‘Family W’
Safeguarding Adult Review
Executive Summary

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Glossary.

AMHP – Approved Mental Health Professional.

ASC – Adult Social Care.

DASH – Domestic Abuse, Stalking and Honour based violence risk assessment.

DHSC - Department of Health and Social Care.

ICB – NHS Somerset Integrated Care Board.

IDVA – Independent Domestic Violence Advocate.

LGA - Local Government Association.

MARAC- Multi-Agency Risk Assessment Conference.

MARM – Multi-agency Risk Management.

SAR – Safeguarding Adults Review

(S) SAB – (Somerset) Safeguarding Adults Board

SC and SCC– Somerset County Council became Somerset Council in April 2023. The acronym 'SCC' is used in the body of the report, 'SC' used to denote the local authority as of April 2023.

SIDAS – Somerset Domestic Abuse Support.

SWASFT – South West Ambulance Service NHS Foundation Trust.

1. Introduction.

1.1 This Safeguarding Adults Review (SAR) is commissioned by Somerset Safeguarding Adults Board (SSAB) following a referral to SSAB from Helen's GP shortly after her death in 2020.

1.2 Case summary: Helen was in her late 80s when she died whilst being treated for injuries arising from an accident. Helen lived with her son, John.

Over a period of years there were concerns that John was controlling Helen and preventing her from accessing primary care and other forms of medical help. John had not summoned any help for Helen after an accident but attempted to treat her injuries himself and her wounds had become infected. Helen was taken to hospital after a police welfare check some days after her injury. There were also concerns about how Helen's money was being used. John's control of Helen may have been related to his previous mental health diagnosis and experiences, he was thought to be afraid of medical professionals. After Helen's admission to hospital, John was admitted to hospital for assessment under section 2 of the Mental Health Act for a short period of time.

1.3 This SAR is commissioned under section 44 of the Care Act 2014 as a mandatory SAR.

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

2. Findings and Learning Points.

There is much good practice to celebrate and build on in this case as detailed in section 2.1 below. We will then explore areas for development across practice, multi-agency working, organisational and strategic responses. There was no easy way to engage with Helen or John during the time considered by this SAR and the lead reviewer is not suggesting that there was something missed that could have prevented Helen's need for urgent medical care being neglected and obstructed by her son. The missed opportunities to get help to her appear to have been exacerbated by the need to maintain the availability of ambulances during the COVID pandemic, the resultant communication errors and human error in making an assumption that an ambulance called means that the person is conveyed to hospital.

However, we can learn lessons from Helen and John's situation which will help us to develop better responses when working in similar situations in the future.

2.1 Areas of good practice.

2.1.1 It is positive that all organisations involved with John and Helen saw John's control of Helen as 'domestic abuse'. This is a significant strength which can be built on. Much research and service development focuses on intimate partner abuse in younger groups with less information on abuse in older age. However, there was anecdotal evidence at the Learning Event that local third sector Domestic Abuse services are keen to receive referrals about older people and are clear that "abuse has no age limit".

2.1.2 Organisations were also made aware of possible financial abuse as local Bank staff acted proactively to try to understand the situation and made appropriate referrals to the police and adult safeguarding. Neighbours were also concerned and prepared to contact the police to protect Helen.

2.1.3 Organisations supported each other in visiting the property with Police at a local and force level being actively involved. Primary care teams continued to be concerned and attempted to get help to Helen through working with other organisations, challenging the decisions made by other organisations and continuing to keep Helen's situation under review.

2.1.4 The work undertaken with Helen and John during the 'window of opportunity' afforded by their respective admissions to hospital was thorough, legally literate and person centred.

2.2 Developing Practice.

2.2.1. Gathering historical information about Helen and John was not easy. Paper notes were transferred to their new GP after they moved into the area. John's notes were not examined in any detail until many years later, after Helen stopped attending the GP surgery. This lack of information inhibited preventative responses in Somerset.

