



Safeguarding Adults Forum December 2024

Karen Littleford
Safeguarding Adults Lead
Partners in Care

Next Safeguarding Adults Forum Date



Online – Zoom (9:30am - 12:30pm)

Thursday 20th March 2025

You can book your place [here](#)



Agenda

Update - Pilot Safeguarding Referral Online Portal - Lisa Millman, Self Service Social Work Lead, Telford and Wrekin Council

Key Themes from a PhD Research Study with Social Care Practitioners about their Experiences of the Mental Capacity Act and Consent - Jay Kirkham (PhD Candidate Keele University Law School)

New Animation – Home Takeover (Cuckooing) - Targeted and Trapped

Learning from Safeguarding Adults Reviews and Domestic Homicide Reviews
Lisa Gardner (Development Officer, Shropshire Safeguarding Community Partnership) and Lisa Jones (Telford and Wrekin Safeguarding Board Manager, Telford and Wrekin Safeguarding Partnership)

Second National Analysis of Safeguarding Adult Reviews Headlines for Adult Social Care – Karen Littleford (Safeguarding Adults Lead, Partners in Care)

Resources and Webinars - Karen Littleford (Safeguarding Adults Lead, Partners in Care)



Update - Pilot Safeguarding Referral Online Portal - Lisa Millman, Self Service Social Work Lead, Telford and Wrekin Council



Update - There is a delay to the introduction of the self-service Portal and Partners in Care will update providers when the launch date is known.

**Key Themes from a PhD
Research Study with
Social Care Practitioners
about their Experiences
of the Mental Capacity
Act and Consent - Jay
Kirkham (PhD Candidate
Keele University, Law
School)**



Consent and the Mental Capacity Act 2005: Exploring the Legal Understanding of Social Care Practitioners

Jay Kirkham

Final Year PhD Candidate

Keele University School of Law

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Research Design and Research Questions

(Crotty, 2015)



- Epistemology: Social Constructionism (Berger & Luckmann, 1966)
- Theoretical perspective: Heideggerian Phenomenology
- Methodology: Legal Consciousness (Ewick & Silbey, 1998)
- Method:
 - Qualitative Episodic/Experiential Narrative Interviews (Squire, 2013)
 - Reflexive Thematic Analysis (Braun & Clarke, 2021)
 - Auto-Ethnography (Ellis & Bochner, 2016)



Episodic narrative interviews: 18 Participants

Type of Organisations	Numbers interviewed from type of organisation		Role/Job Title	Number interviewed from each role
Learning disability	3 people		Managers	4
Domiciliary Care	3 people		Social Care Workers and Healthcare Assistants	6
Hospital	1 person		Clinical or Specialist Lead Nurses	4
Nursing/Care or Residential Homes	11 people		Care Leads (not nursing)	4
Total	18			18

Research Questions

- How do social care practitioners feel about the Mental Capacity Act?
- Why do they defer mental capacity decision-making to others?
- Does their understanding of consent influence their mental capacity assessments?
- What training do social care practitioners feel they need to enhance their legal literacy around the Mental Capacity Act 2005?



6 Key Initial Findings:

- (1) **Legal Awareness** was **Decision Specific** not due to Practitioner experience (Substantial/Significant Decisions versus Day to Day/Experiential Decisions)
- (2) **Legal Consciousness** for some and **Legal Unconsciousness** for others (Managers and Leaders differed from frontline Care Workers)
- (3) Things that **support or hinder** capacity assessments are well documented (Person-centred care, collaboration with others and organisation/systems)
- (4) **Consent** and the ethos of the MCA was understood and applied by everyone
- (5) Only 1 out of 17 participants knew about ss.27-29 **Excluded decisions**
- (6) Online learning (this refers to *eLearning* rather than live online training sessions) was disliked with **face to face learning** the gold standard



Legal Consciousness and the MCA

- Before the law
- Legally Conscious or Legally Unconscious
- Driven by Decisions not Experience
- Embedded values of person-centred care
- Embedded human rights and MCA principles



Consent and Excluded Decisions

- Consent was well understood
- Evidence of embedded values by all
- Excluded decisions and best interests
- Implications



Practitioner Experiences and Learning

- Relationships were fundamental to shaping the MCA experience
- Relationships of trust with individuals and their families
- Collaboration with professionals and the team around the individual
- Information sharing and accountability with respect
- MCA learning with others, shadowing and sharing experiences face to face and limited online learning (eLearning)



References

- Berger, P. and Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. London: Penguin Books Limited
- Braun, V. and Clarke, V. (2022) *Thematic analysis : a practical guide to understanding and doing*. London: SAGE Publications
- Crotty, M. (2015) *The Foundations of Social Research: Meaning and Perspective in the Research Process*. London: SAGE Publications Limited
- Dreyfus, H. (1991) *Being-in-the-world : a commentary on Heidegger's being and time, division I*. Cambridge, Mass: MIT Press
- Ellis, C. and Bochner, A. (2016) *Evocative Autoethnography: Writing Lives and Telling Stories*. Abingdon: Routledge
- Ewick, P. and Silbey, S. (1998) *The Common Place of Law: Stories from Everyday Life*. Chicago: University of Chicago Press
- Käufer, S. and Chemero, A. (2021) *Phenomenology: An Introduction*, 2nd ed. Cambridge: Polity Press
- Squire, C. (2013) *From Experience Centred to Socioculturally-oriented approaches to narrative*, in Andrews, Quire and Tamboukou (Eds) *Doing Narrative Research*, 2nd ed, London: Sage Publications Limited



Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews in Telford and Shropshire

December 2024

Lisa Gardner – Development Officer, Shropshire Safeguarding Community Partnership

Lisa Jones – Safeguarding Adults Board Manager, Telford and Wrekin Safeguarding Partnership

Legal basis for Safeguarding Adults Reviews (SAR's)

Safeguarding Adults Review criteria is contained in section 44 of the Care Act 2014 which states:

A Safeguarding Adult Board (SAB) must review a case involving an adult in its area with care and support needs if there is concern about how partners worked together to safeguarding the adult if:

- The adult has died (or the adult is still alive), and*
- the SAB suspects there has been serious abuse of neglect*



Telford: Email partnerships@telford.gov.uk and the relevant form will be sent to you for completion

welcome

SSCP Business Unit Newsletter - October 2024, Part One

Welcome to the second edition of the SSCP Business Unit newsletter! We thought it would be better, rather than sending several separate e-mails that we try and combine them all together into an easily...

