manager and if the matter is unresolved should utilise either the WST Escalation Policy, Dispute Resolution, or their own agencies escalation policy to address the issue in question.* **(*SAR Recommendation 6*).**
  and
- *Request for the Care Quality Commission to conduct an inspection of Agincare Care Agency into the quality of Agincare's record keeping, decision making, sharing of safeguarding information requiring a referral; the retention of essential documentation including details of staff and ex staff members for any subsequent statutory review which may occur. Furthermore, to ensure that the reported concerns within the SAR for Pat are not being replicated in other Agincare teams providing care to the community and that the lessons in SAR Pat are learnt.* **(*SAR Recommendation 7*).**

Finding 7. Professionals' meetings. Even though there were strategy discussions held, they were not comprehensive as was the case of the MARAC meetings which were not to the standard expected and require improvements.

- *Wolverhampton safeguarding partners and voluntary agencies reassure WST that their staff have been reminded that they can request a prompt multi-agency professional or strategy meeting when continuing concerns with an adult at risk persists, in order to enable professionals to consider the wider aspects and options available in a case, to protect the health and welfare of the adult.* ***SAR Recommendation 8*****).**

Finding 8 - Concerns for the Medication of Keith and Pat. This was addressed at the time with appropriate supervision by health professionals as it was believed additional medication requested by K was not being used correctly and could have been used inappropriately. This was effectively challenged at the time therefore no recommendation is necessary.

Finding 9 - Compliance to complete Safeguarding Referrals and Risk Assessments. There were missed opportunities or delays to refer safeguarding domestic abuse incidents together with no effective risk assessments conducted to a professional standard.

- *Complete and submit safeguarding referrals expediently which are risk assessed for appropriate safeguarding action to be taken.*
- *Ensuring that all available actions and initiatives including Care Act needs assessments and safeguarding enquiries in compliance with Local and National Safeguarding Adult Policy and Procedures are completed and the outcome shared with relevant agencies.*
- *The knowledge and experience of an IDVA must be utilised when dealing with high-risk domestic abuse cases of an adult at risk to give the best possible opportunity to improve their health and wellbeing and to ensure they are effectively protected.* **(*SAR Recommendation 9*)** *and,*

- *Wolverhampton Adult Social Care and West Midlands Police should conduct joint home visits in a high-risk, suspected domestic abuse, adult at risk cases, in order to fully assess the allegation and ensure that a thorough DASH assessment form is completed to support and inform professional practice to protect and safeguard the subject.* **(*SAR Recommendation 10*).**

Finding 10 - West Midlands Police, Quality and Response to Domestic Abuse, Adult at Risk Case. There was identified learning for WMP from the outcome of the information provided to the SAR to be considered and addressed.

- *To clarify with Local Authority Commissioners of statutory reviews the type of WMP report or individual management report required, ensuring that any lesson learnt are included in the report, agreed, and signed off by senior management.*
- *Review the quality of the WMP domestic abuse investigations within SAR Pat to ensure lessons are learnt, including from previous learning from HMICFRS inspections, complying with the West Midlands Crime Commissioner Policing Priority for Hidden Crime (domestic abuse) and Local and National Safeguarding Adult Policies and Procedures.*
- *Review the quality of MARAC meetings, to ensure they are supervised, the recorded minutes, of the meeting reflect the discussion had; the right agencies with knowledge of the case are invited, to consider the wider aspects of an adult at risk case, with safeguarding action plans developed with the rationale of decision making and outcomes recorded.* **(*SAR Recommendation 11*).**

Implementations

Some of the learning from the review has already been implemented by participating agencies during the SAR process. This includes practitioners displaying professional curiosity, such as hospitals ensuring staff conduct a thorough assessment for all patients including older injuries, and how they were sustained, even when there are no concerns about the presentation.

Learning was also disseminated to and between professionals during the SAR practitioner event that was held.

Domestic Abuse Act 2021

The new act became law on the 29 April 2021[1] and was incorporated in the review as it supports the SAR findings and recommendations. The act provides further protection for people who experience domestic abuse and strengthen measures to tackle perpetrators. It now has a wide-ranging legal definition of domestic abuse which incorporates physical violence, including emotional, coercive, or controlling behaviour, and economic abuse. The measures include important new protection and support for victims ensuring that abusers will no longer be allowed to directly cross-examine their victims in the family and civil courts and giving victims better access to special measures in the courtroom to help prevent intimidation. The new Domestic Abuse Protection Notices and Orders (DAPNs and DAPOs) will replace the current Domestic Violence Protection Notices and Orders (DVPN and DVPOs). A DAPO will introduce an alternative application route so that victims and specified third parties can apply for a DAPO directly to the family court. This will enable criminal, family, and civil courts to make a DAPO of their own volition during existing court proceedings, which do not have to be domestic abuse related cases.

DAPNs will provide victims with immediate protection from abusers, while courts will be able to hand out new DAPOs to help prevent offending by forcing perpetrators to take steps to change their behaviour, including seeking mental health support or drug and alcohol rehabilitation. Other measures include: extending the controlling or coercive behaviour offence; established in law the office of Domestic Abuse Commissioner; places a duty on local authorities in England to provide support to victims of domestic abuse and their children in refuges and other safe accommodation; provides that all eligible homeless victims of domestic abuse automatically have 'priority need' for homelessness assistance; places the guidance supporting the Domestic Violence Disclosure Scheme ("Clare's law") on a statutory footing and the expectation that the law will fundamentally transform professional response to tackling domestic abuse by providing much greater protections from all forms of abuse.

Can you effect change from the lessons identified?

[1] Home Office, Ministry of Justice, Gov UK

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