Salford Safeguarding Adults Board

Briefing Document for Christopher

This briefing provides a summary of the key themes and lessons to be learned following a Safeguarding Adults Review (SAR) undertaken by Salford Safeguarding Adults Board (SSAB).

1. About the Adult

Christopher was a gay man with a diagnosis of cancer, both of which are protected characteristics as codified by the Equality Act 2010.

Christopher was known to live with various physical and mental health problems. Christopher's engagement with mental health services over the years was sporadic and he was often discharged from services due to poor attendance and 'non-engagement'.

Christopher was in a long-term relationship and had disclosed domestic abuse. There were also concerns from professionals regarding controlling and coercive behaviour. The couple were known to Multi Agency Risk Assessment Conference (MARAC)[2].

2. What happened?

Towards the end of Christopher's life, he was bed bound due to renal and spinal cancer. Christopher also required bariatric care.

Christopher was taken to hospital after an alleged assault by his partner, Steven. He then disclosed that his partner has been withholding medications, food and drink and kept him alone in the bedroom.

Shortly after being admitted to hospital, Christopher sadly passed away.

3. What worked well

The agency reports submitted to this review and the discussions around Christopher have highlighted examples of good practice[1] from professionals involved with him, including:

A professional contacted the Police reporting Christopher had been assaulted and was a victim of coercive and controlling behaviour from Steven. The police took positive action on receipt of this third-party professional report and arrested Steven.

[1] Good practice in this report includes both expected practice and what is done beyond what is expected.
[2] SSAB website provide further information about Domestic Abuse and MARAC

Once the process on how to move a bariatric patient downstairs was clarified, the Occupational Therapist circulated this information to immediate team colleagues. This information was also shared with the Hospital End of Life Care strategic meeting attended by hospital, hospice and community nurse managers and leads.

The Occupational Therapist and Palliative Care Nurse were proactive and regularly communicated and updated each other regarding Christopher's case because it was complex and there were many challenges.

Christopher's case was discussed on at least three occasions at the joint Hospital and Community Specialist Palliative Care multi-disciplinary team meeting attended by hospital and community staff. It was also discussed at the Hospice Caseload Review meetings which is attended by hospice staff.

There was a great deal of flexibility to arrange admission into hospital. Although Christopher did not attend appointments, alternative arrangements were discussed between Radiology and the Urologists.

4. Key Learning from the Review

Christopher and Steven were in a relationship from 2003. There was a report of domestic abuse from 2009, but no further incidents were reported to professionals until 2016 - when Christopher disclosed to his GP that their relationship had been abusive for many years. Opportunities for agency interventions existed from 2016, but these early opportunities for multi-agency support for Christopher did not develop and the abuse was not recorded effectively to inform future risk management and support.

During the review period, Christopher's health deteriorated. Both Steven and Christopher reported that Steven was Christopher's carer, but Steven frequently obstructed professional contact with Christopher.

Agencies predominantly managed their interactions with Christopher on a single agency basis. Professionals referred concerns into their own agency safeguarding meetings, but, challenged by the ethical dilemma of balancing autonomy with fulfilling a duty of care, professionals demonstrated some uncertainty regarding whether the concerns warranted a multi-disciplinary safeguarding concern. Commonly, as professionals deemed the threshold for a safeguarding referral to have been met, contact with Christopher would be achieved, and their concerns would be temporarily alleviated. Opportunities to ask Christopher routine safeguarding questions (when alone) were not taken, and there is little evidence of professional curiosity being applied to Christopher's home circumstances. This meant professionals had little understanding of Christopher's lived experience.

Christopher's unwise decisions around his support and healthcare were deemed to be a consequence of his mental health. Consequently, referrals to help Christopher address this were made by professionals who clearly cared, but these were ineffective due to Steven's obstruction.

In 2022, Mental Health professionals conducted an emergency home visit to see Steven following a referral from his GP, which recorded that the main contributory factor to Steven's deteriorating mental health was his very demanding caring role relating to Christopher. There was no consideration of the impact on Christopher of Steven being his sole carer.

Christopher, with Steven as his carer, was isolated and unsupported. The Salford Safeguarding Adults Board hope that this review will create an opportunity to reflect upon professionals' understanding of Christopher and his history, serve as a driver of change moving forward and lead us to better practice.

5. Questions to the Salford Safeguarding Adults Board (SSAB)

To address the learning, the review has asked the Salford Safeguarding Adults Board to deliberate the following questions. It is the responsibility of the Salford Safeguarding Adults Board to use the ensuing debate to model an action plan to support improvements to systems and practice.