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- Helping to Keep Communities Safe in Shropshire Resources
- Learning Briefings
- Statutory Case Reviews
- Learning & Development
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Frequently Asked Questions for Professionals



Information For Communities / Parents / Carers / Children & Young People / Adults with Care and Support Needs



Safeguarding Definitions and Contacts



Shropshire Safeguarding Community Partnership

What is the Shropshire Safeguarding Community Partnership?



Threshold Documents



Upcoming Events



Adult Safeguarding and Protection Practice



Child Safeguarding and Protection Practice

<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/#>

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<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/safeguarding-adult-reviews/>

Safeguarding Adult Reviews

Home > About us > Statutory case reviews > More in Safeguarding Adult Reviews ▾

What is a Safeguarding Adult Review?

A Safeguarding Adult Review looks at how well everyone worked together to support and protect an adult with care and support needs from serious harm.

Why do we do Safeguarding Adult Reviews?

A Review should aim to learn lessons from what happened to the adult and the Shropshire Safeguarding Community Partnership should make sure that the lessons change what happens in the future.

The Care Act 2014 says that we must complete Safeguarding Adult Reviews of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) when:

- There is a "reasonable cause for concern" about how professionals have worked together; AND
- The adult has died and it is known or suspected that their death was because of abuse or neglect; OR
- The adult is still alive and it is known or suspected that the adult has experienced serious abuse or neglect.

Serious abuse or neglect is when the adult:

- would have been likely to have died but for an intervention; or
- has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) because of the abuse or neglect.

If you're aware of a case which meets the above criteria please refer to the guidance in the related documents section of this page and make a referral for a Safeguarding Adult Review as necessary. The Shropshire Safeguarding Community Partnership can arrange a review of a case of an adult with care and support needs if it wants to even if the above points do not apply.

How do we do Safeguarding Adult Reviews?

Related Links

- > Published Safeguarding Adult Reviews
- > Shropshire Safeguarding Adult Review Learning Briefings
- > Other Areas Safeguarding Adult Reviews
- > Executive Function - Animation

Related Documents

- > Statutory Learning Reviews In Shropshire
- > Local Child Safeguarding Practice Reviews
- > Safeguarding Adult Reviews And Domestic Homicide Reviews
- > Shropshire Local Child Safeguarding Practice Review, Safeguarding Adult Review & Domestic Homicide Review Process Flowchart
- > Safeguarding Adult Reviews Information For Individuals
- > What Is A Safeguarding Adult Review Information For Families Friends And Carers
- > West Midlands Regional Safeguarding Adult Review (SAR) Guidance
- > Referral For Consideration Of A Safeguarding Adult Review



<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/safeguarding-adult-reviews/>

Legal basis for Domestic Homicide Reviews (DHR's)

Domestic Homicide Reviews (DHR's) were established on a statutory basis under the Domestic Violence, Crime and Victims Act 2004. A DHR is a:

Review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by – someone they were related to, in an intimate personal relationship with, or a member of the same household.



There is refreshed guidance due from government which will change the name of these reviews to "**Domestic Abuse Related Death Reviews**" this is to ensure that the definition covers suicide as well as homicide.

To make a referral:

Telford: Email partnerships@telford.gov.uk and the relevant form will be sent to you for completion

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<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/domestic-homicide-reviews/>

Domestic Homicide Reviews

Home > About us > Statutory case reviews > Domestic Homicide Reviews

A domestic homicide review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

- a) a person to whom he/she was related or with whom he was or had been in an intimate personal relationship, or
- b) a member of the same household as himself, held with a view to identifying the lessons to be learnt from the death.

The purpose of a DHR is to:

- establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
 - identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
 - apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
 - prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;
 - contribute to a better understanding of the nature of domestic violence and abuse; and
 - highlight good practice.
- It is, however, important to note that reviews should not simply examine the conduct of professionals and agencies. Reviews should illuminate the past to make the future safer and it follows therefore that reviews should be professionally curious, find the trail of abuse and identify which agencies had contact with the victim, perpetrator or family and which agencies were in contact with each other. From this position, appropriate solutions can be recommended to help recognise abuse and either signpost victims to suitable support or design safe interventions.
- The narrative of each review should articulate the life through the eyes of the victim (and their children) and talking to those around the victim including family, friends, neighbours, community members and professionals. This will help reviewers to understand the victim's reality; to identify any barriers the victim faced to reporting abuse and learning why any interventions did not work for them. The key is situating the review in the home, family and community of the victim and exploring everything with an open mind. It will also help understand the context and environment in which professionals made decisions and took (or did not take) actions. This would include, for example, the culture of the organisation, the training the professionals had, the supervision of these professionals, the leadership of agencies and so forth.

