REPORT OF LEARNING TOGETHER SAFEGUARDING ADULTS REVIEW

Honor

How effective is the connection between Domestic Abuse and Safeguarding Adults in Swindon particularly for older adults?

Preface

The following report uses the Learning Together (Fish, Munro & Bairstow 2008) systems methodology developed by the Social Care institute for Excellence (SCIE) in Serious Case reviews. The Swindon Local Safeguarding Adult Board and member agencies should take ownership and act in response to the findings from this Adult Review to put in place lasting improvements to services.

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1. Introduction

1.1 Why this case was chosen to be reviewed

Safeguarding Adult Reviews (SARs) are about learning lessons for the future. They make sure that Safeguarding Adults' Boards get the full picture of what went wrong (and what went well), so that all organisations involved can improve their practice. The Clinical Commissioning Group submitted the case for review following the death of Honor and Swindon Local Safeguarding Adults Board (SAB) made the decision to commission a Safeguarding Adult Review under Section 44 of the Care Act (2014) (See Appendix 1). The Board agreed that the circumstances of the case appeared to have a wider significance for practice in relation to how different agencies worked together to support Honor. Ownership of the final report lies with the SAB as commissioner of the case review.

1.2 Succinct summary of case

The period under review begins in June 2014 when Honor's daughter reported concerns about her mother's welfare including financial abuse by her brother. Honor was a 90 year old widow living with her middle aged son in her own home. Honor's daughter continued to raise concerns about her mother's treatment by her brother. The GP, Community Care and Safeguarding Team made repeated attempts to encourage Honor and her son to engage with social care including referrals to the Memory Clinic, admission to SWICC and a befriending service. Honor denied the alleged psychological abuse and neglect and refused assistance from community care apart from a Homeline fob. Police were called to the house following Honor pressing her fob in October 2016.

Between June 2014 and December 2016 six safeguarding referrals were made by different people including Honor's daughter, friend and voluntary organisations. Honor continued to deny the abuse. In December 2016, following a visit by the GP and Swindon Women's Aid Honor disclosed psychological abuse.

In January 2017 Honor's son rang the GP Surgery and asked for a home visit. The GP called Paramedics who took Honor to hospital where she died the same day of pneumonia.

1.3 Family composition

The family are white British. Honor had two children, her son with whom she lived and her daughter who was ten years younger than her brother. Her daughter had moved away quite recently at the start of the review although she subsequently returned to the area. Her daughter's children lived locally and visited their grandmother.

1.4 Timeframe

The time period considered by this Review was June 2014 until January 2017. The Review was commissioned in April 2017 and reported to the Adult Safeguarding Board on 14th December 2017.

1.5 Organisational learning and improvement

Following discussion, the SAB identified that review of this case held the potential to shed light on particular areas of practice, including addressing the following Research Question posed by the Review Team;

How effective is the connection between Domestic Abuse and Safeguarding Adults in Swindon particularly for older adults?

The use of research questions in a Learning Together systems review replaces traditional Terms of Reference for a SAR. Posed at the start of the process, to provide a frame of reference for the review, research questions identify the key lines of enquiry that the Safeguarding Adults Board (SAB) believe are most relevant to current practice.

2. Methodology

In order to comply with these requirements Swindon Safeguarding Adult's Board has used the SCIE *Learning Together* systems model (Fish, Munro & Bairstow 2010) to carry out this Safeguarding Adult Review. The Learning Together methodology is explained in Appendix 2.

2.1 Reviewing expertise and independence

This SAR has been led by two Lead Reviewers who are both independent of the case under review and of the organisations whose actions are being reviewed. Julie Pett is accredited to carry out SCIE Learning Together reviews and has led a number of SARs using this methodology including a previous SAR for Swindon in 2014. Lynn Agnew has completed the Learning Together course and is applying for accreditation in the model. Neither has had any previous involvement with this case.

The lead reviewers have received supervision from SCIE as is standard for Learning Together accredited reviewers. This supports the rigour of the analytic process and the reliability of the findings as rooted in the evidence.

2.2 Acronyms used and terminology explained

In order to explain the terms used in this report, Appendix 3 provides a section on terminology to support readers who are not familiar with the processes and language of adult social care and health provision.

2.3 Methodological comment and limitations

Time constraints prevented further conversations being held with a small number of additional practitioners who were not initially identified including the Memory Clinic Social Worker. In addition, a number of practitioners including Enquiry Manager 1 had left Swindon and were unavailable. Although it would have been helpful to have the benefit of the views of these practitioners, the Review Team do not consider that this has had a material impact on the Findings below. In addition, it would have been interesting to explore the implications of Honor's son's alcohol misuse which was often cited by members of the Case Group and may have impacted on the responses of professionals and case theory developed.

2.4 Review team

The Review Team was made up of senior representatives from different agencies. Team members did not have any management responsibility for the case being reviewed.

The role of the Review Team Member is to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice and to the development of the findings from the review. Review Team members worked collaboratively with the two Lead Reviewers in conducting conversations with Case Group Members, reading documentation and analysing the data. The Review Team was also able to provide useful evidence regarding the practice issues identified in the case.

The Review Team were:

Lynn Agnew	Independent Lead Reviewer
Julie Pett	Independent Lead Reviewer
Rob Mills	Safeguarding Adults Lead Swindon Clinical Commissioning Group
Ruth Gumm	Service Manager, Older People and Physical Disabilities Swindon Borough Council
Jennifer Laibach	Development Manager Risk Enablement Swindon Borough Council
Lin Williams	Domestic Violence Co-ordinator Swindon Borough Council
Jonathan Newman	Safeguarding Adults Lead, Acute Great Western Hospital
Dominic Taylor	Strategic Improvement Officer Public Protection Wiltshire Constabulary

2.3 Structure of the review process

Using the SCIE model, gathering and making sense of information about a case is a gradual and cumulative process. The Review Team held a number of analysis meetings and the emerging narrative and learning from these – the findings as viewed at this point - was presented to the Case Group in what are known as ‘Follow On’ meetings. Over the course of this review the Review Team met five times. Three of these meetings included the Case group, one for an introductory session and then for a full day and a half-day (Follow On) meetings to present the emerging analysis. Attendance and participation at meetings was variable by some members of the Review Team but generally good.

2.4 Sources of data

The systems approach requires the review team to learn how people saw things at the time and explore with them ways in which aspects of the context were influencing their work. This is known as the ‘local rationality’. It requires those involved in a case to play a major part in the review in analysing how and why practice unfolded the way it did and highlighting the broader organisational context. The Lead Reviewers would

like to thank both the Review Team and the Case Group for the valuable contribution they made to the contents of this Report.

2.5 Data from Case Group

The Review Team conducted structured conversations with staff in the following roles, who together formed the Case Group for the review. Two members of the Review Team were involved each time. The following staff contributed to the review by meeting with members of the Review Team for a 'conversation:

Role	Organisation
Community Services Team Leader	Swindon Women's Aid
Enquiry Manager 2	Swindon Borough Council
Enquiry Manager 3	Swindon Borough Council
GP1	
Health Independent Domestic Violence Advocate	Swindon Women's Aid (SWA)
Hospital Social Worker	Swindon Borough Council
Operations Manager 1	Swindon Borough Council
Operations Manager 2	Swindon Borough Council
Paramedic1	South Western Ambulance Service
Police Officer	Wiltshire Constabulary
Rapid Response Paramedic	South Western Ambulance Service
Response Officer	Swindon Borough Council
Social Worker	Swindon Borough Council

In addition one of the Lead Reviewers had a brief telephone conversation with the Senior Social Worker who had previously worked for SEQOL.

2.6 Data from documentation

The following documentation was available for the Review Team:

- GP Notes
- Swindon Borough Council social care and safeguarding records
- Swindon Women's Aid records
- Wiltshire Police records
- South Western Ambulance Service records

2.7 Perspectives of family members

Honor's daughter was visited by the two Lead Reviewers on 5th July 2017. She was able to give a helpful perspective on Honor as a person, and expressed her frustration that she had not been able to gain the support she felt she needed to protect her mother over the years. The two lead reviewers would like to thank Honor's daughter for her honesty and candour. Her input has meant that the Review Team were able to gain an understanding of her experience of the multi-agency system. Her view has influenced the Findings within this Review.

Unfortunately, it was not possible to speak to Honor's son and the Review Team consider this another limitation on the Review as it would have been helpful to gain

an understanding about why he chose not to engage with services on behalf of his mother.

2.8 Structure of the report

The Review Team would like to remind the Swindon Local Safeguarding Adults Board (SAB) that organisational systems are complex. Therefore findings are not presented as recommendations but as a series of problems and puzzles for consideration and local prioritisation.

A case review plays an important part in efforts to achieve safer and more effective systems. Consequently, it is necessary to understand what happened and why in the particular case, and go further to reflect on what this reveals about gaps and inadequacies. The particular case acts as ‘a window on the system’ (Vincent 2004: 13).

3. The Findings

3.1 Structure of the Findings

Six priority Findings have emerged from this Safeguarding Adult Review. These Findings explain why professional practice was not more effective in protecting Honor in this case. Each Finding lays out the evidence identified by the Review Team to show why these are not one-off or case specific issues and why they undermine the reliability with which professionals can do their jobs now and in the future unless remedial action is taken.

3.2 Appraisal of professional practice in this case: a synopsis

This section provides an overview, both of what happened in this case and why it happened and is the view of Review team members about the quality of the practice in this case, including where practice fell below what would be expected. The Review Team has made these judgments in the light of what was known, and was knowable, at the time. Systemic issues are explored in more detail in the Findings and are cross referenced.