2.2.2 There were two opportunities outside of the time considered by the SAR when preventative work may have been undertaken with Helen to explore the impact of her history and John's behaviour on her and to create supports to sustain her. The first occurred in the mid- 1990s when she disclosed her situation to mental health services out of area and the second opportunity, had John's history been known, may have been possible prior to 2013. These observations are not critical of practice but

remind us of the importance of early support to families living with a person with mental illness and of awareness of parent – child domestic abuse. When discussing John with her GP in 2013 Helen remarked that he was '*difficult*'. Older people may refer to a 'difficult marriage' or 'difficult person' when they may be referring to abuse.[1] It is worth understanding what 'difficult' means.

Learning Point 1.

Practitioners need an awareness of domestic abuse in older age groups to inform early identification of potential abuse and conversations to explore what is happening, how the person is coping with the situation and what supports are available to them.

2.2.3 Opportunities to use professionally curious approaches when speaking with John and Helen were very limited. In hindsight we can find areas of exploration which may have supported both Helen and John, particularly in relation to the deaths of close family members.

2.2.4 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', whilst understanding the uncertainty of information is a 'safe position[2]' we must also ensure we understand imminent high impact risk whilst gathering information. Without these approaches we risk falling prey to confirmation bias, using information to confirm our existing opinion. For some practitioners John was seen as '*very aggressive'* with a need for police protection for practitioners. His previous psychiatric history from over thirty years ago was a focus in the absence of any more recent assessment. His behaviour toward professionals was determined as a feature of his mental illness which influenced the decision to assess his mental health. For SCC practitioners John was not frightening but afraid and, if he felt in control of the situation, was less intimidating. These different perspectives, and how they influenced 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

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[1] Bows, H, P, Bromley, Walklate, S. *Practitioner Understandings of Older Victims of Abuse and Their Perpetrators: Not Ideal Enough*. The British Journal of Criminology, 2023, vol 63, 1–18

[2] Mason, B (1993). Towards positions of safe uncertainty. Human Systems, Vol 4 pp 189-200

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.

Learning Point 2.

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 challenging each other's perceptions.

2.2.5 How effectively were the risks associated with alleged domestic abuse assessed and managed? Older people are slightly more likely than those under 60 years old to experience abuse by adult family members rather than intimate partners[3]. Adults aged 60 and over account for at least 1 in 4 domestic homicides in the United Kingdom, despite constituting only 18 per cent of the population.[4] Older women are also disproportionately at risk of being killed by their (adult) children[5] and this dynamic accounts for half of all domestic homicides of older adults[6]. Recent research undertaken with practitioners across all public services[7] highlighted mental health as a key issue where the abuser is a son or grandson, noting that:

"perpetrator vulnerabilities meant that domestic abuse may be missed, either because the victim and/or professional is focussed on these issues as being the cause of abuse, or because ageist stereotypes mean the abusive son or grandson is seen as caring for the victim…risk of missing the woman's perspective".

We can conclude that situations similar to John and Helen's will occur again in Somerset. How might we respond?

2.2.6 The focus on the idea that change may result from attention to John's mental health meant that firstly the complexity of the relationship between mother and son was not understood, and secondly there was limited attention to Helen, what might influence her views and what the actual and future risk to her might be. We can take this learning forward to inform future responses.

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[3] https://safelives.org.uk/spotlight-1-older-people-and-domestic-abuse

[4] Bows, H. (2019a), '*Domestic Homicide of Older People (2010–15): A Comparative Analysis of Intimate-Partner Homicide and Parricide Cases in the UK'*, The British Journal of Social Work, 49: 1234–53.

[5] Holt, A (2017), '*Parricide in England and Wales (1977–2012): An Exploration of Offenders, Victims, Incidents and Outcomes'*, Criminology & Criminal Justice, 17: 568–87.

[6] Bowes, H ibid.

[7] Bowes, H, P, Bromley, Walklate, S. *Practitioner Understandings of Older Victims of Abuse and Their Perpetrators: Not Ideal Enough*. The British Journal of Criminology, 2023, vol 63, 1–18

The complexity of the relationship between mother and son.

Controlling relationships in older age are complex. Some areas for exploration are noted above, i.e. the impact of bereavement on their relationship and the impact on Helen of a close relationship with a son with delusional and paranoid thinking and behaviour, as well as her own isolation and control.

We can also consider issues of power and dependency and interdependency,[8] Johns actions had increased Helen's dependency on him, whilst he appears to be dependent on her for money. Both may cling to the only family relationship they have.

Focusing on Helen's views, her actual and future needs.

