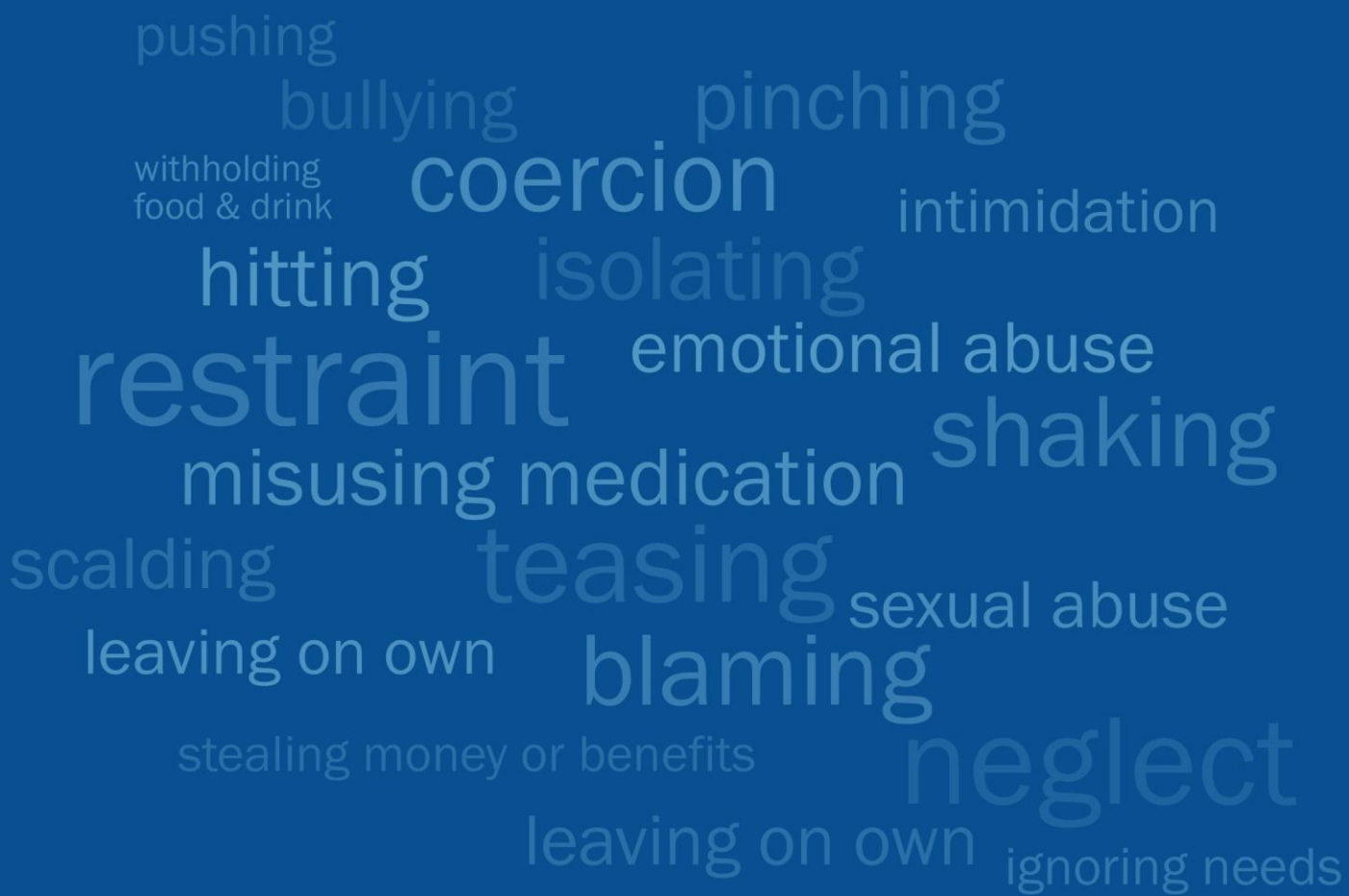
Solihull Safeguarding Adults Board
Protecting Adults Together

SAFEGUARDING ADULT REVIEW

REPORT

John



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1. Introduction

In April 2016 Solihull Safeguarding Adults Board received a request from Solihull Action through Advocacy to arrange an s44 Safeguarding Adults Review due to concerns:

- That John, as a vulnerable adult with learning difficulties, had been living in a risky, potentially abusive environment, for a period of years without adequate review and supervision or alarm being raised;
- Of alleged neglect and abuse in respect of John's mother:
- Of alleged sexual abuse by John's step-father, who also has a serious criminal history and is an alcoholic and
- There is reasonable cause for concern about how the Safeguarding Adult Board member agencies or other persons with relevant functions worked together to safeguard the adult.