Related Links

- > [Domestic Homicide Reviews](#)
- > [Learning from Domestic Homicide Reviews](#)

Related Documents

- > [Multi Agency Statutory Guidance For The Conduct Of Domestic Homicide Reviews](#)
- > [Statutory Learning Reviews In Shropshire Local Child Safeguarding Practice Reviews Safeguarding Adult Reviews And Domestic Homicide Reviews](#)
- > [Referral For Consideration Of A Domestic Homicide Review](#)
- > [Domestic Abuse And Suicide, Learning Briefing](#)



<https://www.shropshiresafeguardingcommunitypartnership.co.uk/about-us/statutory-case-reviews/domestic-homicide-reviews/>

A blue scroll graphic with a white question. The scroll is horizontal and has a dark blue border. The text is white and centered. The scroll has a rolled-up appearance at the top and bottom edges.

**What is the purpose of a SAR or
DHR?**

Why are they carried out?

Local statistics

Referrals since January 2022:

Shropshire

Review type	Number of referrals	Numbers of reviews
DHR	13	8 (3 pended)
SAR	19	9

Telford

Review type	Number of referrals	Numbers of reviews
DHR	8	5
SAR	7	5

Those which have not met the threshold following scoping, but still have learning identified, are progressed outside of formal meetings with final sign off any action plans done through the multi agency panels



Statistics

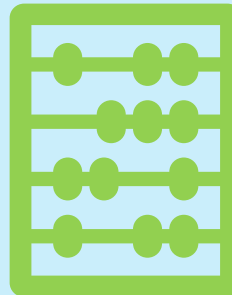


Referrals since January 2022:

Shropshire



DHR's	3	8	
SAR's	11	8	
Age	18-35	36-56	57-85
DHR's	4	4	3
SAR's	2	5	12



Telford



DHR's	2	3	
SAR's	2	3	
Age	18-35	36-56	57-85
DHR's	1	3	1
SAR's	1	2	2

Some themes and trends

Shropshire SAR's

Care provided by family members/friends (5)

Self neglect (5)

Did Not Attend/Was Not Brought to
Appointments/Disengagement (4)

Substance/Alcohol Misuse (4)

Care provided by care staff (2)

Under weight (2)

Obesity (2)

Holistic thinking across all incidents (8)

Telford SAR's

Care provided by family members/friends (6)

Self neglect (5)

Did Not Attend/Was Not Brought to
Appointments/Disengagement (4)

Substance/Alcohol Misuse (3)

Care provided by care staff (3)

Under weight (2)

Obesity (1)

Shropshire DHR's

Mental Health (adult) (6)

Substance/Alcohol Misuse (5)

Separated relationship status (3)

Holistic thinking across all incidents (8)

Telford DHR's

Mental Health (adult) (6)

Substance/Alcohol Misuse (5)

Separated relationship status (3)

Holistic thinking across all incidents (2)

What Learning from reviews we are seeing?

Male Victims
of Domestic
Abuse are
not being
recognised

Multi-
disciplinary
meetings are
not being
called

Informal
carers are
not identified
and
supported

A whole
family
approach is
not taken to
situations

Drug and
alcohol
services are
not consulted if
people don't
engage

Mental Capacity and Alcohol



When someone has an addiction, it will impact their ability to put their decisions into action.

Generally, someone who is alcohol dependent may well be able to “talk the talk but not walk the walk”.

This relates to someone’s executive functioning.

When assessing the capacity of someone who might have executive dysfunction you should include observation of their decision-making ability rather than just talking to them.

Follow this up with a discussion to see if they can use and weigh up the information as well as understand any risk encountered.

Mental capacity assessments with dependent drinkers are "Marathons not sprints"



welcome

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1. Background

Mr M was a 74-year-old man who died in September of 2020 from Sepsis.

Mr M had been laying on the floor for a period of 2 days, he had placed himself on the floor – he had done this previously when depressed.

Mr M had a history of self-neglect when his mental health was deteriorating.

2. Safeguarding Adult Review

Mr M's death met the criteria for a Safeguarding Adult Review.

Mr M had care and support needs, he had died and there were lessons that could be learnt about how agencies had worked together to safeguard him.

The Safeguarding Adult Review can be read [here](#).

3. Recommendations

The Independent author of the Safeguarding Adult Review made a number of Multi-agency recommendations which have been put into an action plan that will be monitored by the Partnerships Joint Case Review Group.

There were also some learning points for agencies and practitioners that are highlighted in this learning briefing.

8. Carers

Mr M's wife like many people cared for her husband on an informal basis, but she did not receive a carers assessment and was not offered one.

Had a carers assessment been completed other services could have been offered which if accepted may have been positive in this situation.

Practitioners should identify informal carers and offer carers assessments.



4. Partnership working

There were times when Practitioners were working in isolation and Mr M and his wife did not receive a co-ordinated and timely response.

Having a multi-disciplinary team meeting at the earliest opportunity will help practitioners to work together to support adults who self-neglect.

Guidance on calling a Multi-disciplinary meeting can be found in [Shropshire's Self-Neglect Guidance](#)

7. Supervision and learning

Staff supervision should help build professional development by including:

- Case supervision
- Practice observation
- Reflective practice

There should also be opportunity for Shadowing, mentoring and coaching

6. Responding to Self-Neglect

[Responding to Self-neglect in Shropshire](#) is a practitioner's guide to working with people who self-neglect.

This guidance should be used alongside the [Working with Risk Guidance](#).

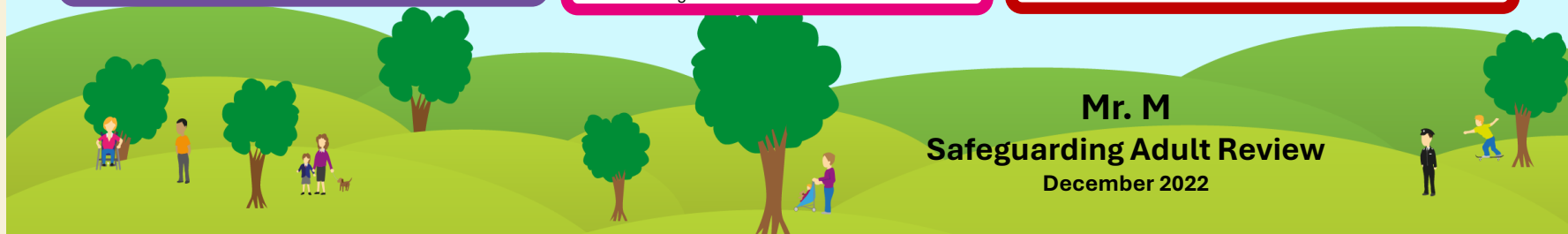
These guides will support practitioners when assessing risk and making decisions with people who self-neglect.

