Safeguarding Adults Forum March 2026

Karen Littleford
Safeguarding Adults Lead
Partners in Care

partnersincare.org.uk

Safeguarding Adults Forum Dates 2026/2027

Online – Zoom (9:30am - 12:30pm)

- 24th June (Wednesday) 2026
- 10th September (Thursday) 2026
- 9th December (Wednesday) 2026
- 9th March (Tuesday) 2027

https://www.partnersincare.org.uk/networking-events/safeguarding-adults-forum

Agenda

- **DBS Eligibility** - Rebecca Haines (Regional Outreach Adviser (West Midlands), Disclosure and Barring Service)
- **'Casual or Unintentional Neglect'** - Karen Littleford (Safeguarding Adults Lead, Partners in Care)
- **SARS and DHR update –** Lisa Gardner (Development Officer, Business Unit, Shropshire Safeguarding Community Partnership) and Fiona Cook, (Review Development & Training Officer, Telford and Wrekin Safeguarding Partnership)
- **Resources and Webinars -** Karen Littleford (Safeguarding Adults Lead, Partners in Care)

‘Casual or Unintentional Neglect’

Karen Littleford
Safeguarding Adults Lead,
Partners in Care

Learning Objectives

By the end of the session, you will be able to:

- Describe what we mean by casual or unintentional neglect
- State how you can address the potential for this in your organisation

Neglect or an act of omission

- An ongoing failure to meet someone's basic physical or psychological needs.

- Neglect and acts of omission include ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating.

This can be intentional or unintentional.

(Brighton and Hove SAB, 2025)

Used in the session until the end of ‘some examples’
Watch it here
https://www.youtube.com/watch?v=11vScTNg0Oc

Casual or Unintentional Neglect

- Unintentional neglect (sometimes referred to as passive or casual neglect) refers to the failure to meet a person's basic needs due to factors such as **a lack of knowledge, understanding, or resources, rather than a deliberate intent to cause harm**.
- This contrasts with intentional (active or wilful) neglect, where a caregiver purposefully withholds care or necessities.

(ProSafeguarding, 2025)

Adult Safeguarding – Neglect Southern Health and Social Care Trust https://www.youtube.com/watch?v=SqiwhmG75HA

Day-to-Day Practices That Start To Become Neglectful

What are our partner agencies observing or being told about by adults using social care services?

What do front line staff and providers think is acceptable?

1. Staff using their phone rather than engaging with the adult

or

- Staff not communicating to the adult that they are on the phone to carry out documentation

What impact does this have?

Day-to-Day Practices That Start To Become Neglectful

What are partner agencies seeing in practice?

What do front line staff and providers think is acceptable?

2. Priorities when on duty? Do staff have an awareness that they are '**at work**'

- Do staff do their own shopping when supporting the adult to do theirs?
  - If the adult asked the Personal Assistant to also do their shopping so that they are doing together, how is this balanced so that it does not become more about the staff members needs?
- Are staff watching a film as an activity but that becomes the focus not supporting the adult?

How is the **balance** achieved? Is the adult still the priority and focus of support?

Take a moment to consider the examples shared

Question -
Can you identify the potential for ‘casual or unintentional neglect’ in day-to-day practice?

What Can Providers Do To Reduce the Risks of Casual or Unintentional Neglect?

What Can Providers Do?

1. Scrutinise qualifications, is training at the right level – is Tier 1 Oliver McGowan training adequate for providing direct support to someone? What else might be need in addition to the **minimum** training requirements?
2. Consider whether induction training equips the workforce to understand their **priority in the workplace is the adult**?
3. Provide professional boundaries support and training, do staff understand their role? Do staff have a consistent understanding of professional boundaries?

What Can Providers Do?

4. Embed safeguarding values in your organisation – zero tolerance of abuse, healthy scepticism, professional curiosity
5. Develop a ‘Speak up Culture’
6. Utilise critically reflective practice in the organisation
7. Consider supervision approaches where supervisors take a collaborative approach as ‘a guide by the side’
8. Recognise the diverse nature of the workforce, don’t assume that common understanding and values exist – how can you address this?

References

- Brighton and Hove SAB (2025) Types of Abuse & Neglect. Brighton: Brighton and Hove Safeguarding Adut's Board. https://www.bhsab.org.uk/what-is-safeguarding/types-of-abuse-neglect/
- ProSafeguarding (2025) *Who might abuse or neglect.* https://www.prosafeguarding.co.uk/training/video/who-might-abuse-neglect

Videos:

- E-Magination Training (2020) *Safeguarding Adults – Neglect.* on the Adventure With Garry YouTUbe https://www.youtube.com/watch?v=11vScTNg0Oc
- Northen Ireland Adult Safeguarding Partnership (2021) *Safeguarding Adults – Neglect.* https://www.youtube.com/watch?v=11vScTNg0Oc On the Southern Health and Social Care Trust YouTube

