Focussed Safeguarding Adult Review:

"Silenced by fear": Greta

April 2022

Slough Safeguarding Partnership

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“Silenced by fear”: Greta

This safeguarding adult review sets out to make a difference to how partners work together to safeguard adults. By March 2023, the following changes will have been delivered, each one with measurable impact, but when combined this will improve the overall collective impact of partners working together in Slough.

Improvement no 1; New multi-agency practice guidance for responding to safeguarding adult concerns will have been devised by partners, delivered in practice and evaluated to assess impact.

Improvement no 2; Multi agency case audits will demonstrate that chronologies are embedded in practice in all partner agencies working with people facing the challenges experienced by the subject of this review.

Improvement no 3; Evaluation of mandatory information sharing training will include increased professional understanding of what action to take when a person they are working with refuses consent to safeguarding procedures. They will understand that inaction is not an option.

Improvement no 4; The MARAC chair will have demonstrated that MARAC meetings include an agenda item on ensuring extended family members are explored and considered and that this has been embedded since the publication of this report.

Improvement no 5; Multi-agency case audit will demonstrate professionals’ understanding of local strategy and published guidance on Violence Against Women and Girls including the approach to perpetrators.

Improvement no 6; Evaluations of training on coercion and control will demonstrates increased understanding of the impact of fear on a victim of any age, and how it impedes their ability to seek and accept help. The professional community will have been saturated in training on coercion and control training and the general community will have received consistent and frequent information to raise awareness about this.

Improvement no 7: Evaluation of the effectiveness of the community mental health team safeguarding arrangements will demonstrate impact on outcomes following a review of arrangements authorised by leaders in Health and Social care sectors.

This is a safeguarding adult review and is about Greta, (*not her real name*) who suffered from physical injuries over a number of years and refused to consent to safeguarding procedures. This review explains why these improvements could help with similar cases in future.

Focussed Safeguarding Adult Review

"Greta"

Introduction

The Safeguarding partnership must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. This also applies when the adult does not die, but where a case indicates that there are lessons to be learned about how partners worked together. Lessons learned will inform future practice so that we prevent risks of abuse or neglect arising in the future.

Why this review is being carried out:

Greta was referred to the Slough safeguarding adult review panel in May 2021 by Thames Valley Police. She had presented to the local hospital Emergency Department on 09.05.2021, just after midnight with injuries following an alleged assault. She reported to the ambulance crew that she had been punched on the head 17 times. She had notable bruising to her forearm and her hands and she had superficial bruising on her left forehead and dislocation to left middle finger. The alleged perpetrator was thought to be her son. Later, she reported a poor recollection of events. At the time of the incident, her daughter was concerned that her mother seemed more confused than normal.

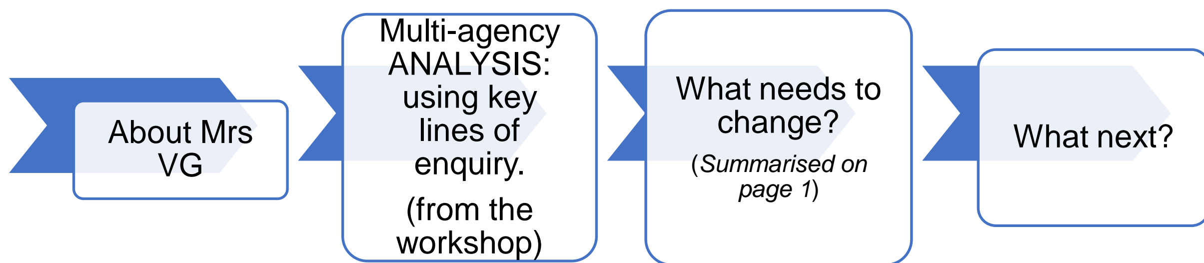
Her son was arrested and questioned and has denied offending or made no comment. None of the investigations reached the evidential threshold for prosecution. Her son was initially on police bail with non-contact conditions with regards to this assault but police concluded that there will be no criminal prosecution.

Partners carried out a scoping exercise and shared available information about Greta with each other. This process revealed a history of recurring injuries and safeguarding concerns over the years. Members of the SARP were concerned to establish if there is any learning with a particular focus on why some of these incidents did not trigger a strategy meeting or formal safeguarding enquiries. The Key lines of enquiry arose from discussions and observations about this. Partners agreed on how the SAR should be carried out and this is explained below.

Principles of this review:

- The process will ensure rigour and transparency while at the same time pursuing new learning.
- Learning will have demonstrable impact on practice.
- The review is focussed only on learning about working together and is not about the actions or inactions of any individual agency. Partners will carry out their own examination of their performance in relation to this case and take appropriate action in house. They will account to partners for this via the SARP group and throughout the process of the review.
- Learning from recent SAR's will not be pursued or repeated by this review
- The right information will be assembled and will be proportionate to the learning.
- A multi-agency analytical, reflective approach will be used, enabling partners to work together to agree on what has been learned.
- The unprecedented pressures on all partners because of the Pandemic requires a model that works efficiently and effectively with minimum intrusion on operational resources so meetings were kept to a minimum and were very focussed.

Report Structure



KEY LINES OF ENQUIRY agreed by partners

Were safeguarding alerts responded to appropriately, including the setting up of strategy/planning meetings? If not, why not?

Mrs VG had mental health problems: did this present any challenges to those working with her in relation to their efforts to safeguard her from abuse?