We need to think about Helen's sense of parental responsibility to help her adult child, or to avoid getting him into 'trouble' with doctors or the police. Was Helen concerned that John would become very mentally unwell again if under pressure? What were her views about herself as John's mother and whether she felt she had a role to play in keeping him well? His behaviour when unwell over thirty years previously will have been very traumatic for her. Did she feel a sense of shame about her situation?

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.

Helen may have also felt a fear of 'being removed', of losing her home and family.

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.

It is hard to discern how practitioners saw Helen's needs. Her previous medical diagnoses would indicate that she needed regular medication and review. It was noted that she was controlled by John and denied access to medical help. She was noted at times to look over her shoulder and be afraid, and at others to vigorously defend her home or to have a '*warm and friendly'* relationship with her son. She told practitioners that she was well and happy, but this was hard for some to believe in

[8] Read more in Wydall, S and Zerk, R (2017) *Domestic abuse and older people: factors influencing help-seeking.* Journal of Adult Protection VOL. 19 NO. 5 2017, pp. 247-260.

the face of witnessed control. The separation of mother and son to ascertain needs and wishes was desirable, but the plan for doing so may not have taken account of the complexity of the relationship or the uncertainties around the situation.

Learning Point 3.

We need to understand the complexities of domestic abuse in older age. These can be about the language used, generational attitudes to home and family, the family history and the impact of this on how those involved perceive their roles and obligations, dependency and inter or co-dependency, fear of loss of independence, shame and social isolation.

2.2.7. Local authorities in England do not have a power of entry to use when a third party is refusing access to a person who may be at risk of abuse or neglect, but where there are no concerns about mental capacity or mental health. Such powers, which exist in other UK countries, have a legal process around them which supports good practice, proportionality and person-centred approaches. The joint DHSC and Home Office 'Safe Care at Home Review'[9] Report was published in 2023. Frontline practitioners, and other stakeholders, consulted during the Review reported that access is difficult if the families of people with care and support needs do not trust statutory services. Social workers had few routes when access to the person is being deliberately obstructed and are unable to prevent or respond effectively to crises, this sometimes resulted in a tragic outcome. DHSC has responded that

'*DHSC will review any new and relevant evidence on powers of entry for social workers since this issue was last considered by government during the passage of the Domestic Abuse Act 2021. This should include Safeguarding Adult Reviews in England and the use of equivalent powers in Scotland and Wales. (Key Finding 3 section d.)'*

2.3 Multi-agency working

2.3.1 Organisations described Helen's situation as one of domestic abuse. Whilst recognition of her situation was good, the responses were not well-developed.

[9] DHSC/Home Office (July 2023) Safe Care at Home: Executive Summary. Available at https://www.gov.uk/government/publications/safe-care-at-home-review/safe-care-at-home-review-accessible#executive-summary

2.3.2 Whilst there were multi-agency meetings to plan the assessment of John and Helen's mental health not all organisations attended. There were no multi-agency meetings prior to Helen's hospital admission that involved all key organisations including adult safeguarding. Safeguarding responses were episodic and dependent on reports of abuse from third parties. SCC decided that Helen's situation did not meet the criteria for the use of the s42 duty in October 2020, a decision which was overturned after challenge by the GP. Although organisations shared information well during these episodes, they had no shared risk assessment or contingency plans to guide their responses. Whilst professionals continued to flag up and review concerns about Helen, the GP surgery found the experience *'fraught with red tape'* and described feelings of desperation about the situation which appeared to be continuing with no plan in place for mitigation or response. The SSAB agreed mechanism for resolving professional differences[10] was not used, and some organisations in 2023 appear to still be unaware of its' provisions.

2.3.3 What might have been different with consistent multi-agency working?

- A shared risk assessment based on respectful uncertainty, exploration and challenge of perceived risk, and a mechanism to review risk when new information was available.
- An appreciation of the role each organisation played and what support they may need. The GP surgery and complex care team continued to focus on Helen and seek support from SCC and other organisations.
- An understanding of each other's legal powers and responsibilities. The Police and AMHP service, and potentially other organisations involved, made assumptions about what was legally possible and what had been agreed with regard to legal powers.
- A commonly owned safeguarding plan based on agreed current risks and risk around potential scenarios. Thinking through the likely life course issues - Helen was likely to need medical attention at some point in the future and John's response could not be guaranteed.
- Given the difficulties in gaining access to Helen the safeguarding plan also needed to function as a contingency plan for a window of opportunity and to be clearly visible on records held by all organisations working with Helen to avoid missed opportunities.