3.2.1 It was clear to the Review Team that Honor was experiencing abuse despite her repeated denials. People raised continual concerns about Honor and yet this did not produce a professional response that kept her safe. The case is particularly characterised by repeated closure of safeguarding referrals without effective investigation. On the other hand, there are repeated efforts to find ways to protect her that sadly proved equally ineffective. However it was not an easy case for practitioners to manage because of the complexities present in the relationships in the family and Honor’s cogent explanations and repeated denials that she was experiencing abuse. This case also typifies both the challenges that non-specialist practitioners face in understanding and recognising the nature of coercive control especially in intergenerational domestic abuse, and the challenges of multi-agency working.

3.2.2 The SEQOL intake team responded to calls from Honor's daughter in May 2014 about her brother's treatment of Honor by making two visits within a month. It

was appropriate that they made these visits to Honor at home although the review team considers that a delay of thirteen days between receiving the alert and visit was too long because of the nature of the concerns. The social workers directly questioned Honor about the allegations only at the second visit, when Honor's daughter was present but her son was not. The daughter had seen evidence that Honor's son had been spending money from Honor's account without accounting for it to Honor. Honor had offered in explanation that she tried to help both her children financially. Honor's daughter pointed out that whilst she had recently made a significant gift to her son she had refused a much smaller gift to her daughter because her son would not allow her to spend her money as she chose. Honor did not dispute this but offered as explanation that there was a conflict between her two children. She also mentioned her anxiety about her son 'getting into trouble' because of these enquiries. The social workers concluded that Honor had capacity to make her own decisions about spending money but were incurious about whether she was free to make such decisions or if all such decisions were controlled by her son. See **Finding 1** which concerns the lack of awareness of coercive control by practitioners. Based on their misunderstanding, the social workers closed the safeguarding investigation down.

3.2.3 The Review Team is critical of the intake team's decision not to re-open the safeguarding enquiry when Honor's daughter continued to call them over the next year with escalating concerns, which were corroborated by one of Honor's friends. The intake team advised Honor's daughter to contact a domestic abuse helpline, indicating that they considered domestic abuse was occurring, but that it did not warrant a safeguarding response. The intake team instead focused on the assessment of care needs, requesting that the GP visit and enquire about Honor's welfare. The case was closed to adult social care before the GP visit was made. **Finding 6** relates to the lack of joint work. In the review team's view joint consideration and planning between adult social care, primary care, domestic abuse services and the police was needed from the start to protect Honor.

3.2.4 The daughter's calls and emails were logged but did not lead to any other response. The review team considers that the intake team was too ready to interpret the repeated calls as indicative of 'family conflict' rather than domestic abuse, and failed to take into account the pressures, such as fear of reprisals or a desire to protect, that may lead someone in Honor's position to accept abuse without apparent complaint. The intake team response was instead based on the judgement that a person with capacity can make an unwise choice to continue to rely on a family member who may be abusive. This failure to consider the impact of duress when applying the Mental Capacity Act or to evaluate ongoing risks when unwise decisions are made is discussed further in **Finding 2**.

3.2.5 After some twelve months, a telephone call from Honor's daughter, raising the same concerns about abuse as in previous calls, prompted a more senior social worker to raise a safeguarding alert with the council safeguarding team. Previously the intake team had made decisions about progressing safeguarding enquiries, but by this time such decisions were taken by the council safeguarding team based on

referral information. Although it was correct to raise the alert, the review team considers that there was inadequate information in the referral, and in particular there was no mention of the previous allegations concerning financial abuse and controlling behaviour. This did not assist the safeguarding team to identify a pattern of abusive behaviour. Instead the son was described in the referral as a carer thought to be having difficulties with providing care. The problem was cast as one of an elderly person refusing services, and a family carer struggling with his caring role. This led the safeguarding team to determine that interventions should focus on trying to persuade both Honor and her son to have necessary help.

3.2.6 Social services at this stage and later appeared to be following the 'rule of optimism' that family members, if they are living in the same house, are providing care however imperfectly. This assumption had the effect of minimising the abuse and downplaying its effects on Honor and was reflected in the use of language which consistently described Honor as a 'service user' and her son as a 'carer' rather than using language appropriate to the investigation of domestic abuse such as victim and perpetrator.

3.2.7 The allocated Enquiry Officer visited Honor with the GP as part of a plan to engage Honor by developing a relationship over time, a strategy which had been successful with other families who required community care but did not engage. Honor agreed that her son was sometimes verbally abusive but denied any other abuse, which was consistent with earlier denials. There was no discussion about any alternatives to living with abuse, or information offered about possible sources of help. This approach was consistent with the Enquiry Officer's that Honor was unwisely refusing care, and 'fiercely loyal' to her son, rather than being controlled or coerced by him .The use of supervision that could assist professionals in identifying intergenerational domestic abuse is discussed at **Finding 3**

3.2.8 In July 2015 Honor was seen by the mental health team and disclosed how she felt intimidated by her son. The mental health worker reported this to the Enquiry Officer but this did not lead to an alert being raised with safeguarding as should have been, because it was not regarded as new evidence of abuse. There was no specialist safeguarding supervision available to challenge this, as discussed at **Finding 3.**

3.2.9 In September 2015 a telephone call from a friend of Honor prompted the next contact by services. The friend spoke of the deterioration in Honor's situation, the lack of food in the house and the son's alcoholism. Honor's anxiety about 'causing trouble' for her son was highlighted to the Enquiry Officer and she referred this to the safeguarding team, specifying 'domestic abuse' on the form. This referral was correctly 'triaged in' as safeguarding and allocated to a safeguarding Enquiry Manager who then instructed the Enquiry Officer to carry out an assessment of Honor's care and support needs and to involve Honor's GP in this. This was an ill-considered departure in the review team's view from a safeguarding approach given the repeated concerns that had been raised about the son's behaviour.

3.2.10 A couple of attempts to gain access to Honor were subsequently made, correctly in the review team's view, but were frustrated first by Honor who would not allow the Enquiry Officer into the house, then by Honor's son failing to comply with an arrangement to which he had previously agreed . At the second access attempt, the family's neighbours volunteered their concerns about the total control Honor's son had over Honor's house and money. This emphatic re-statement of all the concerns expressed by Honor's daughter and friends should in the view of the review team have led to re-focusing and adoption of a safe enquiry approach, which is a cornerstone of best practice in domestic abuse, as discussed in **Finding 1**

3.2.11 Instead the Enquiry Manager incorrectly advised the Enquiry Officer to discuss Honor's case with various health professionals and ask them to conduct tests of Honor's health and her capacity to make decisions about receiving services. This was not an effective safeguarding response as there was no assessment of the ongoing risks to Honor stemming from her son's control of her house, money and access to family or professional help, or of Honor's understanding of these risks or what could mitigate them. Instead the case was seen as a problem of unexplained weight loss and unwise decision making, although no coherent assessment of Honor's decision-making capacity or the factors influencing her decisions had been undertaken. The review team found that such attempts to characterise the case as one of capacitated refusal of care, followed by demands that other agencies assess care needs and capacity, without multi-agency discussion and agreement, was typical of the response in this case. The underlying issue is discussed further in **Finding 6**. During the summer of 2016 the Enquiry Officer continued to try to engage Honor and gain her trust, but this was actively obstructed by Honor’s son and Honor would not allow either the social worker or the GP into the house. The Enquiry Officer, unhappy with the Enquiry Manager's approach, asked for a professionals' meeting to work out a way forward with the case, which the review team considered a sensible suggestion.

3.2.12 As the only professionals' meeting held during the period under review, and although there were representatives from health and social care, the meeting did not function well to share information and evaluate risk. The discussion was dominated by the view of the Enquiry Manager that this was a care management, not a safeguarding case. Police, who declined to attend, and specialist domestic abuse service, who were not invited, were not present to challenge this view. At this juncture in the case a multi-agency meeting had potential to re-focus the case and produce a plan relevant to Honor's actual situation but this was not realised.

3.2.13 As agreed at the meeting, the GP subsequently met with Honor's son in his surgery then met with mother and son at home. It was commendable that the GP persevered with efforts to speak to Honor about suspected abuse but also predictable that Honor did not disclose abuse with her son present. When the GP reported that he had not found anything untoward on his visit, the council team closed the safeguarding case in October 2015.

3.2.14 In February 2016 a further safeguarding alert was raised by a voluntary agency. The alert was appropriately screened into safeguarding and passed on to a different enquiry manager who closed the case again following telephone conversations with the GP and Honor herself. The system of passing reports through a series of filters is discussed further in **Finding 4**.The GP's remarks about his visit to the home were interpreted by the Enquiry Manager as evidence that Honor was making a lifestyle choice 'with capacity' to turn down outside support in favour of continued reliance on her ‘carer' and this informed all council decision making from this point. Difficulties in judgements about 'capacity' in the context of domestic abuse are discussed further in **Finding 2**. The case was closed to care management shortly after the safeguarding case was closed. The review team felt there was a lack of organisational scrutiny of these and similar decisions, discussed at **Finding 3.**

3.2.15 In July 2016 Honor's GP, after visiting Honor at home without her son present and seeing how fearful she was of him, raised a further safeguarding alert. The referral again passed from an Operational Manager to an Enquiry Manager. An informal discussion with the Police specialist unit agreed that because Honor 'had capacity' neither the police nor social services would be getting involved. The use of 'capacity' as a reason not to provide a safeguarding service is discussed in **Finding 5**.