5. Early Warning Signs

Sometimes called "relapse signatures" are the individual signs a person might show when they are becoming unwell again. Knowing what these are and how to respond is important. Mr M had been known to lie on the floor for long periods of time when he was suffering with poor mental health.

Agencies should record when a person has a behaviour that indicates a decline in their mental health and what has helped previously. This will promote earlier positive change

Mr. M
Safeguarding Adult Review
December 2022





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Training

Training and events

Telford and Wrekin Safeguarding Partnership (TWSP) provides a range of training courses and events for all practitioners who work with children or vulnerable adults within Telford and Wrekin, including volunteers. The TWSP training pool is made up of experienced safeguarding professionals, and, in conjunction with the Partnership Team and Telford & Wrekin Council's Organisational Development Team, are responsible for developing and delivering training.

If you have any questions about our training offer or would like further information, please email partnerships@telford.gov.uk

Adults related training



Childrens related training



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7 minute briefings](#)



Key links

Published reviews: Community Safety Partnership (CSP) website -

www.safertelford.org.uk

Learning and training section:

www.telfordsafeguardingpartnership.org.uk



Second National Analysis of Safeguarding Adult Reviews Headlines for Adult Social Care

Karen Littleford,
Safeguarding Adults Lead,
Partners in Care



Observations on definitions of abuse or neglect

The first national analysis of SARs highlighted the difficulty of distinguishing between neglect/acts of omission and organisational abuse. The data in this second national analysis suggest that **the distinction remains insufficient precise, potentially leading to the under-reporting of organisational abuse.** There is also a challenge with recording acts of omission.

Improvement priority four:

DHSC should consult with the National Network for SAB Chairs, ADASS, LGA and NHS England on **potential revisions to the definitions of abuse/neglect contained within the statutory guidance that accompanies the Care Act 2014.**

So What – Social Care?

Challenges with recognising and dealing with organisational abuse issues if not clear in terms of definitions?

Observations on definitions of abuse or neglect

Types of abuse and neglect also overlap. **Modern slavery, which is listed in the statutory guidance as a separate type of abuse/neglect, is criminal, financial and, sometimes, sexual exploitation.**

Cuckooing is an increasing feature in SARs and is a form of exploitation. To promote more explicit identification of the different forms of exploitation identified in SARs, **revised guidance should identify exploitation as a distinct type of abuse/neglect, with different sub-divisions to cover financial, criminal and sexual exploitation, and modern slavery.**

Additionally, understanding of domestic abuse has evolved, not least with the passing of the Domestic Abuse Act 2021.

So What – Social Care?

To be aware of the issues around Modern Slavery not just from traditional safeguarding perspective but also in terms of Modern Slavery involving international staff.

Ensuring there is knowledge around understanding of domestic abuse, definitions etc. have evolved, not least with the passing of the Domestic Abuse Act 2021.

Ensure staff, especially in the community are aware of forms of exploitation including **'Home Takeover or Cuckooing'** and associated issues around County Lines .



Safe care at home

Comparison of the percentages between the first and second national analyses identifies **a rise in cases featuring partners, relatives, friends or unpaid carers from 19 per cent to 25 per cent, endorsing the recent policy emphasis on safe care at home.** Perpetrators classed as ‘other professionals’ (all practitioners apart from care workers or care provider agencies) have increased from 12 per cent to 28 per cent and there was a marginal increase in cases involving social contacts as perpetrators (from nine per cent to 11 per cent). **However, there was a small decrease in the frequency with which care workers / care providers were identified as the perpetrator (down from 30 per cent to 28 per cent).**

So What – Social Care?

Abuse in the adult's own home by care workers in SAR's was reduced slightly in this analysis.

Abuse by ‘other professionals (not care workers) increased – do care staff know what to do if they are concerned about ‘other professionals’?

Abuse by friends, partners, relatives or unpaid carers increased. Be aware in domiciliary service contexts.

Safe care at home

Findings on organisational support have identified shortcomings in the offer and completion of carer assessments and reliance or overdependence on family carers. There were instances also where situations were seen through a lens of carer stress rather than curiosity about relationship dynamics between the carer and the cared-for person, and about whether there was evidence of abuse/neglect.

An absence of professional curiosity and avoidance of difficult discussions can result in risk not being recognised or addressed.

Hospital discharge pressures could result in unsafe arrangements for care at home and there was some evidence of practitioners not feeling supported to raise concerns.

conversations What – Social Care?

Are care agencies in the community equipped to signpost informal, unpaid carers to support locally?

Are staff able to signpost for carers assessments to the local authority?

Are care agencies able to identify risk regarding the relationship between the informal, unpaid carer and the adult they are supporting?

Are staff equipped to have 'difficult conversations'? See *next slide*.



1. What is it...

Good Support & Professional Curiosity sometimes involves difficult conversations.

Try to explore and understand rather than take on face value – find the evidence and signs that things are not right

2. Can happen when.....

- Minimising or avoiding a concern
- Outcome the individual doesn't want
- Complaint about a decision or care
- Person/carer engages in challenging behaviour
- Involvement of significant others

3. Preparation.....

- The key points, the plan you want to convey
- Keep things simple, the reason for the discussion and what you hope to achieve by the end
- Enter with some ideas for possible solutions
- Be prepared for disagreement – have facts and alternative solutions, evidence to support argument
- Set up a time in a private place

7. 7 Top Tips...