[10] SSAB Resolving Professional Differences (updated 2023) find at https://somersetsafeguardingadults.org.uk/information-for-professionals/practice-guidance-and-resources/#Resolving%20professional%20differences

These actions can come out of a multi-agency meeting led by the local authority under the s42 duty or can be formulated in a multi-agency or 'professionals' meeting led by any agency. There must be a lead who has the responsibility to coordinate actions arising from the meeting who is also prepared to review those actions over a period of time. There was no such lead in this case. The SSAB guidance on Multi-agency Risk Management[11] (MARM) emphasises the need for a lead coordinator and provides a template for risk assessment. This guidance can be updated in the light of this SAR to include contingency planning, support for involved professionals and the need to keep risk assessments updated etc. It may be useful to have a set of principles for positive multi-agency working that can be used across adult safeguarding, MARMS, and all other professionals' meetings were risk is discussed. These will be broad principles, about the need for professional curiosity, respectful understanding of role, responsibility and legal duties and powers, as well as the need for risk assessment, contingency planning etc. and the supportive role of the SSAB resolving professional differences protocol.

Learning Point 4.

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

2.4 Learning for organisations

2.4.1 The GP(s) involved in this case reported feeling intimidated by John whilst primary care staff report feeling desperate. Whilst GPs have opportunities to raise and discuss very complex cases with multi-disciplinary colleagues in the ICB and elsewhere, there does not appear to be an identified local support for GPs who feel intimidated by their patients. GPs can access a range of supports via the British Medical Association[12], whilst pastoral care is available for members of the Somerset

[11] SSAB September 2023 https://somersetsafeguardingadults.org.uk/information-for-professionals/practice-guidance-and-resources/

[12] https://www.bma.org.uk/advice-and-support/your-wellbeing#wellbeing-support-services

Local Medical Committee[13]. It is not known if any of these services were accessed or if so, were useful. Feeling intimidated impairs judgement and has other negative consequences for the practitioner and patient.

Learning Point 5.

All practitioners need opportunity to a) reflect on how their experience influences their judgement and b) have a clear pathway to address concerns about their own safety.

2.4.2. The involvement of SCC adult safeguarding decision-makers and safeguarding team was responsive and episodic whilst the GP and AMHP appreciated the on-going nature of the risk to Helen. SCC was concerned with '*no immediate safeguarding risk'* but did not attend to the likely and potentially high impact risk to Helen from John's consistent obstruction of medical help to her.

Learning Point 6.

The criteria for use of the s42 duty is 'experiencing, or is at risk of, abuse or neglect'. Helen was at risk of high impact abuse or neglect. In these scenarios a safeguarding Enquiry with a multi-agency approach followed by a plan to mitigate or for use in contingencies will be helpful.

2.4.3 SWASFT 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.

Learning Point 7.

The assumption that a person will be conveyed if an ambulance is called creates risk for a range of adults with care and support needs. This learning will need to feature in learning materials disseminated from this SAR.

2.5 The partnership between adult safeguarding and domestic abuse services.

2.5.1 LGA guidance [14] on adult safeguarding and domestic abuse suggests a range of ways to link domestic abuse and adult safeguarding including integrated training to ensure that domestic abuse and safeguarding are not seen as separate issues, linking policies and strategies and ensuring that practitioners have a range of practice and

[13] https://www.somersetlmc.co.uk/gpsupport

[14] ADASS/LGA (2015) Adult Safeguarding and Domestic Abuse; A guide to support practitioners and managers. Find at https://www.local.gov.uk/sites/default/files/documents/adult-safeguarding-and-do-cfe.pdf Page 15

legal options to use in prevention and response to adults at risk who are being abused by intimate or family members.