3.2.16 A week later, with no response to his concerns, the GP arranged for Honor's admission to SWICC hospital so that she could be asked about abuse away from her son. The review team considered this intervention showed the depth of the GP's concern and had potential to help Honor. However without a multi-agency plan it ended chaotically with Honor frantic to go home and being removed from hospital by her son. A senior adult Services Manager's call for a strategy meeting was ignored by the Enquiry Manager. From this point there was no attempt to bring agencies together to discuss what, in the view of the review team, was a complex case of intergenerational abuse as discussed in **Finding 6.**

3.2.17 In September 2016, the police received a 999 call from the operator of an emergency call line installed in Honor's home. The operator had overheard Honor being verbally abused. The police officers treated this correctly as suspected domestic abuse and interviewed mother and son separately. Honor disclosed that she was being abused and asked for help. However the officers had no information about earlier concerns. Honor's son indicated that Honor was severely demented but that there were services going in, and this coupled with some strange behaviour from Honor, satisfied the officers that Honor was unreliable as a witness but was not at great risk. Like other professionals, the police officers were influenced by the rule of optimism in this case and saw the son as a struggling carer. Although they passed the DASH to the Police Domestic Abuse Team, this was not shared with either the Police Safeguarding Adults Team or Adult Social Care as discussed in **Finding 1.** The review team commented on the lack of systems for flagging domestic abuse cases not at the highest level of risk. However the lack of multi-agency agreement around domestic abuse in Honor's case means it is unlikely that her name would have appeared on such a list in any case.

3.2.18 In October 2016, a third enquiry manager, unaware of the 999 call, closed the case following a call to Honor's GP, who was also unaware. He then spoke to Honor's daughter, who told him that her brother shouted at Honor and prevented family members from visiting her. The safeguarding team did not reverse the decision to close, but did make a referral to Swindon Women's Aid, the specialist domestic abuse service. In the review team's view this was a characteristic and inappropriate response, where uncertainty about what to do led to case closure followed by referral to a non-statutory agency as discussed in **Finding 4.**

3.2.19 The referral prompted Swindon Women's Aid to offer support to Honor through their GP link worker, and a joint visit was arranged for the worker and Honor's GP. On this visit in December 2016, before it was ended by her son's return home, Honor disclosed the psychological abuse and neglect that she had been suffering. It was evident to the review team that the interview, held in the absence of the perpetrator, with a familiar and trusted supporter in the GP and with a focus on abuse enabled by the specialist skills of the worker, helped Honor to disclose what she had previously tried to hide. The GP and link worker correctly reported their concerns to safeguarding shortly after this interview and asked for action to protect Honor.

3.2.20 Instead of a prompt response, as would have been appropriate given the detail in the referral and the history of the case, this referral was passed around the team with a request for further information to be gathered before it could progress to a full investigation. The safeguarding team was experiencing problems processing referrals because of low staffing levels over the Christmas period, and no priority was attached to the referral. In the review team's view the system was dysfunctional at this point, serving to manage workplace pressures rather than to respond effectively to risk or need as discussed in **Finding 4**. Following receipt of the referral further concerns were raised, by Honor's daughter and by a neighbour. No response was made to the daughter's calls. The neighbour's concerns were passed to the police to investigate, but when they attended the house they reported nothing untoward and there was no further action.

3.2.21 The referral was screened on 16/12/16 and there had been no effective response from the safeguarding team by 19/01/17, the date of Honor's death over a month later.
The practice of the Paramedics who were called to attend Honor by the visiting GP on 19/01/17 was humane and appropriate.

3.3 In what ways does this case provide a useful window on our systems?

The case provided a useful '*window on the system'* because of the important multi-agency interactions and inactions occurring during the review period. This allowed an opportunity to explore common dilemmas and tensions practitioners face when they have to determine whether or not to support and intervene.

3.4 Summary of Findings

The review team have prioritised six findings for the SAB to consider. These are:

No.	Finding	Category
1.	**There is an evident disconnect between strategic and operational levels of the safeguarding and domestic abuse partnerships in Swindon which means that staff on the ground can remain unaware of basic good practice even in areas such as domestic abuse and mental capacity where the knowledge base is clear and guidance is readily available including the need to take account of the views of family members observing abuse.**	**Organisational Norms & Culture**
2.	**No strategic direction is evident to support practitioners dealing with the tension of trying to balance a person's autonomy with a professional's duty of care, leaving practitioners on the ground accepting too readily unwise decisions without adequately exploring whether a person's decision making is compromised by duress and other factors, leaving victims of domestic abuse without protection.**	**Management Systems**
3.	**Quality Assurance processes are not currently working to pick up erroneous thinking about safeguarding in cases, making it more likely that even obvious misinterpretations go unnoticed**	**Human Bias**
4.	**The design of the triage and response process for safeguarding concerns in Swindon manages demand for intervention but consequently could leave the council's compliance with the duty to enquire in question, discourages joint working with domestic abuse services and leaves victims of domestic abuse at potentially increased risk.**	**Management Systems**
5.	**Does the increasing volume of safety incidents being reported by regulated care providers in Swindon risk a reduced focus on adults living in their own homes who may be at risk of abuse?**	**Management Systems**
6.	**In Swindon, attempts to adhere to the principles of Making Safeguarding Personal, have had the unintended consequence of less opportunity to share information, discuss and plan jointly, below the level of meetings such as MARAC, which consider only the highest risk cases.**	**Organisational Norms & Culture**

3.4 Findings in detail

Finding 1

There is an evident disconnect between strategic and operational levels of the safeguarding and domestic abuse partnerships in Swindon which means that staff on the ground can remain unaware of basic good practice even in areas such as domestic abuse and mental capacity where the knowledge base is clear and guidance is readily available including the need to take account of the views of family members observing abuse.

Introduction
Adult safeguarding practice is based on a complex legal framework which spans criminal and civil law. Within this framework, the Care Act 2014 and the Mental Capacity Act 2005 are pre-eminent and are supported by a raft of guidance both statutory and advisory.

Domestic abuse is defined in the statutory guidance to the Care Act 2014 as:
'any incident or pattern of incidents of controlling, coercive, threatening behaviour, violence or abuse between those aged 16 or over who are, or have been, intimate partners or family members regardless of gender or sexuality.' The abuse can encompass, but is not limited to:

- *psychological*
- *sexual*
- *financial*
- *emotional*

The council's safeguarding duty under Section 42 of the Care Act does not apply to all victims of domestic abuse, but it does apply to any adult who:

- *has needs for care and support (whether or not the local authority is meeting any of those needs) and;*
- *is experiencing, or at risk of, abuse or neglect; and*
- *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.*

Current guidance, *'Adult safeguarding and domestic abuse: A guide to support practitioners and managers* (ADASS 2015) sets out the overlaps between safeguarding and domestic abuse and the approaches and legal frameworks for domestic abuse that can be used in the safeguarding context.
However, even if staff are trained, this is less likely to generate desired outcomes if workplaces are not aligned to enable those trained to implement messages from research and standards of good practice.

How did this finding manifest in this case?
The review team were concerned to find that in the professional responses to reports of ill-treatment in this case, some of the most basic tenets of good practice in safeguarding were not adhered to. In relation to domestic abuse and mental capacity for example:

- Reports about controlling, coercive and threatening behaviour, which also included financial abuse, by Honor's son were not recognised or named as domestic abuse, and after the initial response there was little action taken as a result of most of Honor's daughter's repeated attempts to get someone to do something. Reports of abuse were consistently said to indicate that the son might be having problems with caring, or might need further education about his mother's mental health, when no recent visit had been made or any other attempt made to understand the realities of Honor's situation
- Honor was deemed to have capacity to make an unwise decision to rely on her son on the basis of conversations which did not include any consideration of the risks of so depending, or any consideration of the alternatives to tolerating abuse at any level. A key principle of the Mental Capacity Act is that a person only has full capacity if they have access to all the relevant information. This should be offered whether or not the person appears to want it at the time.
- Other than a Mental Capacity Assessment dated July 2016 at SWICC, conclusions about capacity were reached on the basis of brief telephone calls between Honor and practitioners without any discussion of risks.
- Practitioners showed no awareness of the importance of safe enquiry in domestic abuse and attempted to 'engage' Honor's son as a stressed carer, without considering possible consequences for Honor's safety of this approach. She had told professionals from the start that she was fearful of her son discovering that she had been talking to them either resulting in him “getting into trouble” or due to the risk reprisals.
- Council staff had poor knowledge of available specialist services such that when Honor was admitted to SWICC in July 2016, the support of the dedicated domestic abuse worker was not sought because the enquiry manager did not know there was such a role.
- Following an operational Police visit to Honor’s home in response to a report of domestic abuse by the Homeline Operator, the DASH form was passed to the Police Domestic Abuse Team. However this was not discussed with either the Police Safeguarding Adults Team or Adult Social Care.

What makes it underlying (rather than an issue particular to the individuals involved?)

When we explored this with the review team we heard that training had been made available on the application of the MCA in safeguarding and on domestic abuse. However the picture from the case group was that none of this had filtered down and members were unaware of any strategic direction, let alone audit or oversight coming from the Board on either MCA or domestic abuse.

When we discussed their approach more broadly, all the social care professionals in the Case Group described an approach to dealing with all cases that differentiated between 'safeguarding' and 'not safeguarding'. This did not refer just to differentiating between cases where the adult has care and support needs and

cases where the adult does not, which is the low Care Act 'bar' for the safeguarding duty. They did this separation by considering the person’s mental capacity.

Social care professionals also told the Review Team that they deferred capacity assessments concerning safeguarding and other local authority services to other professionals in apparent ignorance of their responsibility to undertake capacity assessments in relation to such services, and cited their lack of training in undertaking assessments as the reason for this.