Coercion, control, violence and fear of violence will affect a person's willingness/ability to consent to safeguarding procedures; what can we learn about our collective duties, responsibilities and obligations to people who do not give their consent to Safeguarding procedures?

Greta had 3 children and we are aware that she also had grandchildren. Are there lessons to learn about understanding vulnerable adults as family members e.g. Her son was known to Slough Children's Social workers; what have we learned about that?

What does the phrase "Adult Safeguarding" mean to safeguarding partners in Slough and what does it mean to vulnerable adults? What did it mean to Greta?

And in conclusion: Were the risks to Greta identified, understood and appropriately shared?

Engaging the family

Greta suffered from serious injuries and at the time of writing is safe and well in residential care. Careful consideration is being, (will have been) given to establishing the most appropriate way to inform her and her family of the review and this will be carried out by consulting those who know her.

Methodology

A multi-agency workshop was arranged and involved the following key stakeholders in the analysis.

- Slough Local Authority Adult Social Care services, including Community Mental Health Team
- Slough Local Authority commissioners
- Slough Local Authority Housing Department
- Domiciliary care providers were invited but were unable to attend.
- Berkshire Healthcare NHS Foundation Trust
- Clinical Commissioning Group/Primary Health Care Services GP
- Slough Children First
- Thames Valley Police
- Hestia
- Community Safety Partnership, Domestic Abuse Partnership Officer
- Turning Point
- Frimley Health Foundation Trust
- Royal Berkshire Fire and Rescue service.

A multi-agency workshop was held to analyse available information. It focussed on the KLOE's above which were shared in good time before the event. Partners were asked to prepare carefully for the workshop by reflecting on their individual report carried out to contribute to the scoping exercise, and to consider the KLOE's from their agency's perspective. They were provided with sufficient time to do this with appropriate staff in their organisation in readiness to engage in the discussion at the workshop so they represented their agencies views appropriately and with authority and in an open and honest way. The event was scrutinised by the safeguarding partnership independent scrutineer who observed the meeting throughout and provided input.

Partners ensured that they had essential case information they needed to share at the workshop and were prepared to share information proportionately and in line with the statutory purpose of the SAR.

Partners worked together to provide succinct learning points at the end of each KLOE discussion. They were forthcoming about the challenges they experienced and the areas for improvements they were making as a result of their learning about the case.

This report has been drafted following the event and shared with those who attended and the SARP group for consultation.

The report was (will have been) signed off by the SARP group and then by the SLG and will be published on the safeguarding partnership website.

A review of the impact of the learning will be carried out 6 months following publication and a detailed review one year following publication.

About Greta, *(not her real name)*

Greta was 82 years old at the time of the incident. She is a white British lady who has lived in Slough for most of her life and has been a council tenant since 1976. She has 3 children and several grandchildren. Greta has bipolar disorder and suffered from depression and anxiety, and so was considered to have a severe and enduring mental illness. She was receiving services from the community mental health team for many years, since 2006. One of her sons, who will be named John, lived with her. She also had another son, Oliver, who the review panel have learned is in a persistent vegetative state and has lived in residential accommodation for many years. Greta also has a daughter. Her son John has children of his own who have been adopted due to abuse perpetrated by John.

Following the incident in May 2020, Greta has been provided with a care home placement. She has had a mental capacity assessment which indicates fluctuating capacity in relation to a range of decisions, including where she lives. She has also been diagnosed with dementia.

Greta is determined to go home and thinks that her family will look after her.

History:

Adult social care services informed the group that Greta has received a Care and Support package from at least 2006 which is as far back as current records are held for her. Historically there were four safeguarding concerns raised (11/6/15; 19/11/18 2/1/19 and 15/2/19) and all had been transferred to the Community Mental Health Team (CMHT) for action. (This is a multi-disciplinary and multi-agency team provided by the mental health provider and adult social care services.) CMHT reported that each incident was thoroughly investigated but could not be pursued, largely because at an early stage, Greta was adamant on each occasion that she did not want intervention of this kind.

The GP noted an attendance by Greta on 4th April 2016 to the emergency department when she had sustained a fracture of the middle finger after "sliding on a wet floor".

In September 2018 Greta saw a practice nurse with superficial cuts on her lower legs and she explained that as she had locked herself out and tried to climb through a window and fell into a patch of brambles.

The domiciliary care provider identified that staff had noted bruising on her face and hand in November 2020 but had not referred or reported to management. The GP reported that on 17th November 2020 Greta had attended the emergency department with a dislocated finger stating in the history “she fell at the front door”. The hospital reported this describing the cause as an “unwitnessed fall”. Greta had sustained a small laceration and bruising to the right eye as well as the injury to her finger. She had crawled to the living room, managed to get onto the sofa, and remained there until her son arrived in the morning before 10AM. Following an x-ray and blood tests, Greta was discharged home. In total, and between 2015 and 2022, there were 10 incidents recorded by partners referring to injuries. On 6 of those occasions, the explanation was accepted as plausible, and on 4 other occasions Greta initially referred to her son as the person responsible for the injuries and later retracted this.