1. A clear framework: purpose
2. Don't start with problem solving
3. Listen without judging
4. Focus on the needs of the person
5. Agree small steps together
6. More than one conversation
7. **Reflection**



6. Closing the Conversation...

- Summarise
- Outcome
- Actions

5. Barriers to communication...

- Significant others
- Time, opportunity,
- Lack of confidence
- Who has the conversation
- Language barriers
- Capacity & understanding

4. Basic Interpersonal Skills....

- Listen – try not to interrupt
- Open (and direct) questions
- Empathy
- Remain open to other persons point of view
- Non judgemental (but curious)
- Be diplomatic, stay objective, stay calm



Safe care at home

Embedded within this focus on safe care at home is **alertness to domestic abuse and coercive and controlling behaviour**. Domestic abuse in this second national analysis is the third most frequently reviewed types of abuse and neglect, after self-neglect and neglect/acts of omission. Despite this, **domestic abuse was not consistently recognised as an adult safeguarding issue**, being sometimes taken only through a Multi-Agency Risk Assessment Conference (MARAC) process.

Improvement priority eight: SABs should consider seeking assurance about local authority performance on **carer assessments**.

Improvement priority nine: SABs should consider seeking assurance about levels of oversight of care at home and should ensure partnership working operationally and strategically between community safety and adult safeguarding practitioners and managers.

So What – Social Care?

Are staff teams working in the community aware of the **indicators of domestic abuse**?

How will the Safeguarding Partnerships address the questions raised?

- SSCP and TWSP will be addressing these questions at a Strategic level (Carers Assessments etc.)



Power of entry

Five percent of SARs in the overall sample featured concerns about denied and/or difficult access, and the absence of a power of entry.

The cut-off date for SARs in this sample was March 2023, **“right care, right person” has now been implemented by different police forces.** For the police to use their power of entry (section 17 Police and Criminal Evidence Act 1984), there must be an immediate threat to life, limb or property. Not all cases of denied access will meet this threshold and provisions available in the Mental Health Act 1983 might not be applicable to the circumstances. **There remains, therefore, a gap in adult safeguarding law in England.** Other jurisdictions have shown how providing for a power of entry can be balanced with considerations of human rights. **Several cases of denied access connect with the government’s priority to promote safe care at home.** The question to answer is not the frequency with which such a power might be used but rather whether there are cases where the absence of such a provision hinders practitioners in their duty of care to ensure that an individual is not subjected to abuse or neglect.

Power of Entry

Evident in some cases was skilled work by practitioners to navigate the challenges of ensuring cases, often in the face of abusive and aggressive behaviour. Despite such skilled work, access was not always obtained. SARs also recognised the impact on practitioners of intimidation and sometimes the insufficient protection that they experienced.

Improvement priority 10: DHSC should consider recommending legislation for an adult safeguarding power of entry along the lines of the provision available in Wales and Scotland. DHSC should also consider the inclusion of social workers in the protections afforded by the Assaults on Emergency Workers (Offences) Act 2018.



So What – Social Care?

How will care providers especially domiciliary care providers keep up to date with proposed changes to Power of Entry? (Partners in Care will update if there are any changes to legislation as recommended in the SAR Analysis).

About the individuals in SAR's

- 82% of adults were deceased – the majority died from natural causes
- 44% female, 49% male, 7% other/not specified
- **Mental health (72%), chronic physical health (63%), substance misuse (46%), impaired mobility (27%) - all increased compared to the first national review**
- 47% lived alone, 30% in a group setting, 10% street homeless
- **9% had experience of care as a child or young person**
- The **most common perpetrator was 'self' (76%)**; 28% were care providers and 28% were other professionals
- **Most abuse occurred in the home (44% own home)** but there were also cases in hospitals (9%), and care homes (20%)
- 6% of SARs featured resident on resident abuse
- Many protected characteristics were not recorded: ethnicity, nationality, religion, sexuality

So What – Social Care?

- The majority of SAR's were about **adults who died** - similar to the first National SAR analysis - how are we learning from cases in social care?
- Male/female split similar to first national analysis.
- Focused on transitional safeguarding (a DHSC requirement) - **9% had experience of care as a child.**
- **Most common perpetrator was self (76%)**

Types of abuse/neglect

(from the 652 SAR's)

- **Marked increase in –**
 - Self-neglect (45% to 60%)
 - Neglect/abuse by omission (37% to 46%)
 - Domestic abuse (10% to 16%)
- **Moderate increase in –**
 - Sexual exploitation (2% to 4%)
 - Discriminatory abuse (1% to 2%)
- **Marked fall –**
 - Physical abuse (19% to 14%)
 - Psychological abuse (8% to 4%)
 - Organisational abuse (14% to 4%)

TYPE OF ABUSE / NEGLECT	%
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

(Braye and Preston-Shoot, 2024)

Types of abuse/neglect

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(Braye and Preston-Shoot, 2024)

So What – Social Care?