Case group members often referred to adults who ‘had capacity' and apparently tolerated abuse as falling into the 'not safeguarding' category, meaning that enquiries would cease in this situation. They also referred to the 'seriousness' of harm, as they judged it, as providing an indicator for whether the enquiry should be taken further or not. We inferred that not only Honor's but other cases were judged against these criteria, which do not appear in any guidance but were used to justify case closures.

Of particular relevance was the lack of awareness of guidance on domestic abuse, mental capacity and safeguarding (ADASS 2015). The case group told us that domestic abuse was not clearly defined for them and that it was very difficult to identify. They told us that they had not had training aimed at improving recognition of, and safe responses to, domestic abuse particularly where this is intergenerational.

Case group members also told us that the test for mental capacity could only be applied by professionals in certain designated roles, showing a general lack of understanding of how questions of capacity should be approached.

Since the review began, social workers in the hospital have organised an educational visit from Swindon Women's Aid which has increased social workers' knowledge of the specialist resource and understanding of how to work together with adults at risk of domestic abuse.

What is known about how widespread or prevalent the issue is?
The governance role of the SAB in Swindon appears to be underdeveloped with limited collection of data concerning domestic abuse and no audits or inspections concerning either the application of the MCA in safeguarding generally or in relation to domestic abuse in particular. The links between the SAB and the Domestic Abuse and Violence Against Women and Girls Board are not as strong as they could be. The Domestic Abuse Board sits beneath the Local Safeguarding Children’s Board which means that the focus is on the needs of children and their mothers rather than intergenerational abuse.

However, this disconnect between knowledge and practical application of that knowledge is not unique to Swindon. The difficulties in application of the Mental Capacity Act have been researched and extensively reported. In a SAR recently completed by one of the Lead Reviewers, but not yet published, it was not clear enough where the strategic lead for the MCA lay and this was impacting upon the ways in which practitioners from all health and social care agencies were supported to apply MCA.

The recent review of SARS in London (Learning from SARS: A Report for the London Safeguarding Board by Suzi Braye and Michael Preston-Shoot July 2017) showed that sixteen of the 27 SARS reviewed found a limited safeguarding 'literacy' that is '*agencies and their staff had* [limited] *knowledge and confidence in safeguarding matters' and that 'staff knowledge and skills were lacking' in two key areas of practice safeguarding and legal literacy* (page 65). '*Evidence suggests that practitioners across health and welfare services continue to find MCA difficult to implement and understand'* (page 64). The challenges of engagement were common to 9/27 of the SARs reviewed where staff 'gave up too soon' and there was little or no understanding of how relationship dynamics are assessed.

Similarly the report 'What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews: A report for south west region safeguarding adults' boards' by Michael Preston-Shoot, October 2017 indicates *'fundamental flaws in how MCA 2005 is understood and applied in practice'* across the south west (page 27).

What are the implications for the reliability of the safeguarding adult system?
When practitioners are unaware of the availability of good practice guidance in such key areas as mental capacity and domestic abuse, then they will not be able to safely support adults at risk to make informed decisions about risky situations and the way they choose to live.

Health and Social care practitioners should be supported with clear guidance and leadership to enable best practice and compliance with the law so that they are able to demonstrate that they are complying with their responsibilities under the Mental Capacity Act 2005 and the Care Act 2014.

FINDING 1
ISSUE FOR CONSIDERATION BY THE BOARD

There is an evident disconnect between strategic and operational levels of the safeguarding and domestic abuse partnerships in Swindon which means that staff on the ground can remain unaware of basic good practice even in areas such as domestic abuse and mental capacity where the knowledge base is clear and guidance is readily available including the need to take account of the views of family members observing abuse.

ORGANISATIONAL CULTURE

SUMMARY

Complex systems involve non-linear dynamics. How things develop are often unpredictable and unintended consequences should be expected. Therefore directing and achieving change is challenging. Strategic leaders need constant feedback loops in order to ascertain how things are actually playing out on the ground. Yet disconnects between strategic and operational levels occur all too easily. This finding has highlighted that such a disconnect exists in Swindon. The focus on core current guidance and good practice principles evident at strategic level, is not evident on the ground. There was a lack of importance given to views of family members. This leaves the quality of service that people locally receive down to luck and the individual practitioners they encounter. It also is less likely that partners act to help and protect all adults in its area who are unable to protect themselves because of their care and support needs. At a strategic level there is a need to strengthen links between the SAB, the LSCB and Domestic Abuse board, but care must be taken to avoid unintentional exclusion of the domestic abuse of older adults from these arrangements.

Questions for the Board and Organisations

- Has the Board been aware of the extent of this disconnect between strategic and operational levels previous to this SAR?
- Is the Board aware of what any partners do to connect strategic and operational levels and does evidence of this come to the Board? What is the Board's role in supporting this? Is the Board aware of the impact of the lack of strategic lead in this area of practice?
- How can the Board be assured that at operational level, across agencies, practitioners have knowledge of relevant legal frameworks that are the bread and butter of adult safeguarding, including where domestic abuse and mental capacity overlap, and that practitioners (from a range of agencies) have the skills to apply these?
- How would the Board know if things had improved e.g. around practitioners' knowledge and application of safe approaches in domestic abuse cases?
- Are there any implications for what information / data the Board routinely receives?

Finding 2

No strategic direction is evident to support practitioners dealing with the tension of trying to balance a person's autonomy with a professional's duty of care, leaving practitioners on the ground accepting too readily unwise decisions without adequately exploring whether a person's decision making is compromised by duress and other factors, leaving victims of domestic abuse without protection.

Introduction
The Mental Capacity Act 2005 (MCA) is an essential tool to support decision-making in health and social care. The MCA and the Care Act 2015 work together to promote the empowerment, safety and wellbeing of adults with care and support needs. A person should be allowed to make an 'unwise decision' if they have capacity. However a principle of the Mental Capacity Act is that a person only has full capacity if they have access to all the relevant information about the decision they are making – such as the decision/s about what, if anything, to do about the risk of abuse they are facing.

All health and social care professionals need a good understanding of the MCA, to be able to put into practice its five key principles, and to understand how to apply the two-stage test for capacity. However special care should be taken over the assessment of capacity in domestic abuse situations, and the possible impact of coercion and control always considered. Current guidance (ADASS 2015) stresses the importance of ensuring that the person has been helped to fully appreciate the risks of continuing to live with an abusive family member, and informed of the alternative courses of action available, before concluding that the decision is freely made.

How did this finding manifest in this case?
At the first two visits by community care staff in June 2014, Honor was assessed as '*having capacity'* to choose to continue to rely on her son for support and decline outside help. This decision was reached in spite of Honor's clearly expressed anxiety about *'getting Boy into trouble'* suggesting the decision was made under some duress.

Although there were continued escalating reports from her daughter of Honor being controlled and intimidated over the next twelve months no further attempts were made to see Honor to re-evaluate this view of her 'choice'. Instead her daughter was told to stop reporting concerns as there was nothing that social work staff could do because Honor had denied the concerns and had capacity to choose.

Subsequent tests for 'capacity' over the next eighteen months in relation to the abuse were inadequate because Honor was not given sufficient time and support to understand that she had any choice other than putting up with the abuse, or access to relevant information about alternative courses of action. Other than a Mental Capacity Assessment carried out in July 2016, Honor's views were on occasion

elicited through telephone calls and without specialist input, for example by Enquiry Manager 2 when closing the case in November 2015 because Honor was deemed to have capacity.

What makes it underlying (rather than an issue particular to the individuals involved)?
During conversations and during discussions at the Follow On Meeting on 31st August 2017, all practitioners talked about the importance of capacity and determining the person's wishes as central to person-centred, outcome-focused safeguarding (Making Safeguarding Personal). This is positive and shows that professionals understand a key principle of the Mental Capacity Act that a person is not to be held as incapable of making a decision, merely because he makes an unwise one.

However, in addition, practitioners were strongly of the opinion that where victims do not wish to complain to the police and they appear to have capacity to decide about this, then this gives reason for exclusion from safeguarding. Instead of a safeguarding response victims or referrers may be offered information about non-statutory domestic abuse services. Even where other cases were identified and named as domestic abuse, professionals told us they had problems with recognising the impact of coercion and control on decision-making. These views expose a lack of awareness of key considerations such as the impact of coercive control when assessing capacity in domestic abuse situations. It also shows practitioners have a lack of understanding of situational capacity and confusion about their responsibility when applying the MCA.
Effective supervision would support practitioners to challenge their own assumptions.

What is known about how widespread or prevalent the issue is?
Swindon practitioners are not alone in finding this type of complex situation hard to manage. The ADASS guidance states:

'*Assessing capacity can be particularly challenging in domestic abuse situations, where the person is cared for by, or lives with, a family member or intimate partner and is seen to be making decisions which put or keep themselves in danger.*

Skilled assessment and intervention is required to judge whether such decisions should be described as 'unwise decisions' which the person has capacity to make, or decisions that are not made freely, due to coercion and control.' (ADASS 2015)

The guidance also notes that *'creating a relationship within which a victim feels safe to discuss the detail of the coercion they face can take time'*. Systems which rely on brief telephone interviews to elicit disclosure will not be able to deliver on this crucial aspect of practice.

The difficulties in safeguarding people who do not lack capacity, but whose ability to make decisions has been compromised because of constraints in their circumstances, coercion or undue influence, are well known and reflected in case

law. D vs A Local Authority and Others (2012) has clarified that there is scope for local authorities using the principle of inherent jurisdiction to commence proceedings in the High Court to safeguard people in such cases.

In 2016 ADASS published Making Safeguarding Personal: Temperature Check, the results of a survey covering 76% of all English Local Authorities. The following comment is relevant here:

'However a warning was sounded by a couple of respondents that some staff had misunderstood the concept and closed cases where abused people said they did not want any intervention, failing to take into account the wider implications of coercion, for others at similar risk and the public duty to protect people.'