ANALYSIS

KLOE 1) *Were safeguarding alerts responded to appropriately, including the setting up of strategy/planning meetings? If not, why not?*

Partners agreed that over the years, responses to individual alerts were largely inconsistent and lacked co-ordination. While the safeguarding procedures were followed, they resulted in an abrupt ending when Greta refused consent. Multi-agency responses were better following admissions to hospital. The workshop discussed inconsistencies in relation to who is invited to strategy and other meetings and it would appear that this relies on local individual knowledge. For example, after the incident in May 2021 that gave rise to this review, the hospital safeguarding team informed the workshop that they were not invited to strategy meetings which, they suggest, is a recurring problem. There is evidence to suggest that the ward staff were invited to that meeting but the hospital safeguarding team were not. This has been rectified during the process of this review. Rigorous attention to inviting the right people, based on a local agreed data base of safeguarding personnel ought to be critical at this stage and needs to be provided to all those with responsibilities in this regard.

The response to safeguarding concerns where consent is not provided or withdrawn is not explicitly agreed by partners. The pan Berkshire procedures are clear about how to respond to safeguarding concerns using formal processes and having achieved consent. Greta experienced physical injuries on 10 occasions over 7 years and on 4 of those occasions she initially said that her son John had caused the injuries, which she then later retracted. National research *(LGA 2020)* indicates this as a recurring feature in intra familial or domestic abuse. Her unwillingness to consent to further enquiries seems to have obstructed the progress of safeguarding enquires and so the multi-agency responses had limited effect.

Why did this happen?

Locally in Slough, information sharing in relation to concerns of this nature about adults appears to be unstructured. There is no locally agreed multi-agency processes which explains clearly what to do in cases where there is a safeguarding concern and consent is withheld. With the formal safeguarding process, there is a structured tool that is used by Adult Social Care in leading formal meetings. While the pan Berkshire procedures are clear about what constitutes a safeguarding concern, and that LA’s lead on co-ordinating the enquiry and subsequent plan, it is very often down to local judgement about how to respond and who to contact when consent is withheld. In this climate, and in the current high demand and low resources environment, if the person affected refuses consent, there will be a natural propensity to cease or suspend the process.

Strategy meetings were not held as those involved with Greta at the time felt that her lack of consent prevented safeguarding action. This placed her at further risk. Greta was living with a challenging mental health problem and with a son upon whom she depended. She may well have had mental capacity when she refused safeguarding procedures in relation to her physical injuries. This does not obviate the statutory duties of partners to make every effort to safeguard her. Adult social care have reflected on this and indicate that more weight should be given to the historical pattern of events and the repeated nature of the finger injuries.

Learning:

Where there are safeguarding concerns and the person affected is refusing to consent to the safeguarding process, a strategy meeting should be held and information shared fully and rigorously with partners to assess the risk. These should be supported by an agreed process such as a multi-agency structure, templates and an information sharing protocol to ensure partners are confident to share information. An agreed list of who to invite and how, should be available to all those setting up such meetings and they should be kept regularly updated.

A fine, carefully balanced and proportionate decision needs to be made at this strategy meeting, balancing the safeguarding concerns with the human rights of the individual to privacy and family life. The decision is not about *whether* to act but about *how* to act, working with partners and sharing essential information about risk. One of 2 decisions need to be made; 1) proceed with safeguarding procedures or 2) proceed with a Multi-agency Risk Tool. There is no option for inaction.

Where there are safeguarding concerns and the person is refusing consent for safeguarding, consideration should be given to the level of risk to the person and whether to override the need for consent. This could then prompt local multi-agency action with a degree of urgency and heightened concern.

This suggests that the principle of proportionately enshrined in the Care Act 2014 around "Making Safeguarding Personal" needs to be visited and re-visited throughout interactions and as part of care plan reviews in relation to people in Greta' situation.

KLOE 2) *Greta had mental health problems: did this present any challenges to those working with her in relation to their efforts to safeguard her from abuse?*

Those who worked directly with Greta described her as having bipolar disorder for many years which was well controlled with Lithium. Most of her care was provided by social care services. After the incident in May 2021, a mental capacity act assessment carried out in hospital identified that she had dementia and the mental capacity assessment suggests she had fluctuating capacity at that time. This review is looking only at what was known to professionals in the time preceding the event.

Throughout the timescale of this review, the assumption of capacity was maintained as her mental health was considered to be stable. This review has established that while her bipolar disorder did not present a specific challenge, her accommodation to, and normalising of the difficult conditions she was living with are likely to have had subtle and intangible effects on her willingness and capacity to accept help. She made a series of decisions that increased risks to her and this poses a practice challenge to professionals working with her. A refusal to consent to one incident is concerning, but a refusal to consent to several similar incidents requires concerted action. Spotting this pattern could have led to a revision of the situation, which should trigger a plan to carry out a mental capacity assessment and even consider the various legal options available. The importance of chronologies and understanding the history described in KLOE 3 below is re-emphasised here as this would have thrown light on understanding of her situation.

Learning:

In conclusion, Greta's bipolar disorder did not present any specific challenges in relation to efforts to safeguarding her from abuse. However, it seems that other issues will have been affecting her emotions and decisions making and these are further explored below in KLOE's 3 and 5.

As Greta had a continuing service from the Community Mental Health Team, safeguarding referrals were swiftly passed to that team for action. In order to understand how the referrals were managed, an understanding of organisational arrangements for Community Mental Health Services is required. Separate meetings with Adult Social care services managers were held to facilitate this and arrangements are summarised below;

- Adult social workers use health case record management systems used by the Community Mental Health Provider organisation for recording social work interventions. This is supported by a central LA managed system.
- Safeguarding referrals for clients who are receiving services from the Community Mental health team are sent by Adult Social Care services to the manager of the CMHT who is responsible to ensure that all referrals are diverted to the correct social worker and acted on appropriately.
- Weekly meetings to track these referrals were set up to engage health members of the CMHT but recently are only attended by social workers.
- Recruitment of permanent staff in both social care and health is an on-going and serious challenge.