Shropshire Safeguarding Community Partnership

Telford and Wrekin Safeguarding PARTNERSHIP

Safeguarding Adults Reviews and Domestic Abuse Related Death Reviews

Lisa Gardner (Development Officer, Business Unit, Shropshire Safeguarding Community Partnership)

Fiona Cook (Review Development & Training Officer, Telford and Wrekin Safeguarding Partnership)

Learning from Case Reviews

Shropshire Safeguarding Community Partnership

Update provided by Lisa Gardner (Development Officer, Business Unit, Shropshire Safeguarding Community Partnership)

SAFEGUARDING ADULT REVIEWS

5

Referrals have been received in the financial year 2025/26

2

3

5 referrals in the financial year 2025/26 two for females and three for males. Two of these did not meet the criteria. Two are yet to be determined, the one that did and the undetermined ones all had themes that were very similar, both were individuals who experienced multiple exclusion homelessness (this is term used to describe a chronic state of homelessness combined with and compounded by additional factors such as substance misuse, severe mental health issues and institutional care, such as the care system or prison).

1. Background

Claire took her own life following a relationship break-up. There was no evidence of domestic abuse in her most recent relationship, but Claire had suffered significant domestic abuse in previous relationships. Claire lived with poor mental health and was also known to misuse alcohol. Claire had three children.

You can read the full DHR/SAR report here

2. Information sharing

Police attended a domestic abuse incident where Claire reported being on anti-depressants and feeling lower than normal. A Domestic Abuse Triage meeting determined the level of need as Level 3 and so Children's Social Care contacted Claire to discuss support for the family. It was decided no referrals to Adult Services were required. Given Claire had reported deterioration in her mental health consideration should have been given to liaising with Claire's GP which may have led to a referral for mental health support.

3. Domestic Abuse Triage

Whilst the Domestic Abuse Triage Meeting ensured that Claire and her family were offered support regarding domestic abuse, insufficient consideration was given to other vulnerabilities and consequently referrals to other agencies, who could offer Claire support in other areas of need, were missed. Multiple referrals, even though determined as Level 1 threshold, should be considered as potentially representing an increased need of support.

8. Take away messages

- When a person reports declining mental health consider sharing information with their GP, with their consent
- Multiple referrals should be considered as representing a potentially increased risk
- Understand the person's lived experience
- Professionals to be aware of the link between Domestic Abuse and Suicide

Domestic Homicides and Suspected Victim Suicides During the Covid-19 Pandemic 2020-2021

Shropshire Safeguarding Community Partnership

4. Multi-agency decision-making

A referral was made to the Harm Assessment Unit, and it was decided that despite needing support with both her mental health and alcohol misuse, and experiencing abuse, Claire did not meet the definition of an adult at risk. Because the criteria was not deemed to have been met, no onward referrals were made to Adult Services and there was no follow up regarding Claire's mental health or alcohol misuse. The Harm Assessment Unit should work with other appropriate agencies to make decisions regarding onward referrals.

7. Lived Experience

Understanding Claire's lived experience was crucial as it illustrated her repeated patterns of abusive relationships, fluctuating mental health, recurring suicidal ideations and binge drinking. Safeguarding planning was affected as a result of no professional gaining a vital understanding of her lived experience. Better understanding of Claire's lived experiences would have helped identify the level of despair she faced and her risk of suicide.

6. Link between Domestic Abuse and Suicide

A number of agencies knew that Claire experienced domestic abuse and suicidal ideation. Whilst professionals addressed the risk of both the link between the domestic abuse, and the risk of suicide went unrecognised. Knowing that Claire was a victim of domestic abuse and was experiencing fluctuating mental health, which often resulted in disclosed suicidal ideations and/or suicide attempts, necessitated a lengthier professional focus regarding the long-term implications and impact upon her mental health.

5. Support for alcohol misuse

Claire disclosed her alcohol use to professionals, and the Police witnessed her intoxicated on a number of occasions. When Claire declined alcohol support services, she was left to manage her recovery alone. However, best practice would have seen professionals who had offered Claire referrals for support with her alcohol, considering other ways to engage her in alcohol services when she declined to consent to referrals.

Claire DHR/SAR Learning Briefing here

January 2026

Fire Risk Referrals are an essential way in keeping vulnerable people safe. You are in a unique position; you visit people's homes everyday and they let you in (mostly).

If a property is hoarded, unkempt, if someone is using emollient creams, smokes, doesn’t have fire alarms, uses a wheelchair, has an air flow mattress or oxygen then make a Fire Risk Referral.