This request was not considered until October 2016 so that the current safeguarding s42 enquiry could be completed. A Safeguarding Adult Review would not be initiated whist there is an ongoing enquiry.

The purpose of Safeguarding Adult Reviews under s44 of The Care Act 2014, is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied in practice to prevent similar harm occurring again.

The purpose of the reviews is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial.

2. Background

John is a 37-year old man with a learning disability and autism who is currently settled in a residential care home outside the Borough of Solihull.

Between 2008 and February 2016 John lived with his mother and step-father at 3 addresses in Solihull. John has a large and complex family with 15 siblings, some of which have criminal convictions. John's step-father is a Schedule 1 offender, was convicted of Murder in 1984, served 20-years and since 2015 has had care and support needs.

In 2008 John moved from a residential care home in Birmingham, into the family home to be cared for by his mother. A full explanation as to why or how this came about is not available. This shortfall in recording results in a lack of clarity about events prior to 2008 which have not been able to be established.

Solihull Adult Social Care's first recorded contact with John was in September 2008 when they were approached by John's mother requesting support to find something for him to do during the day. In 2009 a Direct Payment was provided.

Initially the Direct Payment was used to commission support from a Domiciliary Care Agency to support John to access the community, however within 2 months this support was cancelled.

Between 2008 – September 2015 Solihull Adult Social Care's contact with John/his mother was reactive in that the contact was responding to the GP or John's mother when they felt she felt no longer able to care for him. The contact resulted in no change in care or trying to ascertain how John's Direct Payments were being used for him. John's contact with Health professionals in this period was very limited.

The first formal safeguarding activity was in September 2015 and related to concerns that John's mother was verbally and physically abusive to him and was possibly misspending John's Direct Payment. This safeguarding activity was closed quickly due to lack of engagement from the person who raised the concerns so a full enquiry could not be started.

In February 2016 John was placed in a residential care home outside the Borough of Solihull following an incident the night before when it is alleged John assaulted his mother and police were called to the family home.

After John's move from the family home a second safeguarding concern was received in relation to physical, emotional and domestic abuse from John's step-father and one of his brothers. During this enquiry John's sisters raised a further concern that John has been seriously sexually abused by his step-father. To ensure John's safety a safeguarding plan was put in place. In October 2016 this safeguarding activity was closed following the police's decision not to progress with the case and the safeguarding plan was around ensuring John's safety and wellbeing.

John remains in the residential care home outside the Borough of Solihull, is the subject of a DoLS, received support from an Advocate and has accessed a range of health services such as GP, SALT, Psychology, Optician and Dentist. He has also accessed a range of community services such as a hairdresser and various social activities. It is clear, that John is making good progress in his physical and mental health since moving from the family home in February 2016, where he is settled and well supported. He is gaining some

independence and is in regular contact with one of his sisters who is impressed at the care he is receiving now.

3. Methodology

A Panel of experts who had no direct involvement with John, recommended to Solihull Safeguarding Adults Board's Independent Chair that a SAR should be arranged under s44 (4) of the Care Act 2014 and that it should be proportionate with practitioner involvement.

Solihull MBC Adult Social Care, West Midlands Police, Birmingham Cross City CCG, and Solihull Community Housing were asked to carry out an Individual Management Review (IMR) and provide a summary report detailing:

- Examples of good practice,
- Lessons to be learnt for their own organisation,
- Lessons the wider partnership should consider and
- A declaration of how confident the organisation is with today's practice.

When conducting this review organisations were specifically asked to:

- Conduct the review from John's Perspective - What was it like for him? What is the organisations approach and journey to 'personalisation'? How was John at the centre of all agencies interaction, investigations and safeguarding adult concerns? Did he have a 'voice'? Was he seen alone? How is it evidenced he was listened to?

- Consider if there were opportunities to identify Domestic Abuse/Controlling and Cohesive behaviour in this household? How the impact of Domestic Abuse is considered for adults with care and support needs in such a household? Children in households where there is Domestic Abuse are quickly identified and considered – is this as robust where there are adults with care and support needs?