Further to this, research on intergenerational abuse such as that carried out by McGarry J, Simpson C, Hinchliff-Smith K (2011) showed that beyond the barriers to reporting abuse common to all age groups, specific considerations for older women may be shame or embarrassment from years of accepting abuse without apparent complaint. If sons or daughters are the abusers then parents may feel responsible for their behaviour, including their problems with alcohol or substance misuse.

The recent Thematic Reviews of SARS carried out in London (Suzy Braye and Michael Preston-Shoot July 2017) and the South West (Michael Preston-Shoot October 2017) both cite the lack of 'safeguarding literacy' that is the failure to recognise the presenting picture as one of concern. This was commonly coupled with a lack of management oversight and an absence of adequate supervision. The South West Review specifically points to '*fundamental flaws in how MCA is understood in practice'* and goes on to say that practitioners need *'to consider whether someone's executive capacity may have been impaired by their physical and mental ill health or the dynamics of their lived relationships'.* The London review explains that '*an unthinking adoption of the notion of lifestyle choice ….precludes any exploration of options and alternative possibilities to promote safety and reduce risk'.* Instead there is a lack of professional curiosity about the meaning of a person's behaviour.

What are the implications for the reliability of the safeguarding adult system?
Where there is inadequate understanding of the impact of duress, or of other factors such as the wish to protect the abuser because of guilt, practitioners will make poor decisions and cases will be closed 'because that's what the person wants'. Inability or unwillingness (the rule of optimism) on the part of health and social care professionals to identify abuse of elderly people by the people, including adult children, they live with keeps this problem hidden and prevents the development of effective local approaches.

The failure of practitioners to distinguish between 'unwise decisions' and decisions made under duress may lead to adults at risk being abandoned with the belief that they have only themselves to blame for 'choosing' to live with abuse.

If safeguarding enquiries are ended, without careful consideration of all the factors that may be influencing the decisions made by older people experiencing or at risk of intergenerational abuse then the principles of the MCA are not being adequately or safely applied in Swindon.

FINDING 2 **ISSUE FOR CONSIDERATION BY THE BOARD** **No strategic direction is evident to support practitioners dealing with the tension of trying to balance a person's autonomy with a professional's duty of care, leaving practitioners on the ground accepting too readily unwise decisions without adequately exploring whether a person's decision making is compromised by duress and other factors, leaving victims of domestic abuse without protection.** **MANAGEMENT SYSTEMS**
SUMMARY Professional decision making is often fraught and challenging, involving as it does a question of weighing in the balance the relationship between a person's autonomy and a professionals' duty of care. The current national system balances more in favour of the former, with the Making Safeguarding Personal agenda and unreflective adoption of some MCA principles but not others making it less likely that practitioners understand that they are expected to consider critically and question respectfully a person's choices and the risks inherent in them. Without overt strategic direction about this, victims of domestic violence are more likely to continue to go 'unseen' albeit in clear view.
Questions for the Board and Organisations • Is the Board assured that all partner agencies understand that the application of the Mental Capacity Act is at the heart of the decision making process when safeguarding and domestic abuse overlap? • What is the Boards role in checking on safe practice where domestic abuse is suspected or known? • Is the Board correct in the assumption that practitioners in all partner agencies have access to specialist advice and support when judging whether decisions are 'unwise decisions' or decisions that are not made freely, in cases of domestic abuse? • How clear are practitioners that capacity does not 'trump' everything?

Finding 3

Quality Assurance processes are not currently working to pick up erroneous thinking about safeguarding in cases, making it more likely that even obvious misinterpretations go unnoticed

Introduction

All systems need appropriate and proportionate quality assurance processes to act as a systematic process of checking to see whether a service meets needs and to prevent mistakes occurring.

Effective Quality Assurance will include a variety of processes which combine to measure the quality of the multi-agency safeguarding system. Often this is detailed in a Quality Assurance Framework which covers, amongst other things, level and types of supervision, training and audit.

Supervision can take a variety of forms. Supervision may include informal or ad hoc case discussion, one-to-one clinical reflection on cases, group supervision, observation of practice, or direct instruction of activity. (Bishop (2007), NMC (2016)). These processes are designed to bring check and challenge to the sense making of people directly involved in the case, in order to identify and minimise their inevitable biases.

Psychological research has identified many cognitive biases that people are vulnerable to. For example, confirmation bias is the tendency to search for, interpret, favour, and recall information in a way that confirms one's pre-existing beliefs or hypotheses, while giving disproportionately less consideration to alternative possibilities. People also tend to interpret ambiguous evidence as supporting their existing position. Confirmation bias occurs from the direct influence of desire on beliefs. When people would like a certain idea/concept to be true, they end up believing it to be true. This leads people to stop gathering information when the evidence gathered so far confirms the views one would like to be true and practitioners are influenced by factors such as their own knowledge and values, their own willingness to take risks and the culture of their team and organisation in relation to risk. Quality assurance processes such as peer audit and supervision assist in guarding against confirmation bias.

How did the issue manifest in the case?

A marked feature of this case was that it was misconstrued as a community care issue, when there was enough evidence at the time for concerns about domestic abuse to have been identified by practitioners involved. Yet even when domestic abuse was specifically mentioned by referrers, the ‘case theory’ about Honor i.e. that this was a community care issue was not challenged or discussed critically by colleagues for example:

- Although the case was discussed in supervision between Enquiry Manager 3 and Operations Manager 1 when the case was open to safeguarding between

July and October 2016, this was about length of time the Case was open to safeguarding rather than a critical, structured discussion of risk. Despite this Enquiry Manager 3 referred on to the Domestic Abuse Service, recognising abuse was occurring without seeing this as a reason to continue the safeguarding enquiry.

- When community police officers attended Honor's house in response to Homeline in September 2016, Honor's son told them that Honor had social care coming in which was untrue, but the officers had no other information to rely on and this was not checked with ASC. They concluded that Honor was not at high risk. The junior officer submitted a report internally but the risk to Honor was rated too low to lead to further action.
- The Case was closed by Enquiry Managers on several occasions without discussion with others including internal managers and colleagues from other agencies.

What makes it underlying (rather than an issue particular to the individuals involved?

As part of the review, we set out to explore in more detail whether the lack of quality assurance evidenced in this case was an oddity, or an underlying issue likely to affect case work more broadly.

As part of this, we considered the elements of effective supervision. There is much research available on effective supervision. In essence 'a*n important element in reflective supervision is enabling staff to question their practice, critically analyse and evaluate experiences, and debrief after challenging or stressful encounters. This will lead to a better understanding of the cognitive and emotional elements of practice'* (Scottish Social Services Council).

There is no specialist safeguarding supervision in Adult Social Care. Although ASC supervision includes a supervision agreement and is scheduled monthly there is no audit of supervision to monitor quality. The discussion areas in the supervision template are very general for example 'Case Load discussion' with no prompts about risk or safeguarding.

Cases for discussion at supervision are picked by supervisee not supervisor, making it improbable that the supervisor will see cases that the practitioner is not experiencing as problematic.

There has been some change to providing quality assurance. Although there was no peer supervision during the review period, we understand that is now happening. In addition repeat concerns are now tracked and reviewed by the Management Team within Safeguarding Adults.

There is no robust cross over between domestic abuse team and safeguarding adult team in Police which could assist in evaluating cases which involve both.

What is known about how widespread or prevalent the issue is?
Across the safeguarding partnership the Review Team confirmed a problem of inconsistent approaches to the evaluation of risk. During the review period quality assurance audits were not routinely carried out although it is understood that this is planned by the Quality Assurance sub-group of the Board.

Robust quality assurance systems and poor supervision are not unique to Swindon. The recent review of SARS in London (Learning from SARS: A Report for the London Safeguarding Board by Suzi Braye and Michael Preston-Shoot July 2017) found that in ten of the 27 Reviews, supervision focused on service provision rather than reaching any understanding of the situation observed. '*Supervision for staff focuses primarily on case management rather than reflective practice'*. In the South West (What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews: A report for south west region safeguarding adults' boards' by Michael Preston-Shoot, October 2017) 24% of SARS mentioned both absence and inadequacy of supervision.

The Review Team is aware of the proactive use of specialist child safeguarding staff as a resource by practitioners routinely in NHS organisations, as defined in their statutory roles, which include supporting staff with casework and safeguarding supervision. (HM Government 2015, RCPCH 2014).

In order to improve practice within children's safeguarding, quality assurance frameworks have been widely developed including oversight systems to track decision making and practice. In addition joint audits of case files involving practitioners and identifying lessons to be learned and thematic peer reviews are used to improve practice.

What are the implications for the reliability of the Safeguarding adult system?
When practitioners hold case responsibility in isolation it means that potential safeguarding risks are not articulated or shared and practice cannot be supported to improve. There are also implications for how confident and supported staff feel when managing complex and challenging cases.

The lack of robust supervision within an overall scheme for quality assurance brings professional decision making in adult safeguarding into question. Thematic file audits are necessary and when followed up can transform the quality of practice.