Shropshire
Fire and Rescue Service

Partner Agency Fire Safety Checklist

KITCHEN – 60% of house fires start in the kitchen	Yes	No	Advice Given
Are there any concerns about cooking methods (please expand)			
Potential to forget cooking?			
ELECTRICITY			
Are there any overloaded sockets?			
Does the client use an electric blanket?			
SMOKING – The biggest cause of fatal house fires			
Does the client smoke?			
Do smoking practices of the client cause you concern? (Expand)			
CANDLES / HEATING			
Does the client use candles?			
Log burners / open fire in use?			
Portable heater used in a safe manner?			
SMOKE ALARMS			
Are the working Smoke Alarms? (Minimum one per floor)			
ESCAPE PLAN			
Is the person able to make their escape unaided?			
Are the escape routes free from obstructions?			
Are door keys always to hand?			
Are internal doors closed at night time? (prevents smoke spread)			
Any signs of hoarding?			

Further Comments.....

Client Details

Name .....

Address.....

.....

Contact details.....

Signature .....

Agency Details

Agency.....

Representative .....

Contact Details .....

Date .....

Would you like a visit from Shropshire Fire and Rescue Service? Yes No

(circle as appropriate)

Please return to SFRS via homevisit@shropshirefire.gov.uk

Prevention Team: Tel 01743 260258/279

Shropshire Fire & Rescue Service (SFRS) are collecting Personal Identifiable Information to enable us to provide you with a safe and well check. This information is being processed under GDPR 2018 -Article 6 (1) A). SFRS will not share any Personal Identifiable Information collected with external organisations unless required to do so by law. However, this information will be shared within SFRS and with our partners agencies (Shropshire Council or Telford & Wrekin Council) solely for the purpose of providing you with any help and support you may need. For further details on this view the privacy page on SFRS website page, www.shropshirefire.gov.uk

The form can be found on this link - Responding to Self-Neglect in Shropshire — Shropshire Safeguarding Community Partnership

Shropshire Safeguarding Community Partnership

Telford and Wrekin Safeguarding PARTNERSHIP

Safeguarding Adult Review for "TOM"

Front line teams learning reflections general instructions.

Context and Rationale: Safeguarding Adult Reviews (SARs) are statutory reviews governed by The Care Act 2004. Their purpose is to find out what lessons are to be learnt from multiagency reviews and then to apply that learning to future practice.

There is evidence from important national[1] research and our local diagnostic review which emphasised the vital need to embed learning as intensively as possible across all front-line teams.

Following consultation across key groups it has been recognised that the statutory partnerships in both Shropshire and Telford and Wrekin wish to support all relevant frontline teams with a SAR team led learning event. This will be an opportunity for all relevant teams across different agencies to have focused time in a team gathering to go through the case, discuss the learning and the actions and answer 5 questions. Having become better informed of the learning from the final review each team can decide how they should apply that learning to their work and then agree any team-based learning actions. Support is also available from your organisations safeguarding lead and the Safeguarding Adult Board which is part of the Shropshire Safeguarding Community Partnership as requested.

Steps to follow by business unit/partnership office:

1] The Business Unit/partnership office will share a copy of the SAR, including case summary, learning action plan/recommendations, the 7-minute brief and the author's brief PowerPoint case summary.

Steps to follow by the organisations safeguarding lead:

1] On receipt of the SAR materials from the Business Unit the adult safeguarding/domestic abuse lead for that organisation will decide which teams in your organisation should use the front line teams learning reflections event tool based on the relevance of the issues to the work of that team.

2] They will then distribute the materials to those front-line teams explaining the rationale for this learning opportunity and support the teams as needed.

3] the organisations' safeguarding team will then support front-line teams with any local actions and report back to the business unit / partnership office outcomes using the return template.

[1] Second National SAR Analysis and VKPP review of all DHRs over the last 4 years

Shropshire Safeguarding Community Partnership

LEARNING REFLECTIONS TOOL - TEAM EVENT

Safeguarding Adult Review

"TOM"

Telford and Wrekin Safeguarding PARTNERSHIP

Name of Agency	
Name of Team	
Date of Team learning reflection session	
Date learning reflection returned to agency safeguarding lead	
Agency safeguarding lead name and contact details	

You should have received the following; the You Tube link to the "Tom" video

1.0 As a team please take a few minutes to watch the Tom video. This should be led by the ***"case champion."*** Please share your whole team observations.
As a team what are the most important features about Tom's review.
If you have any questions please liaise with your organisations safeguarding lead. Please record your observations about the issues here:

2.0 Given the information you have read, please carefully consider if things were missed or went wrong in the arrangements to support Tom Please treat this as a reflective space to **explore your ideas and ask yourself could this have happened here. If it could what are the issues you have found? If you feel you have practice and processes which would have made this less likely here, please share those too**. Please record your comments:

Did any of you complete the learning reflections tool after watching the Tom video with your Team (it was emailed to all attendees)
Was it helpful? If you could share your learning with SSCP they would really appreciate it (send it to Karen to pass on).

Tom SAR video https://youtu.be/nPQgoCtUHEQ

We have had 3 Domestic Homicide Review (DHR) referrals since January 2026 in Shropshire

3

Home Office

We have had Three DHR referrals since January 2026

We have scoped one of these and are awaiting a final decision from the chair.
Scoping meetings are planned for the other two.
We have signed two others off which will be going to the Home Office in due course, but we are currently supporting the families to process the findings.
Some headline learning from recent cases for you is about suicide prevention and the impact of post separation domestic abuse and the toll that this can take.