Organisations were also required to identify practitioners and managers to attend a 'Learning Event' independently facilitated, where this case was used as a case study for further learning and action planning.

The SSAB Business Team with Solihull Action through Advocacy sought to ascertain John's perspective.

4. Summary of facts and findings from Agencies Summary Reports

4.1 Significant legislative and context changes during the period 2008-2016:

Between 2008- 2011 Adult Social Care was provided by Solihull NHS Care Trust in agreement with the Local Authority. Solihull Care Trust was one legal entity for the commissioning and provision of health and social care services including social care, mental health services or primary care services. In 2011

Solihull Care Trust was dissolved resulting in Adult Social Care transferring back to Solihull Metropolitan Borough Council.

Clinical Commissioning Groups (CCGs) were created following the Health and Social Care Act in 2012, and replaced Primary Care Trusts on 1 April 2013. CCGs are clinically-led statutory NHS bodies responsible for the planning and commissioning of health care services for their local area.

In 2013 Solihull signed up to the Local Government Association Making Safeguarding Personal Programme. This approach, for the first time introduced a person-centred and outcome focus to safeguarding adults, rather than a professionally led, process driven methodology.

From April 2015 The Care Act 2014 set out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

From the 29 December 2015 controlling or coercive behaviour became a new criminal offence (The Serious Crimes Act 2015), giving the CPS the power to hand out prison sentences of up to five years. Coercive behaviour is a pattern of behaviour which seeks to take away self-worth and the liberty of freedom, it does not have to include physical violence, although it can – it is all about control.

4.2 SMBC

John has been known to Adult Social Care since September 2008.

Intelligence relating to John's step-father was received in August 2003 and he became a user of Adult Social Care in October 2011.

Adult Social Care carried out a desktop review of John's social care records and spoke to staff who had worked with John or his step-father.

Between 2008-2016 it is important to recognise that SMBC had a number of organisational factors and substantial changes in their structure to take into account. In 2008 John would have received a service from the Learning Disability Team. However in September 2013 the structure of Adult Social Care changed with the Learning Disabilities Team being disbanded and two generic Support Planning Teams (North and South) taking on responsibility for adults with Learning Disabilities, Physical Disabilities and Older People (including those with dementia). This resulted in a number of learning disability specialist workers leaving and created a difficulty in recruiting. This meant the focus on people with a learning disability was diminished. At the same time a specific team for Safeguarding was introduced and a specific team to carry out Reviews was introduced.

Since 2008 there have been significant growth and changes in how Direct Payments are set up and monitored. In 2008 Direct Payment support plans were not set up on CareFirst (SMBC's electronic recording system) making

monitoring difficult. Also a system to flag concerns with team managers was not introduced until 2015.

SMBC Adult Social Care identified the following from their Individual Management Review:

- John was always seen in the presence of his mother and usually within the family home.
- John was difficult to engage with as he would rarely stay with staff when they visited.
- The Social Worker supporting John's step-father was proactive in identifying John's vulnerabilities.
- Monitoring of John's Direct Payments was below an acceptable level.
- The Local Authorities computer system was not used to its full capability, which led to a lack of critical intelligence, in that John's step-father was not linked to John's records, there were two records for John's step-father with different spellings and warning markers were not available.
- Annual review performance was below the required expectation.
- Engaging with, and involving individuals with substantial communication difficulties within small family environments is difficult and requires time and skill.
- Safeguarding activity was hindered by the lack of engagement and timely information sharing from West Midlands Police due to poor attendance at strategy meetings.
- As a result of the incident in February 2016 – suitable accommodation was found for John, an Advocate instructed and Deprivation of Liberty Safeguards put in place.

4.3 Birmingham Cross City CCG

Birmingham Cross City Clinical Commissioning Group was asked to review the GP support and contact with John between 2013 – February 2016. During this period John was known to two Medical Centres.

Birmingham Cross City CCG reviewed computerised records, spoke with a GP (senior partner) by phone and face to face with the Practice Manager and secretary.

Birmingham Cross City CCG identified the following from the Individual Management Review of the two Medical Centres who John was known to:

- All medical appointments for John were carried out with his mother present.
- Contact with John was limited to one appointment in 2013 and 3 appointments in 2015 or requests for repeat prescriptions for medication relating to behavioural problems and a skin condition.
- Practice staff were not made aware of any safeguarding concerns with John.