- Even more self-neglect in the second analysis, significant rise from 45% to 60%. **How well equipped are social care to deal with recognising and responding to self-neglect?**
- **Domestic abuse more of an issue**, is this about Domestic Abuse Act, pandemic etc.?
- Fall in organisational abuse SARS – DHSC were asked to consider when neglect or acts of omission are actually organisational abuse. Asked DHSC to review definitions of organisational abuse.
- Certain types of abuse occurred in clusters: e.g. sexual abuse with sexual exploitation; physical with psychological and emotional abuse. Others occurred in isolation (e.g. self-neglect; neglect/omission). **How familiar are services with recognising and responding to exploitation?**

Good practice themes

- ✓ Compassion, kindness, care, empathy and sensitivity of professionals were all noted, along with commitment, dedication, professionalism, skill and diligence.
- ✓ Examples of practitioners able to see beyond the presenting problem, and to find and respect the person beneath.
- ✓ Practitioners going above and beyond; able to 'think outside of the box' to find solutions, sometimes in the most challenging circumstances.
- ✓ Making safeguarding personal to the adult, shown in the ways in which practitioners/agencies had ascertained and paid attention to an individual's wishes and feelings.
- ✓ **Showing patience, persistence and tenacity in engaging with people who were reluctant to work with professionals; with personalised approaches to contact/meetings, home visits and other assertive outreach approaches.**
- ✓ Practitioners building trusted, trauma-informed relationships; using these to support at times of crisis and advocate for the individual, including to other services.

(Braye and Preston-Shoot, 2024)

So What – Social Care?

Direct work - A quarter of reviews (from 229 reviews) good practice risk assessment (31%), MSP was done well (29%), how sensitively abuse was recognised (23%), perseverance with the 'reluctant person' (22%), attention to needs - mental health needs, medical needs, health conditions (21%).

How can social care build on these areas – Making Safeguarding Personal for instance?

How can providers engage reluctant individuals?

Shortcomings: key themes

- **Professional culture and negative attitudes: risky/distressed behaviour viewed as 'lifestyle choice', attention-seeking, noncompliance/engagement. Resignation & low expectation of change.**
- **Safeguarding that was not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs left out of decisions/discussions about their support.**
- Failure to recognise the significance of repeated patterns of engagement followed by disengagement. Some agencies lacked flexibility in their expectations/approach for engagement.
- **Transition for young people to adult services lacked coordinated assessment and planning, leading to a reduction in support.**
- Multiple SARs noted shortcomings in relation to risk; **absence of risk assessment was common.**
- **Uncertainty about when and how to share information without consent; and examples of where key information had not been shared with other agencies as it was viewed too sensitive.**
- SARs show there is a significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding.

(Braye and Preston-Shoot, 2024)

So What – Social Care?

From 229 SARS - more comments about practice shortcomings, **risk management (82%) was the biggest shortcoming, risk not addressed.**

Lack of attention to MCA 58%

Lack of professional curiosity (44%).

Transitional safeguarding lacking

Organisational features - 23% staff lacked training in key skills needed.

How can providers develop professionally curious workforces?

National legal, policy & financial context

- Positive impact of the “everyone in” response to COVID-19 – example of what can be achieved with a funded national policy initiative
- **22% of SAR’s commented of shortcomings from the pandemic: the impact on services, poverty, unemployment, loss of routine, loss of social contact, and reduced access to support**
- **Economic context, legal frameworks, national policy and commissioning** all featured as having negative impacts
- **Interconnected features** compounded the difficulties: **responses to the pandemic alongside the impact of austerity and available legal powers; changes to NHS or social care policy in the context of austerity**
- **Deterioration in people’s lived experience - the impact of welfare benefit rules, e.g. the bedroom tax, the impact of poverty and inequality on disabled people and on people from minority groups**
- **The absence of an adult safeguarding power of entry in England**, unlike in Wales and in Scotland

Features of the national context	% of SARs
Covid-19 pandemic	22%
National economic context	8%
Legal powers and Duties	7%
Health/social care policy	5%
National commissioning	3%
Statutory guidance	2%
Immigration policy	<1%
Regulation of services	<1%

(Braye and Preston-Shoot, 2024)

Reference and Resources

Reference:

Preston-Shoot, M. and Braye, S. (2024) *Second National Analysis of Safeguarding Adult Reviews*. London: LGA, Adass, Partners in Health.

Resources –

Chief Social Worker for Adults, Research in Practice, the Association of Directors of Adult Social Services British Association of Social Workers, Care and Health Improvement Programme, Local Government Association and the NWG Network (no date) *Bridging The Gap Transitional Safeguarding And The Role Of Social Work With Adults*. London: Chief Social Worker for Adults, RiP, ADASS BASW, CHIP, LGA and NWG Network.

https://assets.publishing.service.gov.uk/media/60b108a88fa8f5489192fdb3/dhsc_transitional_safeguarding_report_bridging_the_gap_web.pdf

Second national analysis of Safeguarding Adult Reviews: April 2019 - March 2023

- **Stage 1 report Case characteristics; nature of the abuse and neglect; SAR reviewing process** Stage one of the analysis considers the quantitative data from 652 review reports, reporting on the characteristics of the individuals involved, the types of abuse and neglect they experienced, and the nature of the SAR reviewing process. [Download the Stage 1 report](#)
- **Stage 2 report Analysis of learning** Stage two focuses on the in-depth, detailed learning identified in a stratified sample of 229 SAR reports. [Download the Stage 2 report](#)
- **Stage 3 report Conclusions and improvement priorities** The final stage of the analysis draws together conclusions from the analysis overall and identifies priorities for sector-led improvement. [Download the Stage 3 report](#)
Executive summary This executive summary identifies the headline findings, drawing on the detail contained in three main reports. It also includes six briefings aimed at different key stakeholders, including individuals and families, practitioners, elected members, SAB chairs and managers, senior leaders and SAB chairs and SARs authors. [Read the executive summary](#)





Webinars, Policy, Guidance, Resources and Reports



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Safeguarding Adults Week

Safeguarding Adults Week was a time for organisations to come together to raise awareness of important safeguarding issues. Locally a collaboration between Partners in Care, Telford and Wrekin Safeguarding Partnership and the Shropshire Safeguarding Community Partnership saw events taking place to raise awareness of safeguarding issues.