FINDING 3 ISSUE FOR CONSIDERATION BY THE BOARD Quality Assurance processes are not currently working to pick up erroneous thinking about safeguarding in cases, making it more likely that even obvious misinterpretations go unnoticed HUMAN BIAS
SUMMARY Quality Assurance is a series of checks and balances that aim to prevent mistakes being perpetuated and to assess the quality of services provided. In a safe system, the range and depth of quality assurance systems, including supervision, should be designed to pick up individual errors of judgement and challenge thinking as well as wider systemic issues of quality across multi-agency safeguarding. We know that we cannot police our own biases, so need supervision and other quality assurance processes including peer audit and spot checks to bring fresh eyes and constructive challenge. In Swindon, this does not appear to be the case which leaves it to chance whether erroneous thinking about safeguarding in a case will be picked up and rectified, or if adults will remain at risk.
Questions for the Board and Organisations • What does a safe quality assurance system look like? • Is the Board assured that all partner agencies, including independent and voluntary sector organisations, have access to specialist advice and support for their adult safeguarding practice? • Would the Board consider linking with the Swindon Children's Board to learn from its development of quality assurance frameworks? • Has the Board considered benchmarking with other areas in the South West in order to develop best practice?

Finding 4

The design of the triage and response process for safeguarding concerns in Swindon manages demand for intervention but consequently could leave the council’s compliance with the duty to enquire in question, discourages joint working with domestic abuse services and leaves victims of domestic abuse at potentially increased risk.

Introduction

'Local authorities must make enquiries, or cause another agency to do so, whenever abuse or neglect are suspected in relation to an adult and the local authority thinks it

necessary to enable it to decide what (if any) action is needed to help and protect the adult'
Department of Health. DH (2016) Care and Support statutory guidance.

This duty under Section 42 of the Care Act 2014 applies where adults have care and support needs, and as a result are unable to protect themselves from either the risk of, or experience of abuse and neglect. It applies regardless of whether those needs are being met and regardless of whether the adult lacks mental capacity or not.

Councils receive many calls about people with care and support needs which do not involve abuse, and these also need to be triaged and directed to the most appropriate service. If the call raises the suspicion of abuse or neglect the relevant decision for the council is about the form the enquiry should take and who is best placed to undertake it. This may well be the police or a specialist domestic abuse service in cases of domestic abuse.

How did the issue manifest in the case?
Six separate concerns about abuse to Honor by her son were received over the period under review. Each concern was treated separately yet paradoxically not looked at with fresh eyes so the original case theory that this was a 'family conflict' and care management issue rather than abuse investigation was maintained.

This had the effect that the enquiry was either managed out of safeguarding or held by the safeguarding team without effective investigation. The focus of enquiry was then not on the suspected abuse, but on the assessment of Honor's care needs and her capacity to agree to this, her mental health status, and her son's needs as her 'carer'. Equally, establishing answers to these questions, not themselves relevant to the duty to enquire, took precedence over considering what was actually necessary to help or protect Honor.
For example, in response to concerns about the son's behaviour:

- In May 2015, an alert specifying neglect, financial and psychological abuse was determined as a welfare problem requiring care management.
- In September 2015 the senior social worker was advised to assess Honor's care needs, offer a carer's assessment to the son, and ask the GP for a 'test of health'. The case was closed and passed to the GP following a professionals meeting dominated by considerations of Honor's 'capacity'.
- When Swindon Women's Aid and GP sent in the 6th referral in December 2016 and specifically referred to coercive control, the case was still identified as a community care issue by the Operations Manager who requested that the Response Officer obtain further unspecified information.

What makes it underlying (rather than an issue particular to the individuals involved?)
In recent years the council has moved from the direct provision to the commissioning of community care services using an outsourced model (SEQOL), then back to some direct provision. During the period of the review, Operations Managers held a

verification role within the Council. In this system adults' care and support needs are assessed, care packages developed if criteria are met, and both appropriateness and cost of packages reviewed and approved (verified).

The management of safeguarding was brought back into the Council when the Care Act came into force in 2015 and additional staff engaged. Triage of safeguarding was carried out by Senior Quality Practitioners initially as an 'add on' to the verification of care packages. This had the effect of gatekeeping safeguarding cases. Adults were assessed and judged as eligible for statutory safeguarding services or not, and if not were signposted to non-statutory services. There were also additional staff engaged to manage safeguarding cases.

This problem was exacerbated as the Safeguarding Team were having to triage and coordinate increasing numbers of safeguarding concerns, an increase from 725 in 2014/15 to 1121 in 2015/16. In addition, posts were being covered by locums (some engaged long-term) for much of the period under review. During December 2016 - January 2017 the Team was also split across two sites to assist in the transfer back of Community Care Services to the council.

Although Operation Managers now no longer carry out verifications this model of triage, several 'handoffs' and signposting on continues. Cases which meet the 'threshold' as determined by the Operational Managers are funnelled through to Enquiry Managers who coordinate statutory enquiries, passing investigations to Enquiry Officers. Enquiry Officers may be the case holder if the adult is already known to community care; it may be another member of the safeguarding team such as a Response Officer or it could be someone else. When applied to enquiries and coordination of enquiries this results in an oversimplified/crude assessment process coupled with an over complicated series of handoffs. In effect the system operates as a scheme of filters. The Safeguarding Team inadvertently look for reasons to exclude the case from investigation, for example by asking other agencies to conduct assessments of various kinds and closing the safeguarding case while they do; rather than as part of a safeguarding enquiry or considered plan.

At the Follow-on Meeting 31st August 2017 when the Review Team explored this problem further, practitioners talked about the 'volume' and 'pressure' of concerns received by the council, and confirmed the need to have filters in place to manage these. However, although a safeguarding enquiry may be preceded by an informal information-gathering process, if that is necessary to find out whether the Section 42 duty applies, that process should not be used to delay action where the council has every reason to suspect abuse is occurring, as in this case..

At the second Follow-on Meeting on 2nd November 2017 it was confirmed that a weighting tool has been developed which may assist in prioritising cases. However, practitioners also discussed the blurring of roles between Enquiry Managers and Enquiry Officers because of the volume of cases and that it is not uncommon for Safeguarding Team members to undertake investigations rather than coordinate enquiries.

The Case Group identified other methods of ‘rationing’ safeguarding investigations. For example, if the adult was judged to have capacity and did not want to make complaint to the police, this would end the enquiry. Certainly there was no evidence available to the Review Team of, for example, proactive joint working between the Safeguarding Team and the Police around measures to support adults in this situation who remain at risk.

What is known about how widespread or prevalent the issue is?
In Wiltshire Police the Safeguarding Adults Team is not linked to the Domestic Abuse Team which means that cases are not always transferred across or discussed. There are increasing numbers of safeguarding concerns across England and many councils are struggling to manage the numbers of enquiries safely. Swindon does not have a multi-agency front door or something similar for Adult Safeguarding. The Review Team considered that this may be a disadvantage when triaging and risk assessing cases because there is a danger of silo mentality, when individual professionals see the case within a narrow frame of their own professional background or agency priorities.
For example the council's care management model of assessment and review limits opportunities for longer term involvement and development of relationship based work.

This problem mirrors issues in Children’s safeguarding prioritisation and appropriate response –‘difficulty in seeing wood for the trees’. Children’s Safeguarding continue to have the same triage problem which has been identified over the past ten years. The Triennial Review of Serious Case Reviews (2016) concluded that if social workers have too many referrals there is a risk that some cases may be missed or assessments delayed because of the volume.

What are the implications for the reliability of the safeguarding adult system?
The effect of the current safeguarding triage and enquiry service is to manage council safeguarding resources while attempting to support adults at risk. Casting the problem as tenacious older person / failing care / care management rather than domestic abuse means that the council safeguarding service does not bring in domestic abuse services or the police early enough. Without specialist input the key principle of safe enquiry in domestic abuse is not followed so the victim is placed at greater risk. The Council may not be meeting its Section 42 Care Act duty to enquire or cause enquiry to be made where abuse is suspected.

FINDING 4
ISSUE FOR CONSIDERATION BY THE BOARD

The design of the triage and response process for safeguarding concerns in Swindon manages demand for intervention but consequently could leave the council's compliance with the duty to enquire in question, discourages joint working with domestic abuse services and leaves victims of domestic abuse at potentially increased risk.

MANAGEMENT SYSTEMS

SUMMARY

In Swindon, the safeguarding adults system was designed specifically to comply with the duties of the Care Act 2014 for safe enquiry. As the increase in the number of concerns raised created pressure on resources within the Safeguarding Team, it has had the impact of 'rationing' investigations by introducing irrelevant 'qualifying criteria', and moving cases out of safeguarding by signposting cases to other services. Rather than joint working together with other agencies such as Domestic Abuse Services, which may be dependent on the resources available from those services. Such cases are judged not to be safeguarding and closed. This has the effect of potential higher risks for victims.

Questions for the Board and Organisations

- What checks and balances can be made within the safeguarding triage system to ensure that risks are identified and response is timely and appropriate?
- How can the Board be assured that there is effective joint working between adult social care, specialist domestic abuse services and the police from the start of safeguarding enquiries such that the individual systems join up effectively?
- Can we be assured that agencies recognise coercive control and domestic abuse?
- Does the current system allow for early identification of risk?
- Have organisations provided sufficient resource for this and is it in the right place?

Finding 5:

Does the increasing volume of safety incidents being reported by regulated care providers in Swindon risk a reduced focus on adults living in their own homes who may be at risk of abuse?

Introduction
Nationally safeguarding concerns/referrals have increased, which is positive as this shows that commissioned services are more vigilant and active in reporting incidents but this has also put pressure on local authority safeguarding services.

The statutory guidance to the Care Act makes it clear that safeguarding cannot be a substitute for local authority and health commissioners regularly assuring themselves of the safety and effectiveness of commissioned services. In Swindon there is a Contracts and Commissioning Team that is involved in checking quality of services and also participate in safeguarding cases.

How did the issue manifest in the case?
On 16th December 2016, the final safeguarding referral, from Swindon Women's Aid was allocated to the Enquiry Officer who was on leave at the point of allocation. On return on 21st December 2016 the referral was just one of a number of cases allocated in an undifferentiated bundle to gather more information, with no prioritisation or urgency.