Safeguarding Adults Forum

Fiona Cook

Review Development & Training Officer

Telford and Wrekin Safeguarding Partnership

SARS & THE PROCESS

Safeguarding Adult Reviews (SARs) are multi-agency reviews carried out when an adult with care and support needs dies or is seriously harmed, and abuse or neglect may have been a factor. They aim to understand what happened, learn lessons, and improve how agencies work together, rather than assign blame.

Telford and Wrekin Safeguarding Partnership commissioned an Independent Author to complete the review.

The process took place in the form of panel meetings involving agency leads, practitioner events for those who had worked directly with the adults and reports from involved services including:

- Primary Care (GPs)
- Adult Social Care
- Shrewsbury and Telford Hospital Trust
- Shropshire Community Health Trust
- Midlands Partnership University NHS Foundation Trust
- West Midlands Ambulance Service

“PATRICIA” SAFEGUARDING ADULTS REVIEW (SAR)

OVERVIEW OF PATRICIA'S SAR

Complex Medical and Care Needs

Patricia had multiple serious health conditions affecting mobility and daily functioning, requiring full family care support.

Challenges in Care Provision

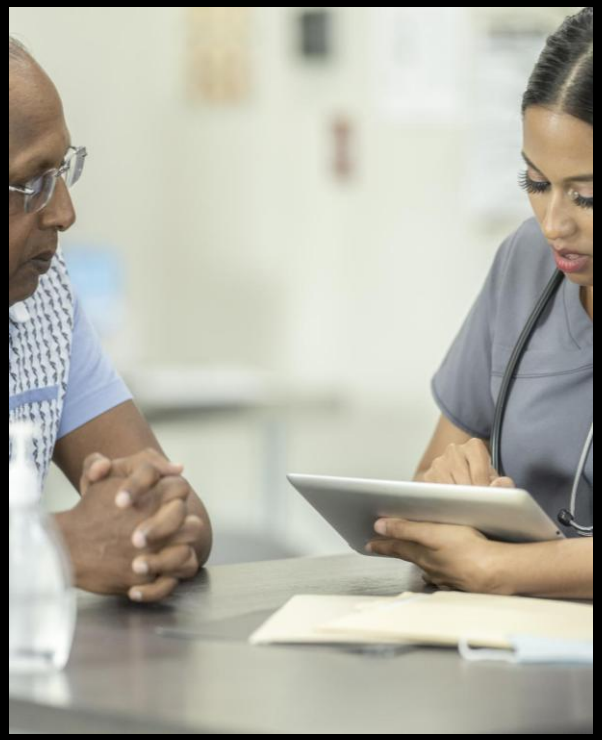
No formal care package was established due to family preferences and misunderstandings about immigration and visa status.

Need for Multi-Agency Collaboration

The review highlights gaps in collaboration, documentation, and risk communication across health and social care agencies.

Importance of Safeguarding Improvements

The case calls for strengthened safeguarding practices, enhanced training, and proactive adult risk engagement.



KEY ISSUES IDENTIFIED IN THE SAR

Escalating Self-Neglect

Patricia's worsening condition was marked by unmanaged wounds and hygiene issues, complicated by refusal of external help.

Lack of Carer Assessment

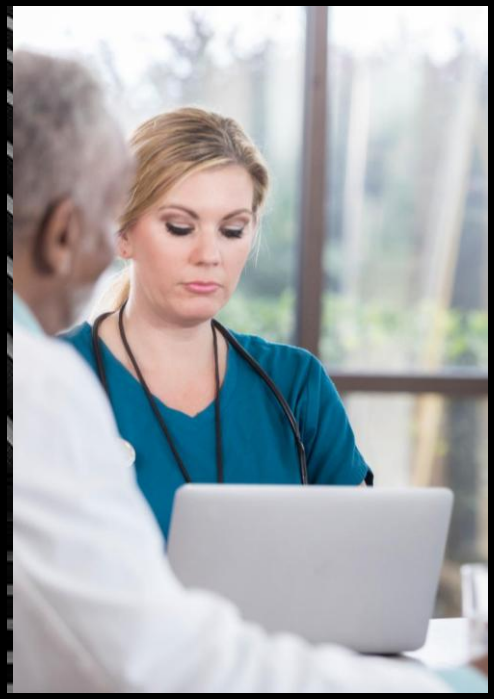
Christine lacked formal assessment and support despite managing complex care tasks without specialist training or respite.

Immigration and Funding Misunderstandings

Misunderstandings about visa status led to refusal of support, influenced by unchallenged agency assumptions.

Communication and Safeguarding Gaps

Missed agency coordination and inconsistent safeguarding decisions weakened interventions and risk management.