- There are gaps in the current process around engagement with patients with a learning disability. This is being reviewed to improve the uptake of the annual health check for patients with learning disabilities.
- The practice holds multi-disciplinary meetings about their most vulnerable patients every 2 months, but can only do this if they are aware of individuals increased vulnerabilities – such as current safeguarding concerns.
- John's mother and step-father were also registered patients, but it was not known that John lived in the same household as John was only ever seen at the surgery, had a different surname to his mother and step-father and when GPs visited John's step-father at home, John was never seen.

4.4 Solihull Community Housing

Solihull Community Housing (SCH) is an Arm's Length Management Organisation (ALMO) set up in April 2004 to run the housing service on behalf of Solihull Council. The Council still owns the properties and is the landlord, SCH delivers the housing services.

John has been known to SCH since 2008 when his mother and step-father became joint tenants. During this period they lived at 3 different addresses.

SCH were asked to review their support and contact with John, his mother and step-father between 2010–February 2016.

SCH reviewed electronic and paper records and interviewed 4 staff members. Their summary report does not detail all routine 'landlord' contacts on rent collection, repairs, estate management and tenancy matters.

SCH identified the following from their Individual Management Review:

- Accommodation moves were requested and made to meet John's needs and latterly to meet the physical care needs of John's mother and step-father.
- SCH staff saw John in the presence of his mother who was seen as John's 'voice'. There was no opportunity, nor any apparent requirement, to speak to John alone.
- SCH staff identified John's mother as presenting as a strong personality (a 'character').
- SCH liaised with other family members/friends, SMBC and DWP.
- SCH adapted their procedures to meet John's mother's needs in that they made weekly calls to her to advise her of current and pending vacancies and carried out home visits so she could sign tenancy papers, which normally took place in SCH offices.

4.5 West Midlands Police

In January 2013 West Midlands Police set up a dedicated Safeguarding team for Vulnerable Adults. In 2015 the 'Adults at Risk' team within the Public Protection Unit evolved with specific responsibility for investigations related to

'Adults at Risk'; where the suspected abuser is a person carrying out the role of 'carer' or the death is suspicious, allegation of sexual abuse, incidents where a pattern or sustained or repeat targeting has taken place and allegations of abuse/neglect or financial abuse.

Solihull Local Policing Unit work with partners in Solihull to prevent and reduce harm and respond to day to day concerns and crimes and emergencies.

West Midlands Police were asked to review their contact with John, his mother and step-father between 2013 – February 2016.

West Midlands Police identified the following from their Individual Management Review:

- The police who responded to the incident in February 2016 spent considerable time with John and his family to secure short and longer term solutions for the family and to protect John.
- WM Police responded to domestic abuse incidents and considered the impact of these incidents on John. It is acknowledged however, that in 2013, which was pre the Care Act 2014, the incident was dealt with appropriately and correctly, but no referral was made in respect of John as force policy at that time would not have required a specific referral to have been made in respect of a vulnerable person present in a household where a domestic incident had occurred. Current professional practice now focuses on identifying all aspects of vulnerability and is underpinned by THRIVE+ and Operation SENTINEL, a long term initiative to increase organisational understanding of 'vulnerability' to provide appropriate responses and safeguarding. It also incorporates learning from statutory reviews and ensures that legislation is understood and engrained within professional practice.

The Individual Management Review did not identify the level or detail of any investigations into sexual, financial, physical or emotional abuse which were the allegations that triggered the Safeguarding activity.

4.6 John's experience

It is not possible to explicitly say what John's experience was at home between 2008 and February 2016 as John is not able at this time to say. However, it is possible to draw some conclusions from meeting John, discussions with John's sister, advocate and the Home's Manager and staff and from reports written by professionals, that:

- John's voice was not central to the majority of the assessment or reviews of his needs.
- There were a number of occasions across a range of agencies when opportunities were missed to intervene and ensure that he had the

opportunity to disclose his experience of living at 'home' between 2008 and 2016.

- It is clear, that he has made good progress in his physical and mental health since moving to his current placement in February 2016, where he is settled and well supported. He is gaining some independence and is in regular contact with his sister who is impressed at the care he is receiving now.