2.5.2 Whilst practitioners recognised that Helen was experiencing domestic abuse, they did not access specialist advice on domestic abuse or use any other multi-agency forum such as MARAC to explore how risk might be mitigated. Research has shown that

"safeguarding professionals are reluctant to use standard domestic abuse tools and processes (e.g. Multi-Agency Risk Assessment Conferences), when assessing older people, thus disadvantaging this age-group and inhibiting access to specialist advocate support such as the Independent Domestic Violence Advisors. Furthermore, practitioners frequently lack the knowledge and expertise to integrate safeguarding and domestic abuse procedures on a case-by-case basis" [15]

2.5.3 Participants at the Learning Event indicated a 'gap' for people who do not meet the DASH risk threshold for referral to MARAC. This group of people are either signposted to helplines (low risk) or referred to a group programme on over-coming abuse (medium risk)[16]. Older adults are less likely to meet the DASH risk threshold for a referral to a MARAC. Using the nationally agreed DASH Risk Assessment Checklist results in a lower risk score for older people. A very experienced assessor may compensate for these factors, but professional judgement is then paramount, rather than agreed assessment parameters. The need for a DASH risk assessment that focuses on older people is beginning to be evidenced[17] whilst other areas have initiated a specific DASH. [18] Somerset Integrated Domestic Abuse Service (SIDAS) are reported by the SSAB Business Unit to think that the time is not right for the implementation of a specific DASH and that priority needs to be the education of GPs as to the existence of SIDAS and IDVAs.

2.5.4 Somerset guidance on Domestic Abuse situations in adult safeguarding does encourage speaking directly to the SIDAS who will consider referrals where professional judgement is required, as well as discussing the case with the organisations MARAC representative for more support. Neither approach appears to have been used for Helen, perhaps because a DASH assessment could not be carried

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[15] Wydell, S and Zerk, R (2017) *Domestic abuse and older people: factors influencing help-seeking*. Journal of Adult Protection Vol 19 no 5 page 249.

[16] https://somersetsafeguardingadults.org.uk/information-for-professionals/guidance-for-safeguarding-adults-in-somerset/domestic-abuse/

[17] https://safercornwall.co.uk/older-people-and-dasv-pilot-project-report/page 16

[18] https://www.cambsdasv.org.uk/web/older_people/567583

out, or because of a lack of confidence in using tools and services. It is noted that a recent SSAB Review[19] recommends that practitioners increase skill and confidence in using DASH assessments.

Learning Point 8.

The current nationally agreed DASH may not be able to accurately assess high risks from domestic abuse to older people. There is a risk that older people are less likely to therefore have access to an IDVA or other specialist resources.

Learning Point 9.

Older people are more likely to experience the 'gap' for people less likely to be able to use a helpline or group meetings. Where other approaches are taken these will need to be informed by guidance and support which understands domestic abuse and its' impact on older groups.

2.5.5 The data published in the Somerset Domestic Abuse Strategy 2021 – 2024 does not include rates of reported domestic abuse by age. There is an intention to improve reporting on demography in the future. The strategy does acknowledge that

Victims aged over 61 years are much more likely to experience abuse from an adult family member or current intimate partner than those aged 60 and under[20]. Page 9

2.5.6 In the current Somerset training module on domestic abuse child to parent abuse is covered by a module on "Adolescent to Parent Abuse" and will not cover the dynamics seen in older people[21].

2.5.7 The Strategy notes that age or need "*could have an impact on their safe accommodation needs, particularly where family members of partners have a caring role*" "*and there are more likely to be mobility and health related considerations for victims aged over 60 years, there is a recommendation in the needs assessment for the safe accommodation offer to be a dispersed model rather than 'traditional*

[19] Kathleen 2021 at https://somersetsafeguardingadults.org.uk/wp-content/uploads/SSAB-SSP-One-page-briefing-DLR-001-.pdf

[20] https://somersetcc.sharepoint.com/sites/SCCPublic/Families/Forms/AllItems.aspx?id=%2Fsites%2FSCCPublic%2FFamilies%2FSomerset%20Domestic%20Abuse%20Strategy%202021%20%2D%202024%2Epdf&parent=%2Fsites%2FSCCPublic%2FFamilies&p=true&ga=1

[21] https://somersetdomesticabuse.org.uk/professional-resources/child-to-parent-abuse/

refuge". However, there is no reference to any of the other complexities that can arise for older people with care and support needs.