SAR RECOMMENDATIONS

Strengthen Professional Curiosity

Revise training to encourage practitioners to explore home situations deeply, especially when support is declined.

Enhance MDT Awareness

Improve use of Multi-Disciplinary Team approaches for timely referrals and collaborative safeguarding discussions.

Equip Staff with Assessment Tools

Provide ready access to self-neglect toolkits to boost confidence in handling complex safeguarding cases.

Improve Ancestry Visa Information

Review and enhance information about ancestry visa entitlements for professionals and families.

“VIOLET” SAFEGUARDING ADULTS REVIEW (SAR)

OVERVIEW OF VIOLET'S SAR

Telford and Wrekin Safeguarding PARTNERSHIP

Case Background and SAR Purpose

Telford and Wrekin Safeguarding Partnership commissioned a SAR due to concerns around how agencies worked together to safeguard Violet, a 75 year old woman who lived in Telford died in May 2024. Violet was receiving twice daily support from an external care agency and was supported by her adult children to meet her care needs. Violet was also supported by a Wrekin Housing Trust officer within her property around hoarding concern.

The SAR's aim is to identify lessons and improve multi-agency safeguarding coordination.

Multi-Agency Involvement

Various agencies provided healthcare and social support, highlighting challenges in interagency communication and coordination.

Health Decline and Incident

Violet's deteriorating health and urgent ASC intervention preceded her death from bronchopneumonia.

Learning and Improvement Focus

The SAR emphasises strengthening safeguarding practices and earlier intervention to prevent similar cases.

KEY ISSUES IDENTIFIED ACROSS AGENCIES

Telford and Wrekin Safeguarding PARTNERSHIP

Delayed Health Recognition

Declining health was not recognised early despite frequent service contact, impacting timely care decisions.

Household Condition Concerns

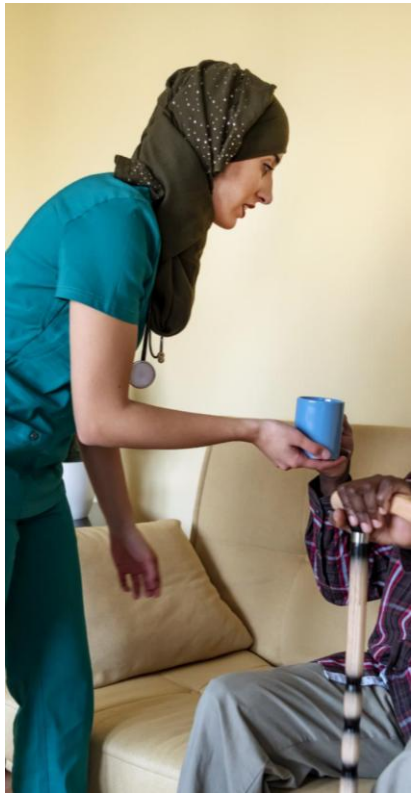
Clutter and poor hygiene raised safety risks though hoarding was inconsistently identified and addressed.

Communication Gaps

Inconsistent information sharing between carers and professionals led to missed appointments and concerns.

Lack of Multidisciplinary Coordination

Absence of a formal team caused agencies to work separately, reducing coordinated support for complex needs.



RECOMMENDATIONS AND NEXT STEPS

Multidisciplinary Team Approach

Increase awareness and use of MDTs to provide holistic oversight and early risk recognition across agencies.

Escalation Policy Awareness

Improve understanding and use of escalation pathways within and across agencies, reinforcing shared accountability.

Communication and Feedback Loops

Enhance communication and ensure consistent feedback on safeguarding referrals to maintain shared risk understanding.

NEXT STEPS FOR TELFORD AND WREKIN SAFEGUARDING PARTNERSHIP

- Review of Telford and Wrekin Safeguarding Partnership Escalation Policy (access here)
- Promoting professional curiosity
- Multi-Disciplinary Team toolkits /training
- Easy Access information on Self Neglect

CONTACT US

Telford and Wrekin Safeguarding PARTNERSHIP

Email:
Partnerships@telford.gov.uk

Webinars, Policy, Guidance, Resources and Reports

Casey Commission

Independent Commission on Adult Social Care

Baroness Casey has requested that DHSC…

1. Set up, immediately, a new National Safeguarding Board, chaired by Sarah McClinton, the Chief Social Worker, and reporting to the Minister for Social Care, which would have statutory responsibility for adult safeguarding: reviewing Safeguarding Adult Reviews (SAR), identifying national risks, and commissioning thematic reviews.

1. Lead an urgent review of existing adult safeguarding statutory duties and powers, to test whether the current framework provides sufficient clarity and leverage in high-risk situations.