All of the above was used to identify the agenda for the Learning Event with practitioners to stimulate debate and discussion and assist with formulating recommendations to the panel.

4.7 Overview of Agency Summary Reports

Within the majority of the summary reports there has been a lack of professional curiosity or challenge. Professionals in contact with John accepted his mother as his voice without formal enquiry or assessment. His Learning Disability 'label' seems to have influenced professionals practice. The impact of the family environment on John was not considered.

John's care from health and social care was reactive and episodic rather than assessments, reviews and interaction being informed by previous knowledge. To date how John came to live with his mother and step-father cannot be identified, John's deterioration in physical health was not identified and how his Direct Payment was meeting his needs was not determined.

5. Summary of facts and findings from Learning Event

Practitioners and managers from SMBC, Solihull and Birmingham Cross City CCG, West Midlands Police, Solihull Community Housing and one of the Medical Centres which John received services from, were invited to attend the event, as their organisation was involved with John and his family and had contributed to the SAR. Coventry and Warwickshire Partnership Trust were invited as specialist Learning Disability advisor and as part of the SAR Panel.

Aims of the Learning Event were:

- To use this case as a vehicle for learning and sharing good practice.
- To provide practitioners with the opportunity to reflect and comment on current and future safeguarding practice and expectations.
- To explore and provide evidence that can give assurance regarding current safeguarding practice.
- To engage with practitioners on the realities of everyday practice across the partnership, not only in relation to safeguarding.
- To provide feedback and recommendations to the panel, who will in turn feedback to the Solihull Safeguarding Board on the outcomes from the SAR and the Learning Event.

Pre-reading was sent out to participants that summarised the key events in John's life and the contact with the various services and organisations.

The Learning Event began with an outline of the case study, followed by a question and answer session, allowing for clarifying questions to be

answered, then pre-agreed questions were given to participants to discuss on their tables and each table was asked to make a maximum of five recommendations to the panel, based on their discussions and experiences.

The pre-agreed questions (see Appendix 1) were divided into three areas:

- Working with Individuals and families
- Working with the Police and
- Working with Health.

The tables contained representatives from each of the agencies involved in the SAR.

Feedback from the group discussions
This SAR has highlighted a number of issues and concerns, some historic, for which there are no answers and some current, which again might not have ready-made answers. The discussions during the event were lively and engaging and on the whole the participants took a learning approach to the case study.

Some of the groups answered the questions systematically, whilst others made notes on the overall discussions and highlighted the recommendations. Not all the questions were answered by every group.

5.1 Working with Individuals and families

The agency's Individual Management Reviews identified that prior to John's placement in February 2016, John was not seen alone by professionals, always in the company of his mother, who was described as a strong personality, a 'character'. John's learning disability and communication needs was a barrier, however there was no assessment of John's ability to participate in assessments or safeguarding activity. There was also assumption about John's learning disability, communication and engagement ability. Routine reviews and assessments by Health and Social Care were not carried out as required. Overall some family behaviours were not challenged – for example, how John's Direct Payment was used, why John did not attend routine Health reviews etc. Both Health and Social Care had different names for family members recording, resulting in missed connections.

Overall it was agreed there are existing standards, procedures and policies to guide the assessment and review processes, which are monitored through supervision discussions, case file audits, annual reviews etc. There was some debate regarding the importance of seeing the adult by themselves and within their own personal space.

Professional's capability/skills to undertake reviews involving complex families so as to get underneath presenting behaviours and ascertain feedback about the cared for person, came into question alongside capacity to deliver assessment and review targets.

All the groups agreed working in pairs and multi-agency pairs would be beneficial, however it was felt that it was not practicable without there being specific concerns.

Particular care is required to ensure pre-conceived assumptions about an individual's diagnosis, needs and abilities do not influence practice and actions.

All the groups agreed there needed to be more professional curiosity, taking a whole family approach to assessments and ensuring that people are seen by themselves in appropriate surroundings, which may have resulted in concerns about John's Direct Payments being resolved sooner and greater understanding of what John's day-to-day 'lived' experience was.

The groups identified the importance of working with the speech and language service where there are known communication difficulties and working with advocates to ensure the voice of the adult is heard and taken into account.

There was debate about how much time is given/is available to read the previous reviews to help create that holistic picture.