The event recordings are available on the Partners in Care YouTube channel [here](#) and resources are on Padlet [here](#)

Subjects:

- Establishing Professional Boundaries
- Reducing inappropriate medication for people within the Learning Disability and / or Autism Communities
- Learning from Safeguarding Adults Reviews and Domestic Homicide Review
- Hoarding Awareness
- Exploitation and Adult Safeguarding

National Safeguarding Adults Week 2024 Playlist on YouTube



Partners in Care

Establishing Professional Boundaries Safeguarding Adults Week 2024

Karen Littleford
Safeguarding Adults Lead
Partners in Care

National Safeguarding Adults Week 2024

by Partners in Care

Playlist • Public • 9 videos • 137 views

Play all

- Establishing Professional Boundaries Safeguarding Adults Week 2024**
Partners in Care • 118 views • 2 weeks ago
- Exploitation and Adult Safeguarding - National Safeguarding Adults Week 2024**
Partners in Care • 138 views • 1 month ago
- Legal basis for Safeguarding Adults Reviews (SARs)**
Safeguarding Adults Review criteria is contained in section 44 of the Care Act 2014 which states:
A Safeguarding Adults Board (SAB) must review a case involving an adult in its area with care and support needs if there is concern about how partners worked together in safeguarding the adult.
• The adult has died (or the adult is still alive) and
• The SAB suspects there has been serious abuse or neglect
Telford, Shropshire Council (shropshire.gov.uk) and the review form will be completed.
ShropshireCouncil • 4 views • 5 days ago
- Hoarding Awareness Seminar**
TelfordWrekin • 15 views • 13 days ago
- Reducing inappropriate medication for people within the Learning Disability and/or Autism Community**
TelfordWrekin • 21 views • 2 weeks ago

<https://www.youtube.com/playlist?list=PLR7h4BzDDmvSX042Ydf-T1obOwbFI5pJv>

National Safeguarding Adults Week 2024 – Resources and PowerPoints



Padlet

Karen Littleford • 20d

National Safeguarding Adults Week 2024

Resources for the week in November. This Padlet has been developed/updated by Karen Littleford, Safeguarding Adults Lead, Partners in Care. The Padlet will be updated with relevant information by Karen (please note external resource inclusion or links does not mean endorsement of content by the event organisers).

- Programme 2024**
 - National Safeguarding Adults Week Programme of Events 2024
- Webinar PowerPoints and Resources**
 - Learning from Safeguarding Adults Reviews and Domestic Homicide Reviews
 - Learning from Safeguarding Adult Reviews and Domestic Homicide Reviews in Telford and Shropshire
 - 20th November 2024
 - Isa Gardner – Development Officer, Shropshire Safeguarding Community Partnership
 - Isa Jones – Safeguarding Adults Board Manager, Telford and Wrekin Partnership
 - PDF
 - Learning from SAR's and DHR's WEB
 - Exploitation and Adult Safeguarding
- Webinar Recordings**
 - National Safeguarding Adults Week 2024 Playlist on YouTube
 - Exploration and Adult Safeguarding National Safeguarding Adults Week 2024
 - Karen Littleford Safeguarding Adults Lead Partners in Care
 - YouTube
 - National Safeguarding Adults Week 2024
- Events and Training**
 - Professional Boundaries Training with Partners in Care
 - partnersincare.org.uk
 - Professional Boundaries
- Safeguarding Animations**
 - Cuckooing - Home Takeover
 - YouTube
 - Cuckooing - Home Takeover
 - Domestic Abuse & Disability: It Happens To Us Too (with subtitles) (Shropshire & Telford and Wrekin)

<https://padlet.com/klittleford2/national-safeguarding-adults-week-2024-f9wwhs623heme402>



Mental Capacity Law, Sexual Relationships and Intimacy – in Conversation with Beverley Clough and Laura Pritchard-Jones The Editors of a new book

- In this ‘in conversation’ with, Alex Ruck Keene talks to [Professor Beverley Clough](#) and [Dr Laura Pritchard-Jones](#) about the edited collection that they have recently pulled together on **Mental Capacity Law, Sexual Relationships and Intimacy**. They talk about the background to the book, including the [JB](#) case, and the different perspectives that it brings to the – possibly? – intractable problems that are encountered when the law reaches into the bedroom. You can watch it here - <https://www.mentalcapacitylawandpolicy.org.uk/mental-capacity-law-sexual-relationships-and-intimacy-in-conversation-with-beverley-clough-and-laura-pritchard-jones/>

Book available [here](#) 50% off in December, use code BUP12 at checkout



Calibrating the definition of ill-treatment by reference to the victim: an important clarification from the Court of Appeal (Alex Ruck Keene, 25th October 2024)

- Whorlton Hall hospital supported patients with longstanding learning disabilities and significant additional psychological and behavioural needs, who required specialist care. Some were detained under s.3 Mental Health Act 1983. Over 38 days, an undercover reporter, Olivia Davies, filmed footage of abuse and mistreatment at the hospital for a BBC *Panorama* documentary. In consequence, 9 members of staff were charged; 5 were cleared, and 4 were convicted on a number of counts of ill-treatment of a person in care, contrary to s.20 Criminal Justice and Courts Act 2015. Two of those convicted, Matthew Banner and Paul Bennett, both of whom held senior healthcare roles there, appealed to the Court of Appeal against their convictions. The Court of Appeal's judgment in *R v Banner; R v Bennett* [\[2024\] EWCA Crim 1201](#), provides an important addition to the (small) stock of reported cases concerning **s.20 Criminal Justice and Courts Act 2015**.
- BBC News article about Whorlton Hall [here](#)




Calibrating the definition of ill-treatment by reference to the victim: an important clarification from the Court of Appeal

Alex Ruck Keene Comments that

- “The Court of Appeal’s approach is helpful and important in confirming **that conduct which might on its face appear to be entirely innocent – ‘twanging’ balloons or speaking French – could, depending upon the circumstances, amount to ill-treatment.** There is a separate point, not before the Court of Appeal, as to whether the sentences that both men got (case a suspended sentence of 4 months imprisonment, and unpaid work requirement of 280 hours) appropriately reflects the seriousness of the harm that they caused to AD and LH”.
- Read the full article [here](#)

Webinar Recordings Recently added - Restraint in A Care Setting - What is restraint? Mental Capacity, Sex and Relationships - now available to watch



Partners in Care MCA and DoLS Webinar 8 – Restraint in A Care Setting - What is restraint?

