Kingston Safeguarding Adults Board

Safeguarding Adult Review Statement

The Kingston Safeguarding Adult Board commissioned a Safeguarding Adult Review on a case relating to Domestic Abuse. The review found three Findings and Recommendations, which are accepted by the Board. These are detailed below and will feed into an Action Plan to enable improvements.

Findings

1. Domestic abuse, risk identification and especially coercive control are not well understood by professionals locally and knowledge of risk indicators and safety measures are not embedded in practice.
2. Systems and practice do not aid multi agency working and information sharing.
3. Assumptions about a person's capacity are being made without full assessment.

Recommendations

1. Improve knowledge and practice on domestic abuse including coercive control
    - The Board should audit the training available around domestic abuse risk, needs and safety planning and instigate a programme that fits any gaps in knowledge or practice. Working with local specialist services an overview of services available could be shared across professional networks. It's good practice to have a service that is available in GP surgeries this should be promoted and utilised bearing in mind that increasing the use of this service may involve increasing funding it to enable it to work to a greater capacity.
    - The specific risk factors for older people with dementia mentioned abuse needs to considered in the 'other relevant information' section of the DASH Risk Checklist and professional judgement used to assess risk in each case. Training within adult services should emphasise this, paying particular attention to the capacity of the victim to engage meaningfully in subsequent safety planning work.
    - The impact of this could be monitored by reviewing adult safeguarding referrals into specialist services and MARAC.
2. Improve robust information sharing between agencies
    - Review the SAB ISP and ensure all the necessary agencies are signed up to it. Promote the use of professionals meeting as a method of gaining and sharing information to enable safe decision to be made. Ensure through supervision that information has been shared appropriately to or from agencies as necessary. This

should pay attention to patients who switch between public health and private providers, sharing safeguarding concerns and best interest decisions.

3. Improve understanding and assessment of capacity
    - Professionals described several instances of capacity being assumed rather than tested. This may be due to knowledge and/or workload. The SAB should assure itself that professionals are aware of how and when capacity should be assessed and have processes in place to monitor and review those with fluctuating capacity. The board may wish to consider an audit of cases of dementia to check whether capacity is being routinely assessed when required or not.