It was mentioned by one group that the impact of organisational restructures cannot be ignored, as staff moved around and out of organisations, can sometimes lead to the erosion of organisational memory, highlighting the importance of good and accurate recording keeping.

Workforce development and learning was highlighted to ensure reviewing staff have access to appropriate training e.g. conflict resolution and assertiveness training.

5.2 Working with the police

From the agency's Individual Management Reviews, the SAR Panel was concerned about John's access to the criminal justice system and therefore other adults with learning and communication difficulties access to the criminal justice system.

Overall it was felt that it is difficult for the police to intervene, where there appears to be no evidence, forensics or witnesses. The Youth Justice and Criminal Evidence Act of 1999 makes provision for the vulnerable to be supported within the criminal justice system, however it was felt that making an initial referral to access the criminal justice system can sometimes be difficult. One group questioned whether an Adult MASH was a way forward to ensure effective and timely information sharing and multi-agency decision making?

5.3 Working with Health

From the agency's Individual Management Reviews, the SAR Panel identified a couple of concerns – How are GPs informed of safeguarding activity, and what is the procedure for following up when an adult does not attend (DNA)

an appointment, when the person requires support from another person to attend?

It was agreed that there needed to be improved communications between GP practices and the local authority and vice-versa, particularly where the person has a learning disability or when that person lacks capacity. This should apply to Health Plan reviews and safeguarding activity. Solihull Health Facilitators may be able to pick up when a person does not attend for annual reviews and may have noted the decline in appearance and physical state in this case – care is needed that this is not lost in any new structures/organisations.

The lack of Annual Reviews or regular medication reviews resulted in missed opportunities for monitoring and a questioning as to how and why regular reviews of John's medication occurred, raising again how all professionals must be mindful that pre-conceived assumptions do not influence practice and actions.

6. Recommendations

These recommendations are intended to improve practice across the partnership:

i. **Health and Social Care providers must review their assessment and review processes to ensure they follow Valuing People principles and The Care Act 2014 duty to promote individuals wellbeing.**
In practice this means assessments and reviews are timely, proportionate and holistic. Individuals are included or supported to be included by someone who is able to do so independently. Assessments and reviews are informed by previous assessments of reviews or information from other relevant sources.

ii. **SMBC must ensure advocacy provision in Solihull is sufficient in capacity and that there appropriate arrangements in place for an independent advocate to represent and support an adult who is the subject of a safeguarding enquiry or Safeguarding Adult Review (SAR) where the adult has 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them**
In practice this means resources match demand and the legislative duty, 'substantial difficulty' is appropriately assessed, and pre-conceived assumptions about an individual's diagnosis, needs and abilities do not influence practice and actions.

iii. **All partners must ensure Information Sharing and Multi-Agency collaboration across the partnership is timely, proportionate and meets legislative duties.**
In practice this means care and attention is given to ensuring key information is sought and shared so agencies interaction with individuals and decisions are informed and up to date. Full consideration is given to informing key partners such as General

Practitioners current safeguarding activity. Solihull via SMBC as the lead for Safeguarding should reconsider an Adult MASH to enable Information Sharing and Multi-Agency collaboration at the earliest point. This could be achieved by looking at the Wolverhampton and Warwickshire MASH Models.

iv. **SMBC must provide the Board with assurance that when a Direct Payment is agreed, practices and processes provide evidence that the allocation is used to implement the individuals support plan arrangements – this must include robust monitoring arrangements and an escalation process for concerns.**
In practice this means holistic assessments, clear support planning, robust monitoring and clear escalation process for concerns.

v. **SSAB Learning and Development Steering Group should review current Learning and Development programmes across the partnership to identify how the following issues are included in current or future plans:**
- **Professional Curiosity,**
- **Working with Difficult Dangerous and Evasive people/families,**
- **Coercive and Controlling Behaviour,**
- **Assertiveness and Conflict Resolution and**
- **Whole Family Systems Approach to assessments and reviews.**

Where these issues are not available the SSAB Learning and Development Steering Group need to consider how they can be in the future.

vi. **SMBC should ensure their client record system and record keeping practices enable good intelligence gathering to support staff decisions and judgements.**
In practice this means systems are developed to support intelligence gathering, staff are aware of and are monitored to ensure recording practices are accurate.

vii. **WM police are invited to facilitate a workshop with partner agencies in Solihull to explore roles and responsibilities when assisting an individual to make a complaint or disclosure and access the criminal justice system**.