Lorraine Currie,
Mental Capacity Consultant

Mental Capacity & Deprivation of Liberty ...

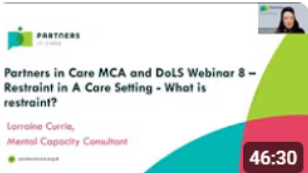
by Partners in Care

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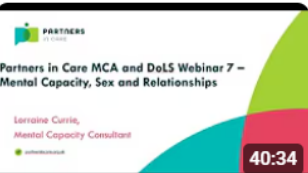
Partners in Care MCA and DoLS Webinar 8 – Restraint in A Care Setting - What is restraint? October 2024

Lorraine Currie,
Mental Capacity Consultant

46:30

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

Partners in Care • 4 views • 2 hours ago



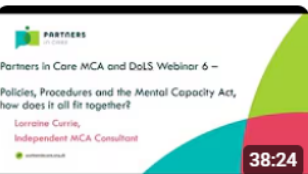
Partners in Care MCA and DoLS Webinar 7 – Mental Capacity, Sex and Relationships

Lorraine Currie,
Mental Capacity Consultant

40:34

Partners in Care MCA and DoLS Webinar 7 – Mental Capacity, Sex and Relationships

Partners in Care • 106 views • 4 months ago



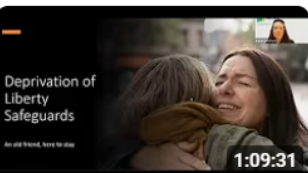
Partners in Care MCA and DoLS Webinar 6 – Policies, Procedures and the Mental Capacity Act, how does it all fit together?

Lorraine Currie,
Independent MCA Consultant

38:24

Policies, Procedures and the Mental Capacity Act, how does it all fit together?

Partners in Care • 136 views • 5 months ago



Deprivation of Liberty Safeguards

1:09:31

Partners in Care MCA and DoLS Webinar 5 – Back to Basics, Deprivation of Liberty Safeguards

Partners in Care • 453 views • 9 months ago



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



Karen Littleford • 12d

Partners in Care MCA and DoLS Webinar and Newsletter Resources

Scroll down in each section to access the resources. Access to these resources is a benefit of attending the live webinar.

Newsletters

- Karen Littleford 2mo: September 2024 - MCA and DoLS Newsletter
- Karen Littleford 4mo: July 2024 MCA/DoLS Newsletter
- Karen Littleford 7mo: March 2024 MCA/DoLS Newsletter

PowerPoint Slides

- Karen Littleford 21d: October 2024 - Restraint in a Care Setting - What is restraint?
- Karen Littleford 4mo: July 2024 - Mental Capacity, Sex and Relationships
- Karen Littleford 7mo: Partners in Care MCA and DoLS Webinar 7 - Mental Capacity, Sex and Relationships

Previous Webinar Recordings (public after 3 months)

- Karen Littleford 21d: Mental Capacity, Sex and Relationships (Webinar 7, July 2024)
- Karen Littleford 5mo: Policies, Procedures and the Mental Capacity Act, how does it all fit together? (Webinar 6, March 2024)

MCA Webinar Flyers


- Karen Littleford 3mo: Webinar 9, November 2024 - Managing Food and Diet. What to do when someone wants to ignore professional advice about their diet - do they have mental capacity to decide?
- Karen Littleford 3mo: Webinar 10, March 2025 - Contact. Managing contact in care settings and what about those challenging situations in the persons

MCA Tools, Templates and Resources

- Karen Littleford 21d: Promoting less restrictive practice: reducing restrictions tool for practitioners (2024)
- Karen Littleford 21d: Promoting less restrictive practice: reducing restrictions tool for practitioners

Other

- Karen Littleford 12d: MCA Guidance MCA



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

MCA Webinar 10 - March 2025 - Contact.

Managing contact in care settings and what about those challenging situations in the persons home? Some thoughts around contact with family and others and the Mental Capacity Act.



- 27th March 2025 11:00am-12:30pm
- £18 per learner (members) £25 (non-member)
- Book [here](#)



**Partners in Care
Mental Capacity Webinar
Series - Webinar 10**
Contact – Managing Contact in Care
Settings and what about those
challenging situations in the persons
home?

A webinar with
Lorraine Currie, Independent Mental
Capacity Consultant

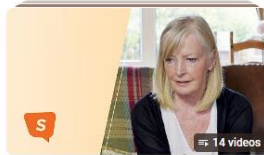
These webinars are an opportunity to upskill around
the topics of Mental Capacity and the Deprivation of
Liberty Safeguards

Partners in Care YouTube Channel -



Playlists

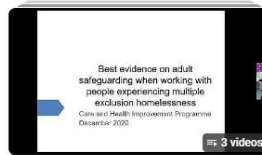
A-Z ▾



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Adult Safeguarding and Homelessness
Public - Playlist
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Adults who Self-Neglect or Hoard
Public - Playlist
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Advocacy
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County Lines and Cuckooing/Home Takeover
Public - Playlist
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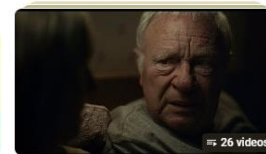
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