These arrangements give rise to the following observations:

Using the health case management system can lead to cumbersome arrangements for senior social care services management oversight, scrutiny and challenge of practice. When referrals are made to CMHT social workers, there does not appear to be clear arrangements for continued specialist safeguarding support and follow up for social workers in that team.

Currently a single manager is responsible for overseeing all safeguarding referrals coming to the team. This produces risks as there is an overdependence on one person, or one post to carry out this function.

The relationship between this team and the rest of adult social services is unclear. Social workers in CMHT seem professionally isolated from social workers working elsewhere in adult social care.

Recruitment pressures further add to capacity concerns at the front line and can mean that consistency of practice is challenging to achieve.

It cannot be established by this review if this affected Greta at all, but these features explain the context in terms of the pressures on managers and staff making decisions. It adds to the suggestion in KLOE 1 that when a person refuses consent, establishing alternative options is complex and time consuming and practitioners, managers and staff need convincing that investing resources into exploring these options can provide them with support and the client with acceptable solutions.

Managers in adult social care are reviewing these arrangements and are working to recruit a safeguarding specialist social worker to the CMHT. This is likely to provide support to the manager and social workers and so lead to increased confidence in practice.

More needs to be done at strategic level to facilitate effective collaboration and support at tactical and operational levels between the mental health provider and adult social care services. The arrangements have not been revised for many years having been set up 20

years ago and so they are open to challenge. A review of CMHT arrangements, in terms of its effectiveness and impact on outcomes needs to be carried out to provide assurance to safeguarding leaders about what is going well and what need to change. It can also lead to creative solutions to support current practice. Without such a review, safeguarding leaders cannot be so assured.

KLOE 3) *Coercion, control, violence and fear of violence will affect a person's willingness/ability to consent to safeguarding procedures; what can we learn about our collective duties, responsibilities and obligations to people who do not give their consent to Safeguarding procedures*?

The home office statutory guidance *(Home office 2015)* provides the following definition of coercion and control as follows:

Controlling or coercive behaviour does not relate to a single incident, it is a purposeful pattern of behaviour which takes place over time in order for one individual to exert power, control or coercion over another. This (new) offence focuses responsibility and accountability on the perpetrator who has chosen to carry out these behaviours. The cross-Government definition of domestic violence and abuse outlines controlling or coercive behaviour as follows:

***Controlling behaviour is**: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.*

***Coercive behaviour is**: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim.*

A Briefing by RIPFA in 2016 provides some helpful insight into this.

"Coercive and controlling behaviour can impact on decision making. The sociologist Gilbraith (1983) described coercive power as 'used to inflict unpleasant or painful consequences on a person acting on their own choices so that they "choose" to follow the preferences of the person inflicting harm rather than their own' (Ingram, 2016: 2). People experiencing coercive control live in fear of the consequences of going against the rules that the person perpetrating the abuse has set up for them to follow. The tactics used by perpetrators of coercive control include threats, intimidation, isolation, and control over aspects of everyday life, whereby the perpetrator may 'limit space for action' (Home Office, 2015: 4), including space to make independent decisions. This is now recognised in the statutory guidance, as demonstrated in the guidance to police to ask 'questions about rules, decision making, norms and fear in the relationship, rather than just what happened' (ibid: s2.27) when looking into identifying the offence".

Psychiatry UK also provides clues as to why this is so difficult to identify in practice:

"Coercive control is a complex form of abuse and there are complex reasons as to how it comes about which are to do with the types of personalities involved and the unique dynamics of their relationship but one of the reasons it often persists for so long is that the victim is forced, by their own fear and absence of control, to comply. It is extremely hard for them to see a way out or to feel that they will be believed. The victims in these cases sometimes deny there is a serious problem or they fluctuate as to whether or not they want any help. The Mental Capacity Act 2005 can be brought to bear in some safeguarding cases because an individual's capacity is compromised if they are subject to fear or coercion."(https://psychiatry-uk.com/coercive-control)

The impact of coercion and control on Greta's decision making is difficult to quantify. Subject matter experts on domestic abuse contributed their expertise to the discussion at the workshop. There was consensus that Greta depended on John for support and this made her vulnerable to being controlled. John managed her finances and it was not possible to establish when this started or for what reason. There were concerns during 2015 when Greta's care was not paid for and she had debts outstanding. This was eventually resolved but it will have been a difficult time for Greta and may also have been very confusing, particularly if there were physical injuries suggestive of assault as well. At times, carers observed and recorded that Greta had been frightened of John and during one visit, hid behind a carer. This resulted in an increased care package but did not lead to formal safeguarding procedures as Greta would not agree to it.

There is therefore suggestion of financial and physical abuse during that period and so Greta must have been fearful of her son, his behaviour and the implications in terms of possible repercussions of getting help.

Why was coercion and control not considered when Greta refused consent?

A retrospective view (see table 1) identifies recurring themes suggestive of coercion and control. This can only become visible when her situation is viewed over time. It cannot be seen during a single episode. This means that chronologies and checking out the history are not just helpful tools, they are critical to understanding risk. They help identify areas of risk that would otherwise be unseen.

