The audit of 5th August 2020 reviewed the records of six adults who were referred to Adult Safeguarding because of Domestic Abuse. This audit was scheduled to take place in May, but was delayed due to Covid-19. The aim of the audit was to ascertain whether there were good multiagency standards for managing cases and whether organisations have implemented a robust and consistent response in line with statutory and good practice guidance, SGSAB policies and procedures and the six key principles underpinning all adult safeguarding work.

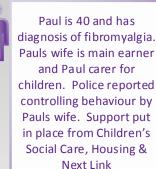
Michael is 97 years old and suffers from vascular dementia, poor mobility and has a catheter. Lives in his own home and his son, who lives nearby supports him and he has a package of care. Referral following Michael reporting that his son had threatened to hit him and had then hit him. Michael had injuries to his arm and nose, some of which could have been explained by a fall. Carers reported controlling behaviour by the son. Enquiry took place but no evidence abuse had taken place and closed.

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Organisations that audited their involvement with the six adults were: Adult Social Care, GPs, Sirona, NBT, Police, Next Link



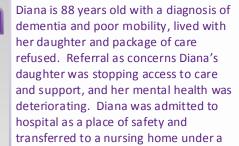




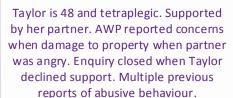
Tracey is 65 and has diabetes and poor eyesight. 1st language is Punjabi. No package of care. Police reported incidents of Domestic Violence. Tracey and her son moved to alternative accommodation away from her husband.

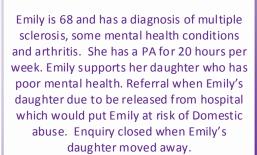
FINDINGS

- Most recent event Contact made with Children's Social Care by police, but not with Adult Social Care, Next Link and GP
- Evidence of good practice and multi agency work for Paul and Emily
- Emily's family had some uniquely complex features and Adult Social Care worked exceptionally well in difficult circumstances and there was good multi agency work.
- The daily huddles that now take place in Adult Social Care encourage reflective practice
- Translation services not always used, and family translation used
- Recording in case file doesn't reflect the work that has happened for Tracey, and management oversight is not reflected in recording
- Creative strategies used to progress work where it seems stuck
- Consistent offer of support for Taylor, which was always refused.
- Sirona visiting Taylor but no information had been shared with them
- AWP information is missing from this audit
- Incidents relating to Michael were not reported to the police
- Michael had a 'This is Me' document, but records do not refer to this apart from on admission to hospital.
- Inclusion of alleged perpetrator in review of Michael.
- The new process in Adult Social Care from 1st September 2020 will improve case working for adults like Diana. This is in line with Making Safeguarding Personal and provides consistency.



best interests decision.







Recommendations

- When a referral is made to children's social care, the referrer must Think Family where there are care
 and support needs for the adult, especially when there are 'hidden disabilities' as in Paul's audit information also not shared with Sirona for Taylor
- Agencies should use independent translators when English is not first language
- Managers should have oversight and ensure recording accurately reflects the work that is ongoing
- AWP need to contribute to the case audits. Lack of representative from NBT, Police and AWP at the
 meeting led to questions that could not be resolved.
- When adults have a 'This is Me' document, this should be shared with all practitioners from every organisation that work with the individual
- When a family member is the alleged perpetrator, care should be taken to ensure their involvement in planning and review is appropriate
- Where there are concerns about domestic abuse of an adult with physical injury, this should be reported to the police

Domestic Abuse Guidance available by clicking here

Contact Next Link
Domestic Abuse
Service by clicking
here

Training about
Coercive Control
available by clicking
here