7. Conclusion

The learning event provided a forum for debate and discussion, not only regarding John but also regarding the safeguarding adult process in Solihull. Clearly there are policies and procedures in place and training and development activity that supports the implementation of those processes. And yet John was “unseen” by very many agencies both physically and metaphorically. Who was in a position to notice John? Who should have noticed John’s physical care needs appeared to be deteriorating and yet he was just 37years old?

It was clear from this review that John was unlikely to disclose abuse or neglect himself, however greater professional curiosity in day to day work with John to ascertain what was going on in this family and what Johns 'lived' experience was might have identified concerns when dealing with an un-associated issue. Particular care is required to ensure pre-conceived assumptions about an individual's diagnosis, needs and abilities do not influence practice and actions. All agencies identified John's anxious behaviours and lack of verbal communication and accepted it as 'normal' behaviour for him/adult with learning disability.

Workloads, management oversight and organisational restructures also played a significant role in the effectiveness of professional practice.

There must be assurance in the paperwork being able to deliver practice intentions, and that professionals will be accountable for their practice and challenge situations that require challenge and not to accept anything less than best practice for those who are the most vulnerable in this locality.

There is different practice in Solihull from Birmingham for supporting GPs to check and ensure adults who need support to attend appointments do so – need to ensure this is not lost in any new structure/organisation.

In situations like John's where there are unremarkable circumstances to easily identify a safeguarding concern, it relies on professionals who come into contact with an adult with care and support needs routinely to have: good record keeping as failing to keep basic and accurate records can put people at risk, effective information sharing processes and good partnership working so as to maintain individual's safety and wellbeing and avoid harm and abuse.

The key questions are:

- Were the circumstances John found himself in **predictable**?
- Were they **preventable**?

The evidence from this review suggests circumstances John found himself in may well have been predictable and therefore it is reasonable to assume there were then preventable.

One of the overall lessons from this Review is that enabling and empowering adults like John to have control over as many aspects of their life as possible, whilst at the same time keeping them safe within their family, is an extremely complex task requiring a high level of thinking and skilled evidence based practice.

This report has been produced by the SAR Panel:

Rob Vickers & Tracey Denny	SMBC Adult Social Care
Ron Winch, Samantha Portman & Mark Burnell	West Midlands Police
Luisa Blackwell	Solihull Clinical Commissioning Group
Chris Evans	Coventry & Warwickshire NHS PT
Lorna Wallace-Davis	Independent Facilitator, The Change and Development Co.
Date:	

Appendix 1

Safeguarding Adult Review - John
Questions for the Learning Event

Working with Individuals and families.

How can we create a standard regarding assessments/reviews that allow for a change in attitude, deterioration, demeanor, engagement levels etc. to be identified and escalated as appropriate? How do we/can we use the MCA to support our concerns?

When undertaking assessment/reviews, how much time is given to understanding the context and the past of the family? How do we/can we ensure that questioning and curiosity are skills used and we challenge the "taken for grantedness" of some family situations?

How can/do we effectively work with individuals where there are (substantial) communication difficulties? How can we/do we ensure that an individual is seen alone?

At what stage can we/do engage the services of an advocate when dealing with individuals with (substantial) communication difficulties?

Where there may be an unspecified concern, would it be possible to undertake assessment/reviews in pairs - allowing for the adult to be seen alone, by a worker?

How confident are we that carer's stress is appropriately identified and actioned?

How do we/can we see underneath presenting behaviour to ensure adults are receiving appropriate support?

How do we/can we recognise abusive and controlling behaviours?

Working with the police.

What is our experience of providing information to the Police for investigation? Format, style, content, presentation, levels of detail, requirements, inclusion of key words/phrases?

How do we/can we identify signs of abuse, when there is no disclosure from the adult?

What experience do we have of working with the Police regarding complaints vs disclosure? How do we maintain vigilance when an offence has not been committed but concerns remain?

Working with health

How do we/can we ensure that GP practices are “in the loop” for safeguarding concerns and understand how to flag a concern, e.g. if a patient with a learning disability does not attend appointments and reviews?

How do we/can we inform GP’s if a safeguarding alert has been raised concerning a patient in their practice?

How do we/can use the mediation review /repeat prescription process to seek assurance that patients have not deteriorated, are well and healthy and that there are no causes for concern?