Baroness Casey in her remarks at the Nuffield Trust Summit, Baroness Casey of Blackstock said:

> ‘Among all the issues I have considered in the past year, one of the most concerning has been the abdication of responsibility, by successive governments, to protect people who are vulnerable and at risk of abuse.’
>
> ‘Instead of a robust national safeguarding system, serious safeguarding failures are addressed as isolated local problems, meaning the same concerns are identified repeatedly without national scrutiny, action, or consequences.’
>
> Baroness Casey 03 March 2026

Casey Commission

Independent Commission on Adult Social Care

You can read a press release here (5th March) https://caseycommission.co.uk/baroness-casey-calls-for-a-moment-of-reckoning-on-adult-social-care/#:~:text=Baroness%20Casey%20also%20confirmed%20she,reform%20needed%20in%20these%20areas **and watch the speech here** https://caseycommission.co.uk/baroness-casey-calls-for-a-moment-of-reckoning-on-adult-social-care/#:~:text=Baroness%20Casey%20also%20confirmed%20she,reform%20needed%20in%20these%20areas**.**

Read the response from the Department of Health and Social care here – Correspondence Letter from the Secretary of State for Health and Social Care to Baroness Casey of Blackstock DBE CB https://www.gov.uk/government/publications/letter-from-the-secretary-of-state-for-health-and-social-care-to-baroness-casey/letter-from-the-secretary-of-state-for-health-and-social-care-to-baroness-casey-of-blackstock-dbe-cb

Shropshire Council - Communicating with the Safeguarding Adults Team or Raising a Safeguarding Adults Concern

Communicating with the Safeguarding Adults Team - when there is an open safeguarding concern or a Section 42 Enquiry is taking place

The Safeguarding Team has optimised the use of the S42enquiry@shropshire.gov.uk mailbox, which was already well-known to providers. Historically, this mailbox has served as the designated channel for the return of Section 42 and other safeguarding enquiries conducted by external agencies. Since February 2025, the mailbox has also been utilised to support with communications from external providers and professionals seeking updates regarding existing open safeguarding concerns or Section 42 enquiries.

The S42enquiry@shropshire.gov.uk mailbox is monitored daily, and any pertinent correspondence is promptly forwarded to the appropriate member of staff with in the Adult Safeguarding Team for a timely response.

Raising a Safeguarding Adults Concern with Shropshire Council

Any general queries relating to non-open matters will be redirected to the First Point of Contact (FPOC), in accordance with Shropshire Councils established protocol. So, if you are raising a Safeguarding Adults Concern with Shropshire Council by phone the First Point of Contact team on 0345 678 9044 Monday to Thursday, 9am to 5pm, and Friday 9am to 4pm.

If you have urgent adult safeguarding concerns outside of these hours, please phone the Emergency Social Work Duty Team on 0345 678 9040.

Linked from the Partners in Care YouTube here https://www.youtube.com/playlist?list=PLR7h4BzDDmvQp3x6-8oxgjb62AJGkmu_i

And the DBS YouTube here - https://www.youtube.com/@DisclosureandBarringService

Series one

1. What is DBS, and why does it matter?
2. Understanding DBS Checks: What they are and how they work
3. Basic Checks – What You Need to Know
4. The Update Service
5. The Regional Outreach Service
6. Myth busting & What's Next |

MCA Webinar dates 2026/2027 subjects to be determined

July 2026 (MCA and DoLS Webinar 15)
Tuesday 7th July 11:00am-12:30pm

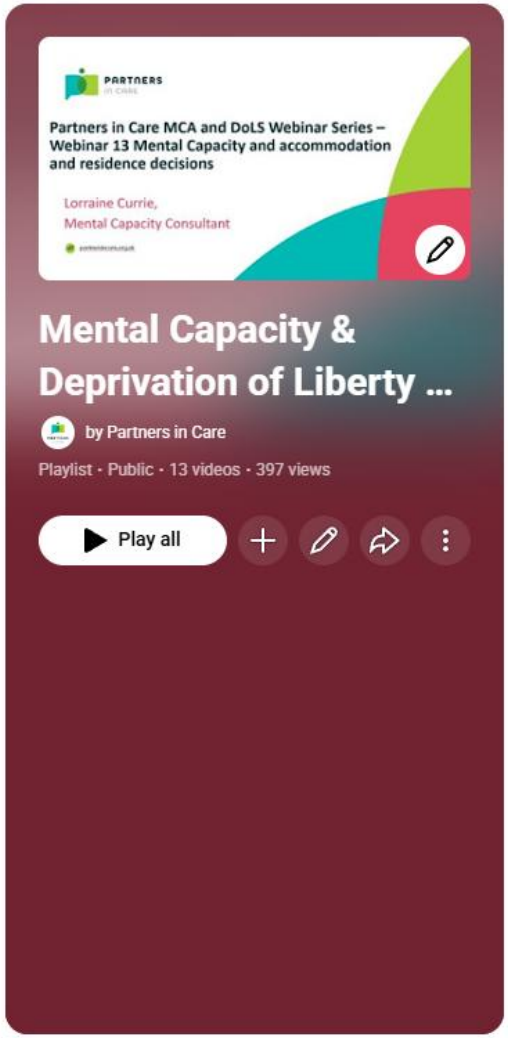
October 2026 (MCA and DoLS Webinar 16)
Monday 12th October 2026 2:00pm-3:30pm