Greta may have been fearful of either further harm being done, or of losing her son to criminal justice, or both. While her condition has been recognised as stable in recent years, it is possible that her needs will have been challenging to support. The group learned that her son, John, perpetrated violence on his partner, witnessed by his children. This demonstrates that his capability of handling the emotional demands of other vulnerable family members has been compromised. While it cannot be categorically declared that he would have perpetrated violence on his mother, the evidence shared in this report is highly suggestive that he was. There is, therefore a strong probability that Greta was physically abused by her son, but this cannot be forensically proven.

Professionals working with Greta will have been frustrated and concerned by their inability to help her as she refused consent on so many occasions. In one incident, a carer was assaulted by Greta's son and so his violence was even a threat to those working with the family. This was referred to police and adult social care services. Mitigating the threat to Greta and the inertia that followed, was beyond the collective capability of partners working with her at the time. Their awareness of coercion and control, as it is currently understood in legislation and research, did not go far enough for them to apply this thinking in practice. More needs to be done to raise awareness of domestic abuse, coercion and control and the additional vulnerability of adults with mental health challenges living with these issues. Our knowledge about these issues continues to grow. We need to make sure that it is applied in contemporary practice and widely promoted amongst staff in adults and children's' services.

Learning:

There is a need to increase awareness raising about coercion and control and domestic abuse. This needs to be widespread for both the public and all professionals working with families and should be prioritised by Slough community safety partnership.

Understanding coercion and control and how it affects mental capacity needs to be incorporated into training, policies and procedures around information sharing and risk assessment in Slough.

Practitioners need to be mindful that coercion and control affects a person's ability to consent to interventions and ensure they understand national and local guidance on this. Guidance for police, for example, suggests that there is a need "*to ask questions about rules, decision making, norms and fear in the relationship, rather than just what happened' when looking into identifying the offence" (Police guidance 2016:).* This can equally apply to all those working with people they suspect may be victims of abuse. Skilled and sensitive dialogue, using open ended questions and careful listening, will provide the right environment for the person to disclose what is happening in their lives. Using judicial language such as "investigation" "enquiry" may imply that the main objective is to find out "who is to blame".

Greta probably just wanted the abuse to stop and a dialogue that enables her to talk about this in a way that suggests that partners are there to help, is more likely to help her engage.

This review has learned that practitioners worked skilfully and diligently to try to persuade Greta to change her mind but to no avail. There is evidence of excellent practice, where Mental Health and commissioned Care staff have kept regular contact with Greta. Adult social care also suggest some areas where practice can be improved, for example reviewing the care and support plan regularly to incorporate the weighing up Greta's views against the risks.

Some of the government funding to support the implementation of the new DA act could be used to support whole systems delivery of awareness raising of coercion and control, for professionals, volunteers and the general community as this has been highlighted in this review.

Domestic abuse is a key feature in child protection enquiries in Slough and it also impacts on vulnerable adults. The extent of coercion and control cannot be measured. It is reasonable to deduce that, as seeking help with domestic abuse happens after a prolonged period, that there are many more victims who are silenced by fear.

Partners are very aware and concerned about DA as a key feature in the lives of families and vulnerable people in Slough. They refer to paucity of resources in the public sector to raise awareness in the community and provide regular training and development for practitioners and managers about this. The current strategy for violence against women and girls is a helpful summary document. More detail on the role of the community safety partners and safeguarding leaders in leading on this and including tangible products and measurable performance indicators, as well as evidence based practitioner guidance, regularly updated and promoted through training and communications is needed.

This does not necessarily require additional or new resources. It requires doing things differently, re-prioritising and doing it collectively. One collective effort, which is owned by all partner agencies, including relevant voluntary sector groups and victims will produce the consensus and leadership needed to create a whole systems approach in Slough.

RIPFA *(RIPFA 2016)* summarise the implications for practice as follows:

"Be aware that the person will be adapting their behaviour and decisions to minimise their risk. They may be fearful of the consequences of resisting, and fearful of the possible negative impact that outside intervention may have on them". and

"Remember the person knows the situation best, and knows the level of risk they are facing. Do not try to impose or force a decision (e.g. to leave a relationship); instead, focus on building trust".

The collective duty is therefore to strategically align one approach on coercion and control across community safety, safeguarding partnership and well- being board, and to ensure practitioner and community awareness activities are developed in a sustainable way. The key component of this is to ensure that professionals working with people in similar situations to Greta need continuing support and development, in the form of training and supervision to help them with these complex challenges.

KLOE 4) *Greta had 3 children and we are aware that she also had grandchildren. Are there lessons to learn about understanding vulnerable adults as family members? Her son was known to Slough Children's Social workers; what have we learned about that?*

The group learned from Slough Children's Social Care Services (*Then, "Slough Children's Trust", now "Slough Children First")* that her son, John, perpetrated violence on his partner, witnessed by his children who were eventually adopted. This demonstrates that his capability of handling the emotional demands of other vulnerable family members had been compromised. While it cannot be categorically declared that he would have perpetrated violence on his mother, the evidence shared in this report is highly suggestive that he was. There is a strong probability that Greta was physically abused by her son, but this cannot be forensically proven.

