From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Family W

A SAR overview Report has been completed, but the SSAB has taken the decision that an Executive Summary only will be published due to the circumstances of the case. The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Learn to recognise the signs of domestic abuse in older age, think about how you can have conversations with people in this situation and where to go for support. Take time to read up on domestic abuse in older age by following the links in this article: https://somersetdomesticabuse.org.uk/am-i-being-abused/older-people-and-domestic-abuse/

We also describe some of the complexities around adult children abusing parents below.

Consider: What changes will I make to my own practice?

Do I need to seek further support, supervision or training on working with adults who are experiencing domestic abuse?

Key features of Family W Case

Mother and son lived in the same household, Mrs W was, at the time of events, in her 80s and had experienced a number of health issues. Her son controlled access to her and was particularly controlling around any contact with primary care services. Mrs W later told hospital health practitioners that her son did not like doctors following his experiences with mental health services many years previously. Mrs W had not had health checks or medication for many years despite efforts to see her. There were also reports of Mrs W being financially abused by her son. Mrs W was admitted to hospital after an accident, her son had attempted to treat her serious injuries at home, and she had developed an infection. Mrs W later died from unrelated causes.

Key considerations for practice arising from the review: Domestic Abuse in older age.

Recognise what is happening.

Every practitioner needs an awareness of how domestic abuse presents in older age groups to order to inform early identification of potential abuse and conversations to explore what is happening. Think: how the person is coping with the situation and what supports are available to them?

We can conclude that situations similar to the W family will occur again in Somerset. How might we respond?

We need to understand the complexities of domestic abuse in older age.

These can be about the language used, a marriage or person may be described as 'difficult' rather than abusive. We need to understand the impact of family history, including bereavements or separation/divorce. Consider issues of power and dependency and the interdependency,[1] of caring responsibilities and financial dependence. Perpetrator and victim may cling to the only family relationship they have. An older person may have a fear of 'being removed', of losing home and family.

A parent's sense of parental responsibility may lead to the wish to help an adult child, or to avoid getting them into 'trouble' with doctors or the police. When a child has been mentally unwell the parent may be concerned not to increase 'pressure' on them and cause further illness. How does a parent feel about their child? Do they feel a sense of shame about their behaviour?

Some older women, particularly those born pre 1945 may feel that protecting the status of the family and private sphere from external agencies is more important than their needs. The term 'older people' is often applied to adults aged sixty and above, but this

may span several generations, we need to understand societal differences in attitude as well as individual differences.

Knowing where to go for support.

Learn how to undertake a DASH (Domestic Abuse, Stalking and Honour) assessment. The current nationally agreed DASH assessment may not be able to accurately assess high risks from domestic abuse to older people so do speak directly to Somerset Domestic Abuse Services (SIDAS) who will consider referrals where professional judgement is required. Find out who the MARAC representative is in your organisation, discuss the case with them.

Contact SIDAS at Phone: 0800 694 9999 (option 2) or email: SIDAS@somerset.gov.uk

Professional Curiosity.

We need to use our professional curiosity in all aspects of our practice, whether this is when gathering information and reading notes, working with multi-agency partners, or having conversations with families and individuals. Professionally curious approaches should be used in all aspects of gathering information and assessing risk and need. It can be hard to remain uncertain in situations of risk, multi-agency working can support this approach through shared risk taking. This may also involve using professional curiosity to challenge each other's perceptions.

It is important to remember two key concepts related to the use of professional curiosity, firstly the idea of 'respectful uncertainty', the continual analysis of received information in a spirit of open mindedness. Secondly the need for 'safe uncertainty', it is safer for the person if you understand that you do not know all information, you cannot be 100% sure of all the facts. This will keep your mind open to alternative explanations. Without these approaches we risk falling prey to confirmation bias, using information to confirm our existing opinion.

Organisations and individual practitioners may have different perspectives on what is happening, these different perspectives, and how they influence the possibility of engagement as well as the risk assessment, needed to be shared and discussed. Without on-going discussion there can be a fundamental division in how an alleged perpetrator is seen and what the risks to the adult are thought to be. We also risk over optimism, that because a person cares about the adult they are able to undertake the decisions and actions necessary to keep them safe, or we may take approaches that are out of proportion to actual risk because of our assumptions about the meaning of the person's behaviour.

Even if we cannot see a person face to face, we need to preserve a respectful uncertainty about what is informing their behaviour and how they perceive their needs.

Multi-agency working.

Multi-agency work, including that undertaken under the local authority s42 duty, is a creative and useful approach to give direction and support in situations where risk is hard to mitigate. Such an approach must be coordinated by a lead organisation and

underpinned by clear guidance and confidence in progressing actions during and after a multi-agency meeting.

Read through the SSAB guidance on Multi-agency Risk Management (MARM) at https://somersetsafeguardingadults.org.uk/information-for-professionals/practice-guidance-and-resources/

Should any organisation be concerned that agreed risk mitigation is inadequate, or should a vital organisation refuse to attend a multi-agency meeting, the SSAB resolving professional differences protocol can be used to resolve the concern quickly.

You will find the SSAB resolving professional differences protocol at https://somersetsafeguardingadults.org.uk/information-for-professionals/practice-guidance-and-resources/#Resolving%20professional%20differences.

Support when feeling intimidated.

Some practitioners felt intimidated by Mrs W's son. Feeling intimidated impairs judgement and makes it hard for us to work well with the person. Ask: who do you turn to in your organisation if you are feeling intimidated. Can you discuss this with your manager? You will feel more confident if you know what supports are available to you to help you reflect on the situation and to resolve any issues there may be.

Consider history and cumulative risk.

Reported safeguarding concerns about Mrs W's safety were considered as separate incidents and often closed without review of previous incidents or an appreciation of cumulative risk. We need to information gather by reviewing past incidents as well as speaking with other practitioners who may have been involved with the person for a long time. We also need to remember that the criteria for the use of the local authority section 42 duty includes 'is experiencing, or is at risk of, abuse or neglect'. It is hard to judge whether a person might be at high risk of abuse without looking at previous concern referrals or section 42 enquiries.

An ambulance called does not mean the person has gone to hospital.

The ambulance service reports that practitioners from all organisations at times make the assumption that a person will be conveyed to hospital if an ambulance is called. This leads to a belief that the person is in a safe place, when in fact they may be in a situation of increased risk. Always double check, has the person been taken to hospital? Have they been admitted or returned home?

Further information

Somerset Safeguarding Adults Board:

- Somerset Safeguarding Adults
- Somerset Domestic Abuse Website
- Mental Capacity Act (somerset.gov.uk)

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to: (e.g. all district nurses; duty social workers etc.)	
This briefing was used in: (e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	