Question 1: How can partner agencies assure Salford Safeguarding Adult Board that their professionals understand and can recognise indicators of domestic abuse occurring within any LGBTQ+ relationships and are able to support victims?

Question 2: How can partner agencies assure Salford Safeguarding Adult Board that their professionals have a full understanding of the safeguarding concern process?

Question 3: How can partner agencies assure Salford Safeguarding Adult Board that professional meetings are being convened when an adult with suspected or known vulnerabilities is not attending appointments?

Question 4: How can partner agencies assure Salford Safeguarding Adult Board that their Mental Capacity training is incorporating Executive Functioning/Capacity?

6. Development and changes that have taken place since the scoping period

Agencies have already made some important amendments to practice since the scoping period of this review. Some of these developments have been included in the body of this report.

Others include:

- Greater Manchester Police revising their overarching domestic abuse policy, published in August 2022. This incorporates all aspects of dealing with Domestic Abuse incidents, from initial attendance through to custody processes and post-incident victim and perpetrator support. This has been supplemented by training inputs across all districts, delivered by Greater Manchester Police's Public Protection Governance Unit and Investigation and Safeguarding Review Team to inform about the changes and focus on the onward referral of all

triaged Domestic Abuse incidents. To supplement this, a "Domestic Abuse Matters" continual professional development input is also being rolled out by charity SafeLives across Greater Manchester Police until March 2023.

- Adult Social Care are exploring a warning indicator for domestic abuse cases on their electronic recording system.

- Adult Social Care's Liaison Domestic Abuse lead now attends all teams to share information on domestic abuse services.

7. Signposting and Resources

If you are worried about an adult – you can report any concerns of abuse or neglect by telephone on 0161 206 0604 or online by using the 'Report a safeguarding concern form', please see the links which provides all the necessary information to report your concern.

For professionals there are additional resources available via the following websites:

- Greater Manchester Police
- Salford City Council - I am a professional • Salford City Council
- Getting help for domestic violence and abuse - NHS (www.nhs.uk)

In Salford, a Domestic Abuse Toolkit has been developed in Salford to support practitioners to work safely and effectively with adult victims, children and perpetrators of domestic abuse and aims to ensure everyone has the expected level of support.

For further information please visit Domestic abuse toolkit | Salford Safeguarding Children Partnership

Support and Services for Domestic Abuse

In 2022, Salford has created **'Safe in Salford'** domestic abuse service which brings together a number of partners to deliver a holistic service. **Salford Foundation** was commissioned as the Lead provider.

There are five elements to the partnership:

1. **Crisis Services** (Independent Domestic Violence Advocates, or IDVAs) for victims / survivors.
2. **Advice and Support** Services for Victims / Survivors
3. **Specialist Support** for GP's (known as IRIS which stands for Identification and Referral to Improve Safety)
4. **Children and Young People's Support** (Harbour)
5. **Behaviour Change Programme** for Perpetrators.

Please visit **Salfordfoundation.org.uk/safeinsalford** for further information regarding the support available to the public and professionals. The website also advises you of the referral pathway for the service.

Please visit the SSAB website Safeguarding Policy and Procedures. Tri-x has provided a list of useful and key National Contacts including National Domestic Abuse Helpline, which is 0808 2000 247.

Other national resources for both professionals and the public

- Mankind – Helping men escape domestic abuse – **01823 334244 to speak to them in confidence**
- Respect Men's Advice line – they are there to support men experiencing domestic abuse with no pressure, no judgement, just help **– Freephone 08088 010 327**
- Galop – Support LGBT+ people who have experienced abuse and violence - **National Helpline for LGBT+ Victims and Survivors of Abuse and Violence – 0800 999 5428**

Bite Size Briefing

The SSAB held a Bite Size Briefing (a short online briefing session) on the Safe in Salford domestic abuse service in January 2023.

A Bite Size Briefing has also been held to explain the purpose of MARAC (Multi-agency Risk Assessment Conference/MAPPA (Multi-Agency Public Protection Arrangements) /DAPP (Domestic Abuse Perpetrator Programme)

Both these sessions were recorded. If you would like to access the recording, please e-mail your request to ssabtraining@salford.gov.uk

Learning has been shared with all agencies involves a robust Action Plan developed to address the key themes and learning, which will be monitored on a regular basis.

The SSAB will develop further mechanisms to disseminate learning for practitioners to raise the profile of lessons learned and areas of good practice from this case and other SARs in the system in due course.

For more information visit our website https://safeguardingadults.salford.gov.uk/.