December 2026 (MCA and DoLS Webinar 17)
Tuesday 1st December 2026 11:00am-12:30pm

March 2027 (MCA and DoLS Webinar 18)
Thursday 4th March 2027 11:00am-12:30pm

- £20 per learner (members) £28 (non-member)
- Book here https://www.partnersincare.org.uk/training-courses/mca-dols/mca-and-dols-webinars
- Flyers with topics will be added here - https://padlet.com/klittleford2/partners-in-care-mca-and-dols-webinar-and-newsletter-resourc-e7qspc6fy3mmze8w

Webinar Recordings



Manual

Partners in Care Webinar 13 Mental Capacity and Accommodation and Residence Decisions

Partners in Care • 52 views • 3 weeks ago

Partners in Care Webinar 12 Mental Capacity and End of Life Decision Making

Partners in Care • 67 views • 3 months ago

Partners in Care MCA Webinar 11 – 'Preparing to do a mental capacity assessment'

Partners in Care • 140 views • 6 months ago

Partners in Care MCA Webinar 10 – 'Contact and the MCA'

Partners in Care • 98 views • 9 months ago

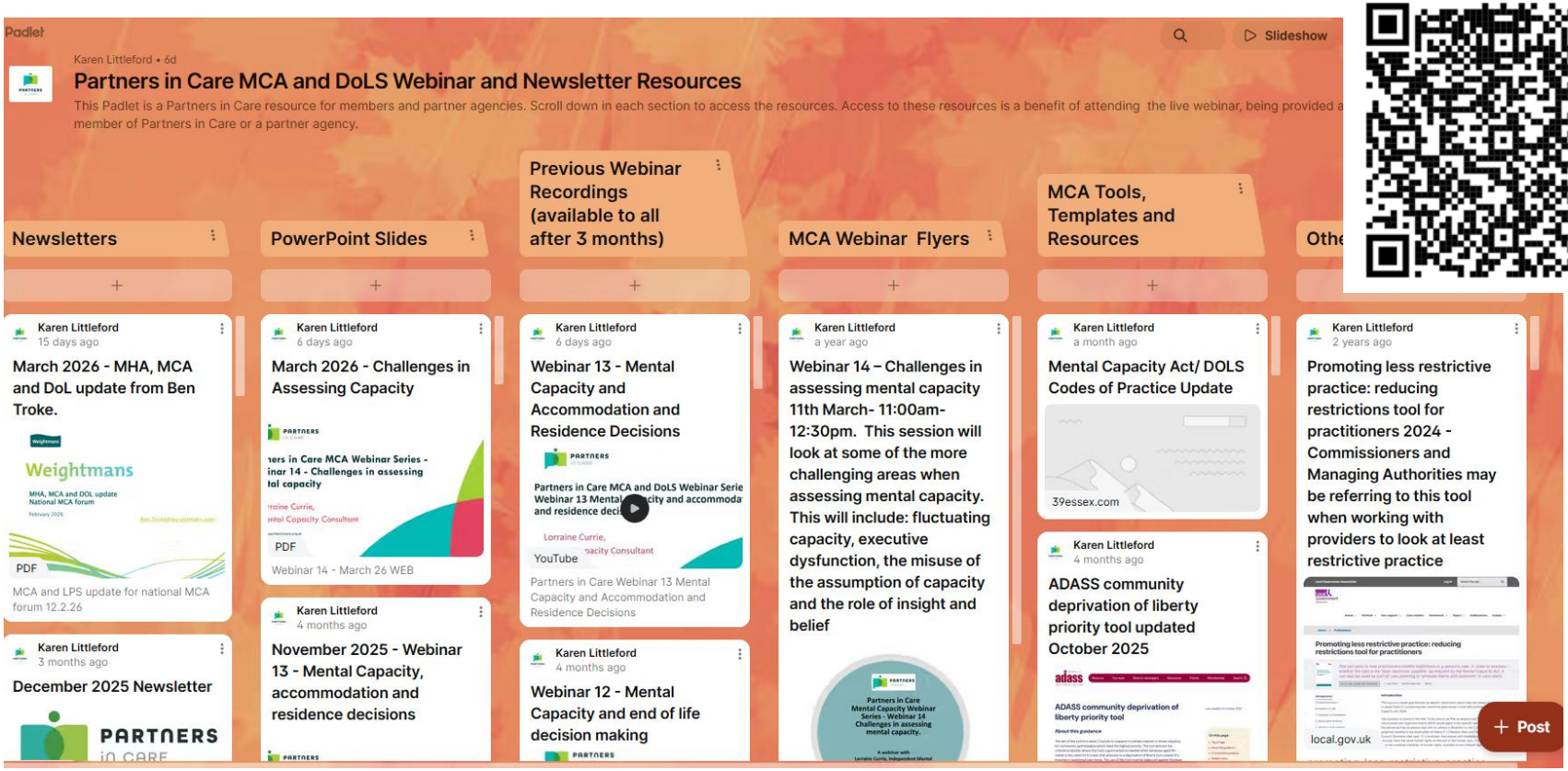
Partners in Care MCA Webinar 9 – 'Managing Food and Diet'