Children services focus on the children as their clients, appropriately fulfilling the paramountcy principal in the Children Act 1989. Information about Greta may not have featured in their assessments. John told them that for some time he had been living with his partner and his children. Adult services working with Greta showed him as having lived with his mother for some years. Children' services only had the address of his children. The connection was not made. This serves as a reminder of the importance of checking family affiliations including addresses as part of the assessment process in Children's services.

Her other son is in adult residential care in a catatonic state and so will have had involvement with adult social care for some time and this will have been on record.

John was subject of a MARAC meeting when there were concerns about his children and before they were adopted. (*"Slough holds monthly MARAC (Multi Agency Risk Assessment Conference) meetings to provide risk assessment for people suffering with domestic abuse. At this meeting information is shared on the highest risk domestic abuse cases between representatives of local police, health, child protection, housing practitioners, Independent Domestic Violence Advisors (IDVAs), probation and other specialists from the statutory and voluntary sectors.)*

He is now a subject of a MATAC meeting. *("MATAC exists to identify standard and medium risk repeat domestic abuse offenders and provide a multi-agency approach to reducing harm and demand caused by those offenders." These arrangements are led by police)*

Greta does not appear to have featured in the MARAC meetings when he was violent towards his partner.

Why did Greta not feature at meetings to discuss her son's violence towards his partner?

Information available to partners will have emphasised the family unit he was living with at the time and their assessment relies on information he shared at the time. He is unlikely to have been forthcoming about his mother and, as concerns were about the children and his partner as victims, the extent of assessment were confined to this remit. In these circumstances, those working with the family are unlikely to have been aware of Greta or of her relationship with him

and her dependency on him. There were several incidents during 2015 and 2016 when John's family were breaking down and this suggests that pressures on the young family were possibly impacting on Greta. Concerns about his partner and children were serious enough to be considered at the MARAC meetings. There may have been missed opportunities to consider if there are any other vulnerable family members affected by his violence. This is difficult in practice if the perpetrator does not share information about the extended family and requires a pro-active approach to find out if he has other addresses in Slough.

Learning

A logical conclusion of the above might be to suggest that Children's social workers establish if there are any other vulnerable members of the family if they possibly can. This suggestion is constrained by our knowledge in practice that Greta may not have featured in John's presentation to children social workers and they can only work with what John or his partner may have told them about family life and he is unlikely to have been forthcoming with this information. This emphasises the importance of making checks of adult files including addresses when carrying out such assessments.

This review suggests that MATAC should establish if there are any extended vulnerable family members who might be affected by the perpetrators violence.

This review learned that John had problems of his own, involving substance misuse and family breakdown and the natural emotional and psychological challenges these bring.

In the light of this, this review identifies the key features affecting family life in Slough and borne out by research and national experience. Adult mental health problems, substance misuse and domestic abuse have seriously and adversely impacted on this family through 3 generations. Each local partnership with responsibilities in these areas, (Slough Well Being Board, Slough Community Safety Partnership and Slough Safeguarding Partnership) make efforts to fulfil their statutory duties in this regard. The potential for collective action, across all 3 partnerships on these serious threats to the health and safety of Slough residents has not yet been explored. Tackling the safeguarding, community safety and health implications of these social problems separately has limited impact. Tackling them together, using one strategic movement across 3 partnerships is more likely to have a more powerful impact on local people.

KLOE 5) What does the phrase "Adult Safeguarding" mean to safeguarding partners in Slough and what does it mean to vulnerable adults? What did it mean to Greta?

The workshop did not address this KLOE in detail so below the author's analysis based on the discussions in the five KLOE's above, and reviewing partner's reports.

The phrase "Adult Safeguarding" seems to have a different meaning in the current narrative. and is open to varied interpretations by various partners.

Why is the phrase "Adult safeguarding" interpreted differently by different people?

The pan Berkshire safeguarding adult procedures refer to criteria for *adult social care intervention* as applying to a small cohort of adults, those with existing clearly recognised and identified care and support needs. Expectations, custom and practice around this has largely been unchanged since the implementation of the Care Act 2014. The procedures, in describing this narrow cohort for the interventions of one agency, have the unintentional effect of obscuring the extended or general interpretation of the term "safeguarding" as understood by partners and society in general and so they reduce multi-agency possibilities. Each partner has safeguarding duties and in suggesting conditions for one agency's involvement, partners' contributions may not be applied in practice at the onset of concerns. So, when adult social care services say "it is not safeguarding", they mean "this information

suggests that there are no grounds for formal adult social care safeguarding intervention". They are referring to the single agency duties. When partners talk about safeguarding, they are referring to the need of a person, the risk of harm to them and what can be done to help safeguard them and this can include safeguarding at a more generalised level. These different perspectives can create tensions and misunderstandings and can increase the propensity for multi-agency inertia when a person refuses consent.

KLOE 3 above refers to national and local research and experience leading to increased awareness of coercion and control and exploitation and its many forms. Mental capacity can fluctuate and be affected by fear, intimidation and violence to such an extent that these conditions are normalised. The victim can even blame themselves. In these circumstances a person can meet the criteria for formal intervention and the assumption of mental capacity can be open to challenge. However, in practice, this can be very difficult to apply. Our understanding of Safeguarding Adults is broadening as we learn about these factors. In practice, partners are struggling to stretch local outdated procedures and protocols in an effort to make them fit current concerns. This is unsustainable and new thinking is required.