The Enquiry Officer concentrated on gathering information on abuse enquiries in several provider organisations as these had deadlines attached to them at the time. As this was the Christmas period there was an absence of senior figures to discuss the prioritisation of Honor's case. The Enquiry Manager was also on leave during the Christmas leave but at different times to the Enquiry Officer and their time in the office never overlapped.

The Enquiry Officer had a timescale of five working days in which to gather information and felt 'pressurised' by the large number of cases referred from residential care sector, which needed attention in order to meet the given deadline. By contrast, a report originating from a family member in the same period concerning neglect and poor care of Honor in her own home was not responded to in any way by the team.

What makes it underlying (rather than an issue particular to the individuals involved?)
The focus of the Care Act 2014 is on Making Safeguarding Personal and yet much of the work carried out by adult safeguarding teams focuses on poor practice and poor quality care by providers, ultimately the concern of health and social care commissioners and regulators. The evidence in this case suggested that reports of abuse concerning people living in their own homes may not be viewed or responded to with as much urgency, or may not have been taken as seriously as institutional abuse.

Case Group members spoke of the pressure to respond to the high volume of routine incident reports from some providers, and the lack of a system other than the council safeguarding service to process these.

Certainly figures confirm that both the number of concerns received overall and the proportion of concerns being progressed have increased significantly. Using 2014/15 as the baseline, concerns received in Swindon increased by 55% between 2014/15 and 2015/16, by 63% in 2016/17 and by extrapolation of data on the first six months to 68% in 2017/18.

This Finding has been formulated as a question because the Review Team endeavoured to explain the Safeguarding Team's practice in relation to the Honor Case. They theorised that the increased focus on care homes may be the cause. However the Review Team considered that additional work is needed to identify the reasons for the lack of response to calls for action from the GP and domestic abuse specialist.

SAB has already identified ‘inappropriate’ referrals as an issue to be examined by the Quality Assurance Sub-Group and has a target of 30% fall in such referrals.
The proportion of concerns that progress to an enquiry has slowly increased from a low of 38% in 2015/16 to 42% in 2016/17 to a projected 45% in 2017/18. Actual figures are shown below:

	14/15	**15/16**	**16/17**	**Apr-Sept 17**
Total No. Concerns Received	725	1121	1184	601
Total No. Concerns progressed to an Enquiry	382	426	498	271

Interestingly, although the proportion of concerns received from non NHS Care Providers has remained at roughly 30% of the total, NHS concerns have increased as a proportion from 21% to 29% between 2015/16 and 2016/17. Although statutory providers including the NHS and larger private providers of residential care may appear to have less need to report all incidents as safeguarding concerns as they have developed internal incident reporting systems (DATIX for example in health), it appears that they are increasingly identifying incidents as safeguarding issues.

In terms of concerns received about people living in institutions rather than their own homes, there does not appear to be a change in the proportions of concerns. The proportion of concerns raised about people living in their own home has remained relatively constant at just over 50% of concerns raised as does the proportion of concerns raised about people living in institutions at just over a fifth of concerns. Although data is available on whether concerns about people in their own homes are in relation to domiciliary care services, or to family, friends or the wider community, there has been no analysis of the volume of staff time involved compared to that spent on work with residential and nursing homes.

What is known about how widespread or prevalent the issue is?
Repeated reports highlighting systemic neglect and abuse in institutions large and small, from the Rowan Ward inquiry (2003) to the Francis Reports (2010 and 2013) and more recently the Mazars Report (2015), have done much to heighten awareness of the risk of abuse and neglect in institutional care.

Public and political concern about standards of care in care homes, hospitals, and domiciliary care, commissioned by both councils and the NHS, has driven increased incident reporting to council safeguarding services. In addition there is pressure from the Care Quality Commission for local authorities to investigate institutional abuse. The impact of austerity on the capacity of councils to respond to increasing demands for safeguarding services must be considered here. In 'What difference does legislation make? Adult safeguarding through the lens of serious case reviews and safeguarding adult reviews: A report for south west region safeguarding adults' boards' by Michael Preston-Shoot, October 2017) cites a number of examples where 'safeguarding referrals were not adequately responded to' and investigations were insufficiently robust.

In other local authority areas health and social care commissioners monitor provider quality and effectiveness issues by using an incident logging system for providers which sits alongside safeguarding adults, and helps to reduce the number of provider safety concerns being managed as default by adult safeguarding teams. Such systems can be reported and monitored via Provider Forums as well as linking into the Board Quality Assurance Framework and Learning and Development systems.

What are the implications for the reliability of the multi-agency safeguarding adult system?
Under pressure from the volume of work, managers and practitioners in Swindon adopt ad-hoc methods of prioritising cases for action, relying on an approach to risk which is not individuated or evidence-based. Failure to respond in a timely and adequate way because of poor risk assessment risks people's safety, well-being and even their lives. If potential abuse in peoples' own homes is identified but not prioritised because of volume of work from care providers then risk assessment is ineffective, people will not be adequately protected and will suffer unnecessarily.

FINDING 5 **ISSUE FOR CONSIDERATION BY THE BOARD** **Does the increasing volume of safety incidents being reported by regulated care providers in Swindon risk a reduced focus on adults living in their own homes who may be at risk of abuse?** **MANAGEMENT SYSTEM**
SUMMARY The increase of safeguarding referrals both in volume and from care providers makes it possible that concerns about people in their own homes with informal care may be missed. In addition, the skills required to manage quality concerns and allegations of poor care or abuse in an institution are often very different to those required when investigating abuse of someone living alone or with family in their own home.
Questions for the Board and Organisations • How is the Board confident that safeguarding enquiries are appropriately risk assessed and prioritised? • How can the Board support Health and Social care providers and other referrers so that safeguarding concerns are appropriate? • How effective are the links between Commissioners, care providers and the safeguarding team in terms of differentiating between poor practice, poor care quality and safeguarding?

Finding 6

In Swindon, attempts to adhere to the principles of Making Safeguarding Personal, have had the unintended consequence of less opportunity to share information, discuss and plan jointly, below the level of meetings such as MARAC, which consider only the highest risk cases.

Introduction
Alongside involvement of the adult at risk in decision making, multi-agency partnership lies at the heart of the national safeguarding principles set out in the Care Act 2014. The opportunity to share knowledge about a situation, air differing views about a case and agree a way forward is vital in protecting adults at risk. Yet it is one of the hardest elements to get right, and an area where safeguarding practice often fails.

Making Safeguarding Personal (MSP) is an Adult Social Care sector led initiative, developed to enable safeguarding to be done with, not to, people, and to move away from a process of 'investigation' and 'conclusion ' towards one which enables all concerned to know what difference has been made.

MSP is not incompatible in any way with multi-agency working; rather it gives the local authority a key role in co-ordinating the efforts of agencies to ensure that whatever action is taken has as its goal meaningful improvement of people's circumstances. Clearly there will be cases where social work skills are the primary means to achieve this but it will more often be the efforts of a number of agencies that are needed.

How did this finding manifest in this case?
There were multiple instances in this case when a multi-agency planning meeting should have been held.

During 2015 the (SEQOL) adult care team continued to be worried about Honor’s safety when they received reports of abuse and were reluctant to close the case because of these. However there was no discussion with other agencies such as police and specialist domestic violence services about alternative approaches.

The only multi-agency meeting held, in October 2015, resulted in a plan for Honor's GP, who had not been present at the meeting, to ask her son if he wanted a carer's assessment. The GP subsequently arranged for Honor's admission to Swindon Intermediate Care Centre (SWICC) in the hope that Honor would disclose abuse whilst in a safe place. However, without multi-agency agreement on an approach, no progress was made with this during the admission, although while carrying out a mental capacity assessment Honor indicated that she wanted to return home to her son.

Whilst Honor was an inpatient, the hospital Mental Capacity Act manager advised that it was necessary to call a strategy meeting in view of the ongoing concerns about abuse, but Honor was discharged without any clear plan in place for managing the continued risks.

What makes it underlying (rather than an issue particular to the individuals involved?)
Although meetings are not the only vehicle for effective multi-agency work, the review team were told that the replacement of the 'No Secrets' approach to adult safeguarding with 'Making safeguarding personal', as understood in Swindon, had significantly reduced the number of professional meetings.

The approach to safeguarding in Swindon appears less multi-agency and more narrowly led by the council with decisions about 'safeguarding/not safeguarding' the prerogative of the safeguarding team with minimal input from other agencies.

At the Follow-on Meeting on 31st August 2017, the Case Group confirmed that professionals *'hardly ever'* held strategy meetings since the adoption of Making Safeguarding Personal. Instead the approach to multi-agency working was that other professionals (e.g. GPs, mental health professionals) were instructed as to the tasks they should undertake (carry out assessments of capacity, mental health, care needs etc.), which members of the safeguarding team, lacked either time or specific expertise to undertake. It was agreed that this happened as routine in cases such as Honor's.
Whilst a reduction in meetings was seen as positive in Swindon as it was elsewhere, as they are viewed as time consuming, the Case Group told us that it went alongside a perceived reluctance on the part of other agencies to be involved in plans for people's safety, particularly where these were likely to be long term.

What is known about how widespread or prevalent the issue is?
An enquiry under Section 42 of the Care Act may be any action in response to indications of abuse or neglect, ranging from a conversation to a more formal process leading to a multi-agency plan, but any action chosen must be relevant and proportionate. In a complex case where there are repeated allegations of domestic abuse which are repeatedly denied and it is clear that the victim is unable to protect herself because of her age, possible dementia and dependence on the perpetrator, a multi-agency approach bringing together the police, specialist domestic abuse services and adult social care will be necessary.