2.5.8 Similar to other areas, the Somerset Domestic Abuse needs assessment identifies the issue of a perpetrator's complex needs, including mental health and substance misuse, and suggests co-location with mental health services to support this work. The Strategy also has a focus on prevention to avert crises, and a welcome focus on making service provision accessible to everyone, "*with a focus on flexible entry points to encourage older people to report and access all service elements"*[22].

Learning Point 10.

There is a need for professional development focusing on domestic abuse and older people with an equal emphasis to that of adolescent to parent abuse and intimate partner abuse. Domestic abuse across the lifecycle is an important principle. The different generational attitudes and potential complexities of older people need to be well understood.

2.6 Co-operation with the SAR

SC Adult Social Care did not contribute information and analysis of the events considered despite request and internal escalation. For a SAR to produce good learning for a local system all partners need to contribute. Rather like a multi-agency meeting, the success of the SAR is created through the collaboration of all organisations involved.

Learning Point 11.

The absence of information from all relevant partners will detract from learning, both for ASC and the wider partnership. The Care Act (2014) s45 requires organisations to comply with requests for information for the purpose of enabling or assisting the SAB to exercise its functions.

3. Conclusion.

There is much to learn from Helen and John to inform how we work with older people who are being controlled by a relative. There are no easy answers to how we can intervene in situations where there is a high degree of obstruction to helpful organisations. However, we have identified the helpfulness of a professionally curious

[22] Ibid Objective 5

and person-centred approach, even when we are unable to spend time with the person, together with persistent multi-agency working which utilises agreed risk assessments, mitigation and contingency planning with the support of multi-agency knowledge and skills.

4. Recommendations to the Somerset Safeguarding Adults Board.

4.1 The SSAB is recommended to share the learning from this SAR with the Safer Somerset Partnership.

4.2 The SSAB is recommended to seek assurance that the Safer Somerset Partnership develops the guidance and development opportunities below.

- Specific guidance on working with older people experiencing domestic abuse including additional risk assessment tools that work alongside the standard generic DASH assessment
- A development programme which addresses child to parent abuse when children or grandchildren are adults.
- Guidance that supports practitioners to effectively address the needs of older adults at risk who do not meet the threshold for MARAC.

4.3 The SSAB is recommended to work in partnership with the Safer Somerset Partnership to ensure that the guidance and development opportunities described in 4.2 are promoted and embedded within all health and social care organisations across Somerset.

(Learning Points 1, 3, 8,9, and 10)

4.4 The SSAB is recommended to extend the current guidance on professional curiosity to include the concepts of respectful uncertainty and safe uncertainty and to extend the guidance beyond the current conversation-based model.

(Learning Point 2)

4.5 The SSAB is recommended to review MARM guidance in the light of learning from this review and consider whether best practice guidance in multi-agency or 'professionals' meetings is required.

(Learning Point 4)

4.6 The SSAB is recommended to re-launch the updated "Resolving professional differences" protocol with a view to encouraging confident and consistent use of escalation in a range of circumstances, for example organisations not contributing to

multi-agency approaches or potential high impact risk remaining unmitigated, as described in this SAR.

(Learning Point 4)

4.7 The SSAB is recommended to include the necessity to address the assumption that if an ambulance called, a person is not always conveyed to hospital, in all learning materials and discussions related to this SAR.

(Learning Point 7).

4.8 The SSAB is recommended to

i) ask SC Adult Social Care for assurance that there will be full co-operation with future SARs.

ii) develop a process to address non-compliance with s45 by any organisation or team.

(Learning Point 11)

4.9 The SSAB is invited to use this SAR (Finding 2.2.7) to contribute to the DHSC as evidence of the need and framework around a Power of Entry in adult safeguarding in England.

5. Recommendations to individual agencies.

5.1 Somerset Council is recommended to audit a range of s42 decisions to ensure that the statutory criteria of 'at risk of' abuse or neglect is considered in decision making and to consider the implications of audit findings for guidance revision or practice development.

(Learning Point 6)

5.2 All partners are recommended to review their arrangements to support staff who feel intimidated or are threatened by the people they are serving. Particular attention may be needed for services, like GPs, who are not employed but have a key role in identifying risk and working in situations that pose a risk to them.

(Learning Point 5)