Learning: "*What did the phrase "Adult Safeguarding" mean to Greta?"*

The term "Adult safeguarding" is used interchangeably, referring to teams, individuals, meetings and procedures sometimes at the same time. It is therefore understandable that when approaching a vulnerable person like Greta, the suggestion of safeguarding can be frightening, appear intrusive and feel very stigmatising. It is not difficult to understand why a person would not want such a process to invade their family life however fragile or risky it might seem.

Greta's decision can be clearly understood in this context. This review has learned that a care co-ordinator gained her trust and confidence and worked very skilfully and diligently with her to persuade her to agree to the safeguarding process but Greta continued to refuse consent to be involved in Safeguarding procedures.

As our understanding of safeguarding adults is broadening since the implementation of the Care act 2014, a new local multi-agency protocol needs to be devised and applied ensuring case such as this as discussed by partners together to decide on whether to proceed with safeguarding concerns or use the Multi-Agency Risk tool. This should clearly describe the purpose and structure of such a multi-agency meeting which should be held where there are safeguarding concerns with or without the consent of the adult concerned. Misunderstandings about data protection need to be addressed to ensure understanding that current legislation *(GDPR 2018)* supports information sharing without consent. A strategy meeting held in these circumstances can initiate either safeguarding procedures or the Multi-Agency Risk Framework and Tool (MART).

If a person is considered at risk of harm and they are refusing consent to safeguarding services offered then the safeguarding partnership Multi Agency Risk Tool should be applied immediately. In such circumstances, adult social care services should lead at the first meeting at least. This learning should be monitored closely by the safeguarding partnership.

Inaction is never an option in such circumstances and practitioners should be supported and encouraged to take what action they can together.

CONCLUSION (and KLOE 6): ***Were the risks to Greta identified, understood and appropriately shared?***

Partners agree that safeguarding concerns were largely responded to legitimately and in compliance with procedures but were limited in their effectiveness as they did not reduce the recurring risks to Greta. Responses were not informed by the history, (see table 1 summarising incidents) and so could not have been adapted to address Greta's individual personal circumstances. This review has identified the factors that limited partners' ability to resolve Greta' situation. When the injuries were identified and concerns raised, those working with Greta encouraged her to get the help she needed. However, she consistently and repeatedly refused interventions. During the last 10 years, her mental capacity was not in any doubt and so partners felt unable to pursue this further.

Why did this happen?

In analysing this, partners taking part in this review came up with 3 related themes to explain why this can come about in practice. These themes are referred to throughout this report.

Inertia arising from refusal to consent

When a person with mental capacity refuses consent, there is a danger of inertia as partners can feel unable or ill-equipped to take proportionate action. There were times when professionals gained her co-operation and trust but the line was drawn by her at the point where concerted action to safeguard her was suggested. So, despite the best efforts of staff working with her, her decision had to be respected. GDPR *(GDPR 2018)* has led to widespread awareness of the importance of preserving the privacy of clients and maintaining confidentiality. However, these regulations also allow for the sharing of information without consent where there are concerns about a person's safety and/or to prevent crime. Education and training on the provisions of the data protection legislation largely emphasises the former without balancing it with the latter. This leads to a default position, a tendency not to share. This propensity obscures practitioner's professional judgement in practice. They can sometimes feel that they are operating against their own professional intuitive inclination to help and support as they feel bound by misinterpreted legislative requirements.

Added to this is the concern that practitioners will have if they do proceed to take action without consent as they are concerned that it might be perceived by the client as a betrayal of trust.

There may have been an assumption that the only intervention was police action when there were other ways to protect her which she may have agreed to.

The impact of fear, coercion and control has on a person's mental capacity and therefore their ability to consent needs to be made explicit in procedures, training and practice. Greta's experience is also a reminder that domestic abuse can be interfamilial and is not confined to intimate partners.

All of these factors are at play when a practitioner is making decisions about what, if any, action to take. There is a suggestion that this could render the system helpless to help, unless we learn from this case.

Episodic approach

Retrospectively, episodes of similar injuries and Greta's refusal to consent to safeguarding procedures can be seen as themes in table 1. The time lapse between episodes and the absence of chronologies resulted in a blindness to see the pattern of events happening to

Greta over the years. Each episode generates concern and this dissipated over time. The next episode is likely to be dealt with by a different set of partners so it is taken at face value.

What have we learned?

Domestic abuse is the root cause of concern for many vulnerable families in Slough. This case demonstrates that Greta's son is likely to have adversely impacted on the lives of his mother and his own children. KLOE 4 concludes that there is a need to prioritise awareness raising and training in relation to domestic abuse, coercion and control as well as the importance of whole systems community awareness raising. High quality multi-agency training for professionals is underway but this is not enough. Understanding the impact of coercion, control and fear on mental capacity is not yet embedded in practice. Research on national and local experience needs to be shared and translated into concerted action to support partners to understand these issues in practice. Abuse impacted adversely on 3 generations in this family and they will not be the only family living with these issues in Slough. Research and local experience indicates that children living with Domestic abuse are more vulnerable to exploitation. Fear and its effect on people's ability to seek help affects all ages so there is considerable evidence to support the diversion of resources to provide training and development for professionals and managers and to raise awareness about this in the general community and involving those who work with children and with adults.

Awareness and utilisation of the Multi-Agency Risk Tool (LINK) is gradually increasing. This tool is designed for use when a person does not give consent or does not co-operate with helping services. Promotion of this tool needs to be accelerated. Work to evaluate the impact of the tool is underway and this should be prioritised.