The limited data available indicates that this move away from multi-agency strategy meetings is not unique to Swindon. In 2016 ADASS published Making Safeguarding Personal: Temperature Check, the results of a survey covering 76% of all English Local Authorities. There was no particular focus on how far the adoption of MSP had reduced the number of meetings held, however the following comments from respondents highlight the issue:

‘*There were reports of a big decline in meetings of professionals which had been replaced with individual meetings with the individuals concerned, often in their own homes’* and *‘The number of formal meetings has significantly reduced as a result of MSP.’*

However a number of respondents commented that MSP was not owned by other safeguarding partners in localities which left local authority teams feeling responsible and isolated.

Learning from SARS: A Report for the London Safeguarding Board by Suzi Braye and Michael Preston-Shoot July 2017) found that in a third of reviews there was no joint strategy to secure engagement with people.

What are the implications for the reliability of the safeguarding adult system?
The marked reduction in strategy meetings as routine in Swindon jeopardises a multi-agency approach by removing opportunities for multi-agency discussion and planning, particularly important in complex cases of domestic abuse where these are needed from the start.

FINDING 6 **ISSUE FOR CONSIDERATION BY THE BOARD** **In Swindon, attempts to adhere to the principles of Making Safeguarding Personal, have had the unintended consequence of less opportunity to share information, discuss and plan jointly, below the level of meetings such as MARAC, which consider only the highest risk cases.** **ORGANISATIONAL NORMS AND CULTURE**
SUMMARY The application of Making Safeguarding Personal has led to adult social care carrying out undertaking enquiries in isolation. Local authorities and their relevant partners must collaborate and work together or risk breaching their statutory duties of co-operation.
Questions for the Board and Organisations • Has the Board considered undertaking a local Health Check of the impact of Making Safeguarding Personal on multi-agency working? • How can the Board encourage all partner agencies in Swindon to collaborate and work together on safeguarding enquiries from their earliest stages?

Conclusion
This Review has shown that there are a number of systemic issues, some of them quite significant, illustrated by the case of Honor, which show that the connection between Domestic Abuse and Safeguarding Adults in Swindon particularly for older adults is not as effective as it should be. This case has provided a "window on the system" to understand the challenges that practitioners face in understanding and recognising the nature of coercive control especially within family relationships, and the challenges of multi-agency working.

The Findings explore the systemic reasons underlying why some practitioners find it difficult to implement good practice guidance and have identified that one of the reasons for this may be the lack of strategic leadership within and across the partnership including strong quality assurance. Some unintended consequences of the Care Act and the adoption of Making Safeguarding Personal are also identified as factors.

APPENDICES

Appendix 1: Care Act 2014
The Care Act 2014 requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

- A*n adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,*
  And
- T*here is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.*

The Care Act states that: *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:*

- *Identifying the lessons to be learnt from the adult's case,*
  And
- *Applying those lessons to future cases.*

The Care and Support Statutory Guidance [14:138] DoH, October 2014, sets out the following principles which should be applied by SABs and their partner organisations to all reviews:

- *There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice,*

- *The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined,*

- *Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed,*

- *Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith,*

- *Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.*

Appendix 2: The Learning Together model
This Safeguarding Adults Review was carried out using the systems methodology called Learning Together (Fish, Munro & Bairstow, 2010). The focus of a case review using a systems approach is on multi-agency professional practice; so the primary emphasis is on what the practitioners did, thought and felt, not on the service user.

The aim of a Learning Together Review is to move beyond the specifics of the particular case (what happened and why) to identify the underlying issues that influence practice more generally. These generic patterns become the 'Findings' from a case. Changing them will therefore help to improve practice more widely.

What is referred to as the "Methodological Heart" of the Learning Together model is made up of 3 distinct stages:

1. The **"View from the Tunnel"** - understanding how practitioners understood the 'local rationality', allowing us to reconstruct what happened without the benefit (trap) of hindsight
2. Carrying out an **"Appraisal of practice"** to understand what happened and explain why it happened through the analysis of Key Practice Episodes (KPE's).
3. Using the case as a **"Window on the system"** to assess its relevance and understand the implications for wider practice.

This approach studies the system in which people and the context interact. It requires the use of qualitative research methods to improve transparency and rigour. The key tasks of a Learning Together Review are therefore data collection and analysis. The data is obtained through structured conversations with the practitioners involved in the case, and from documents provided by the organisations.

Structure of the review process
The SCIE model uses a process of iterative learning, gathering and making sense of information about a case. This is a gradual and cumulative process. This review entailed a series of meetings between the Lead Reviewers, Review Team and Case Group members over the course of the review. An introductory meeting then took place with the Case Group and the Review Team. At this meeting the SCIE model, and their role in the review process, was explained to the Case Group and Review team. Case Group members all agreed to be involved in the individual conversations and Review Team members signed up to assist with these.

Individual conversations were carried out during July 2017. After this there was further meeting with the Review Team to consider the Key Practice Episodes (KPEs), the "chunks" of time that are then analysed and appraised in relation to the practice of the practitioners at the time.

The next meeting with the Case Group and Review team started the process of moving from the specific case to the generalisable learning that is at the core of the Learning Together model. Following that the Review team met again to consider and re start to refine the draft Findings. Finally the draft Findings were shared with the

Case Group in order to receive their input into the systemic issues raised and developed by the Review Team.

Date	Meeting Purpose
19/04/17	Initial commissioning meeting between Lead Reviewer, Safeguarding Adults Service Manager and Safeguarding Support Manager
06/06/17	Introductory meeting with Case Group and Review Team
Various during July 2017	Individual Conversations with Case Group members and Honor's daughter
07/07/17	Review Team met to agree KPEs
31/08/17	Follow on meeting with Case Group and Review team to consider KPEs and consider underlying patterns
6/10/17	Review team agreed draft Findings
1/11/17	Second Follow On Meeting to consider draft report Review team and Case Group in attendance
14/12/17	SAB receives final report

Appendix 3: Glossary and explanation of terms

Term	Explanation
ASC	Adult Social Care (Swindon Borough Council)
Community Care	'community care' is used to describe the various services available to help people manage their physical and mental health problems in the community e.g. nursing or social work support, home help, day centres, counselling, supported accommodation. Community care is usually arranged by social services departments or Community Mental Health Teams (CMHTs).
DASH	Dash stands for domestic abuse, stalking and 'honour'-based violence. When someone is suffering domestic abuse, completion of a Dash is an assessment of the risks in the form of a multi-agency checklist.
EM	Enquiry Manager in Safeguarding Team
EO	Enquiry Officer
IMCA	Independent Mental Capacity Advocate
LSCB	Local Safeguarding Children's Board
MARAC	A Multi-Agency Risk Assessment Conference is a local, multi-agency victim-focused meeting where information is shared on the highest risk cases of domestic violence and abuse between different statutory and voluntary sector agencies
MCA	Mental Capacity Act, 2005. The Act provides the statutory duty of agencies to formally assess capacity whenever there is a concern that a person may lack the mental capacity to make significant decisions regarding their care and treatment arrangements.
MSP	Making Safeguarding Personal. MSP seeks to achieve: • A personalised approach that enables safeguarding to be done with, not to, people • Practice that focuses on achieving meaningful improvement to people's circumstances rather than just on 'investigation' and 'conclusion' • An approach that utilises social work skills rather than just 'putting people through a process'
OM	Operations Manager in Safeguarding Team
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SCIE	Social Care Institute for Excellence
SEQOL	Set up in 2011, was an integrated social enterprise delivering adult social care and community health services on behalf of the council and Swindon Clinical Commissioning Group. Social Care Services were taken back in house in February 2017.
SSW	Senior Social Worker
SWA	Swindon Women's Aid is a Voluntary Organisation providing a range of services to victims of domestic abuse
SWICC	Swindon & Wiltshire Intermediate Care Centre. Orchard Ward is community "Step Up" ward to avoid need for hospital admission

Appendix 4: References and useful resources

Care Act (2014) The Stationery Office, London

Department of Health. DH (2016) Care and Support statutory guidance.
.Available at: .https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance.

The Mental Capacity Act 2005 Code of Practice together with comprehensive advice on the Act can be found at: www.justice.gov.uk/ protecting-the-vulnerable/mental-capacity-act

Mental Capacity Act guides and resources from SCIE
www.scie.org.uk/publications/mca/index.asp

Domestic Violence, Crime and Victims (Amendment) Act 2012, Ministry of Justice Circular No. 2012/03

Adult safeguarding and domestic abuse – a guide to support practitioners and managers http://www.adass.org.uk

DL v A Local Authority and Others (2012) Use of inherent jurisdiction by the High Court to protect adults with capacity.
www.bailii.org/ew/cases/EWCA/Civ/2012/253.html

Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively" – NICE Guidelines February 2014 www.nice.org.uk/ guidance/ph50

End the Fear – Greater Manchester Against Domestic Abuse – example of local resources
website to help and support the public and professionals www.endthefear.co.uk

Local Government Association (2014) Making Safeguarding Personal. Available at :http://www.local.gov.uk/publications/journal

Older women and domestic violence in Scotland "...and for 39 years I got on with it" NHS Health Scotland www.healthscotland.com

Safeguarding adults at risk of harm: A legal guide for practitioners SCIE report no. 50, December 2011, Michael Mandelstam
www.scie.org.uk/publications/reports/report50.pdf

“Standing together against domestic violence – a guide to effective domestic violence partnerships”
http://www.standingtogether.org.uk/fileadmin/user_upload/standingUpload/Publications/HOP_-_guidance-_final_July_2011.pdf