Partners in Care • 134 views • 1 year ago

Partners in Care MCA Webinar 8 – Restraint in A Care Setting - What is restraint? October 2024

https://www.youtube.com/playlist?list=PLR7h4BzDDmvRKI8NFFtHQiRe4-HB3hRT1

Mental Capacity and Deprivation of Liberty Safeguards Padlet (Partners in Care)



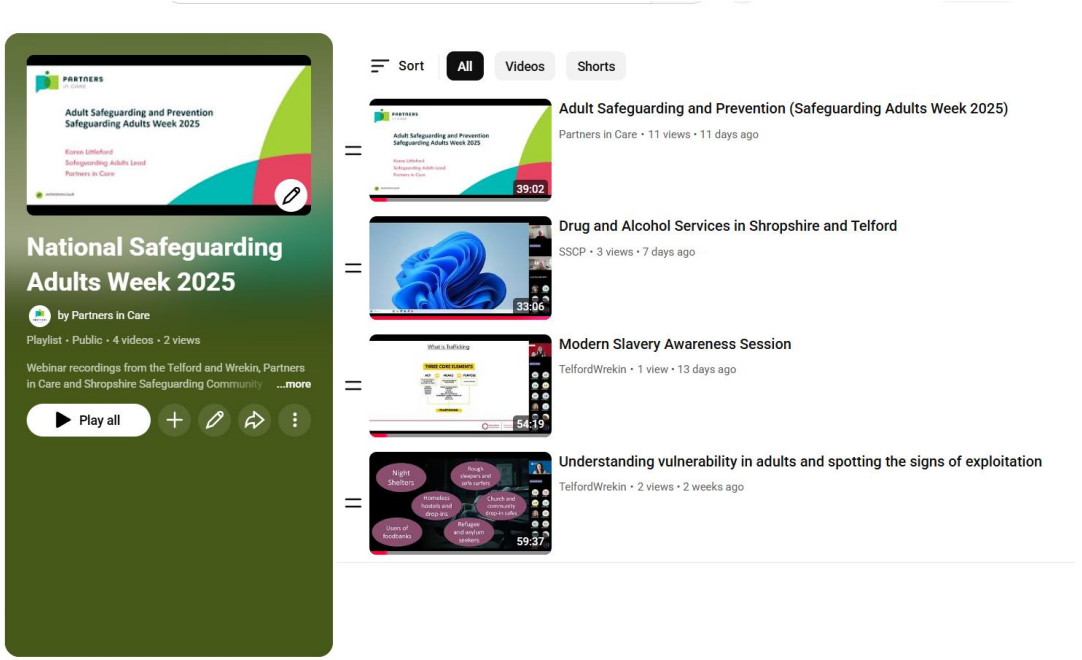
https://padlet.com/klittleford2/partners-in-care-mca-and-dols-webinar-and-newsletter-resourc-e7qspc6fy3mmze8w

Safeguarding Adults Week Event 2026 – November 16th - 20th

Previous Event Recordings

The 2025 resources and webinar recording can be accessed on Padlet here.

You can watch the events from Shropshire and Telford and Wrekin or the Partners in Care YouTube channel 2024 here and 2025 here



Partners in Care YouTube Channel -

Playlists

A-Z

Adult Safeguarding
Real Safeguarding Stories · Playlist
View full playlist

Adult Safeguarding
Public · Playlist
View full playlist

Adult Safeguarding and Homelessness
Public · Playlist
View full playlist

Adults who Self-Neglect or Hoard
Public · Playlist
View full playlist

Advocacy
Public · Playlist
View full playlist

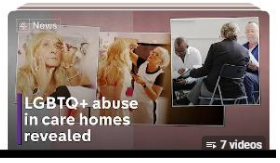
County Lines and Cuckooing/Home Takeover
Public · Playlist
View full playlist

CQC Out of Sight report one year on Response Event by CoProduce Care
Public · Playlist
View full playlist

Cyber Crime
Public · Playlist
View full playlist

Data Security Protection Toolkit (DSPT)
Unlisted · Playlist
View full playlist

Dementia
Public · Playlist
View full playlist



Domestic Abuse: It Happens To Us Too' animation BSL version Domestic Abuse Playlist) here

Playlists menu https://www.youtube.com/@partnersincare8598/playlists

PARTNERS
in CARE

01743 860011

info@partnersincare.org.uk

partnersincare.org.uk

Partners in Care (Shropshire, Telford and Wrekin)
Registered in England & Wales No: 04660475.
Registered address: 6 The Farriers, Annscroft, Shrewsbury, Shropshire SY5 8AN