Chronologies are vital to the risk assessment process not an-add on!

This review has demonstrated that the episodic approach presents risks to vulnerable people as if the history and context is not understood, patterns of abuse are not identified and acted on appropriately.

All safeguarding concerns should include a historical chronology as a basis for risk assessment and recurring features recognised and acted upon and this should be a mandatory requirement and scrutinised in supervision and case audit in all partner agencies.

Thresholds of risk and criminal prosecution

The evidence required for criminal prosecution is different to that required to assess risk to inform multi-agency safeguarding action. When risks are present, and criminal proceedings cannot be pursued, and the person refuses consent or to co-operate, no one should stand down. The opposite should happen. This should be a trigger to implement the multi-agency risk tool, developed in 2019 by the safeguarding partnership. This tool enables any partner managing risks of this nature to share information and share the management of the risks. While Greta may not have wanted to engage with police for fear of the implications already described, she, at times, agreed to the provision of further support. An example of this is seen in an incident in 2015 where Greta accepted an increased care package having refused to engage in safeguarding procedures. Practitioners worked hard to support and persuade her. These efforts would have been greatly enhanced by encouraging partners to share the risks, and creatively use MART meetings to come up with a non-stigmatising approach that she could accept. Establishing a trusting relationship that results in the abuse stopping ought to be the collective aspiration. This should not be obstructed by her refusal to consent to safeguarding procedures. We need to find a way that she finds acceptable and keep trying until we find it.

What needs to change? *(This is also summarised on page 1)*

New multi-agency arrangements for responding to safeguarding adult concerns on cases similar to Greta's should be agreed by partners and have the following features:

They should

- be devised and agreed by partners
- refer to what, not whether, further actions should be taken following a safeguarding concern.
- result in one of two options, the MART tool or formal safeguarding procedures.
- Be initiated and led by adult social care services.
- Contain templates and guidance on how to set up meetings, who to invite, minute taking and timescales and template agendas for meetings.

Chronologies must be completed for all safeguarding cases and for cases similar to Greta's. Managers need to ensure that practitioners are convinced of their benefits so they can accept that they are mandatory in practice and are included in supervision and case audit. This should be scrutinised by the Advancing Safeguarding Practice Group as part of the safeguarding partnership learning and improvement framework.

Mandatory multi-agency training on information sharing is provided to all practitioners in partner agencies and this needs to be updated to provide competencies to make the right decisions at the front line with specific reference to cases were the person refuses consent for safeguarding concerns.

MARAC should ensure to explore cases further to establish if there are any vulnerable members in the extended family. Also, should it come to light that the alleged perpetrator is known for DA in relation to other victims, it should be raised to MATAC for review from a perpetrator perspective.

The Violence Against Women and Girls strategy should be revised to include agreed identifiable outcomes and Key Performance Indicators. The Well Being Board, Slough Safeguarding Partnership and Slough Community Safety Partnership should work together to deliver this. It should include;

- prevention,
- early intervention
- responding to concerns
- an agreed approach to perpetrators.
- Associated professional guidance should describe the practice elements of these areas.

A comprehensive, evidence informed approach to training on VAWG.

The new VAWG strategy should result from consensus from partners and led by the Safeguarding Leaders Group as the community safety partnership is a constituent member of this group.

Awareness raising about coercion and control should be accelerated and prioritised across the safeguarding and community safety partnerships. It should include all those who work with children and families as well as those working with adults. This should specifically increase professional competences around understanding the impact of fear on a victim and how it impedes their ability to seek and accept help. The phrase "silenced by fear" stimulates thinking in a broader sense.

A review of arrangements for safeguarding in the community mental health team should be commissioned by senior leaders in health and social care to evaluate the effectiveness of current arrangements and the impact on safeguarding outcomes for clients.

What happens next?

This report was approved by the SARP group in February 22 and the Safeguarding Leaders' group in April 2022.

Learning began as soon as the SARP began as the workshop provided all partners with a stimulus for change.

An action plan will be devised by the Safeguarding Adult Review Panel. Actions will be diverted to appropriate sub-groups and individuals and leads for each action delegated by the SLG.

The impact of the learning from the review will be assessed 6 months and 1 year following publication (March 23) by the SARP group. This will include individual agencies providing an account of the impact of their learning on practice.

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Analysis of Safeguarding Adult Reviews April 2017 – March 2019

Local Government Association, December 2020

Incident/injury reference	Pre-Care Act 2014	June 2015 to present day	Total
Injures to Hand and wrist	**4 in total -** • Sept 2011 • April 2012 • November 2012 • February 2014	**?3 in total** • 1 in April 2016 • ? 1 in June 2015 • May 2021	**7 injuries to fingers/wrists**
Injuries to face	**0**	**2** • 2019 • 2021	**2 incidents**
References to financial problems/Debt (Son in control)	**4**	**0**	**4 incidents**
Incidents		**10 incidents in total** (2015 Son arrested for assault on partner- Mrs VG denied abuse) • June 2015 • 2 in August 2015 • December 2015 • April 2016 • June 2016 • Feb/March 2018 • November 2018 Carer punched in face • Jan 2019 • May 22	**10 Incidents**
Denied or refused to consent to safeguarding (Remaining incidents will be where an explanation was accepted)	**1**	**4**	**5 times**