A Safeguarding Adults Review In Rapid Time: Systems Findings Report

The Dorset Safeguarding Adults Board, 14 October 2021

In 2019, an 85-year-old woman was admitted to hospital following a reported assault by her husband. She later died. The case was originally considered for a Domestic Homicide Review by the Dorset Community Safety Partnership however a forensic pathology report concluded that she had died of natural causes (Cerebral Haemorrhage). The Police were not undertaking any further enquiries and therefore the case was referred to the Dorset Safeguarding Adults Board (DSAB) for a Safeguarding Adults Review (SAR) to be undertaken.

S44 of the Care Act 2014 places a duty on Safeguarding Adults Boards to arrange a SAR when an adult 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. A SAR promotes learning and identified improvements to prevent future death or serious harm occurring again. The process is supported and agreed by all members of the Dorset Safeguarding Adults Board.

The DSAB Chair maintained contact with family members throughout the review period to offer condolences and to outline the SAR Process. The Chair both wrote and spoke with family members to ensure clear communication was maintained. The findings of this review are confidential. To protect identity family members were asked to choose a pseudonym. The name Katherine was chosen.

Katherine was a white British woman who in her later years experienced a number of physical health issues. She initially accessed support from services in respect of her role as carer for her husband but latterly for her own care and support needs.

Katherine was 85 years old at the time of her death. She was born and lived in Dorset all her life and was married for over 60 years. Both she and her husband held strong religious beliefs. These beliefs guided and informed her decision making throughout her life. Katherine was a hard worker and for many years worked alongside her husband.

Katherine's children described her as a loving mother who would always play games with them including tennis, take them on long walks, pick wildflowers and as someone who loved to cook and bake. She would often make sponge cakes with the children, allowing them to mix all the ingredients and scrape the bowl too!

There were always animals in the house. Katherine loved her dogs and always had a cat. In her later years particularly, they provided her with friendship and comfort.

Katherine took pride in her appearance and always liked to look nice, she would never leave the house without putting her lipstick on. She enjoyed painting, knitting, reading,

gardening and took great pleasure in feeding the birds. She was friendly to everyone she met.

Throughout her contact with services Katherine described a married life in which she had experienced domestic abuse and coercive and controlling behaviour over many years. As her husband's health deteriorated, she became his carer. This increased his dependence and demands on her and ultimately placed more strain upon her emotional and mental wellbeing.

Some years before her death Katherine experienced a heart attack. This resulted in a significant decline to her physical wellbeing. Katherine was less able to independently move around the home, access outside areas or the community. She became increasingly reliant on her husband for her care, but this also created further pressure and conflict within the marriage. Katherine remained a loyal wife despite the difficulties and abuse she experienced throughout her marriage. She believed that her place was by his side. Her children advised that they could never understand why she did not leave despite the support they had offered her to do so. They believe this to be because of pride and being of a generation where it wasn't the acceptable thing to do.

The DSAB collaborated with the Social Care Institute for Excellence (SCIE) to develop a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

Identified Abuse Types: Domestic Abuse
Discriminatory Abuse

What is a SAR In Rapid Time?

The model of a 'SAR In Rapid Time' aims to turn around learning in an approximately 3-6 week timeframe, following the set-up meeting. The set-up meeting is held after the decision has been made to progress with a review. An outline of the process is set out on page 3.

The learning produced through a 'SAR In Rapid Time' concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

Standardised processes and templates support an analysis of a case to identify systems findings in a speedy turnaround time.

The process is supported by remote meeting facilities and does not require any face-to-face contact.

The SAR in Katherine's case used the process and tools of the 'SAR in Rapid Time' model but did not follow the rapid timescale.

Outline of a SAR In-Rapid-Time

1. **Set up meeting**
2. **Check of agency records**
3. **Produce early analysis report to structure discussion**
4. **Participants read report in preparation**
5. **Structured multi-agency discussion**
6. **Systems findings report published**

This document

This document forms the final output of the SAR on Katherine's case, using the 'SAR In Rapid Time' template. It sets out the systems findings that have been identified through the process of the SAR. These findings are future oriented and this means that learning is adapted from Katherine's case to ensure that they focus on social and organisational factors that will make it harder or easier to help someone in circumstances such as Katherine's, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning, the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately.

Each system finding is first described. Then a short number of questions are posed to aid the SAB and partners in deciding appropriate responses.

Contact

If you have any questions or queries about this SAR, please contact the SAB Business Unit:

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Systems findings

What are the key barriers/enablers we have learnt about that make it harder/easier for good practice to flourish and that need to be tackled in order to see improvements?

The SARs In Rapid Time methodology distinguishes between case findings and systems findings. Systems findings are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Each finding attempts to describe the systems finding barrier (or enabler) and the problems it creates. This requires that we think beyond Katherine's case, in this instance, to the wider organisational and cultural factors. It also requires that we hold off at this stage from solutions or articulating what is needed, to specify first what the current reality of barriers/enablers is, that the SAR process has helped us understand.

FINDING 1: Enabling practitioners in all agencies to have a role in 'sowing the seeds' with an older domestic abuse victim, of doing something about the abuse

Systems finding

The disincentives for older people who have been living with domestic abuse over years, to do something about it, are many. These include attitudes and beliefs particularly around the role of women, financial dependency on their abuser, or preconceptions about their husband or partner's inability to manage, due to illness and dependency, without their care. There is just so much at stake. In this context, Safer Lives' 'spotlight' publication on *Safe Later Lives: Older people and domestic abuse*[1] highlights the importance of professionals engaged with the victim thinking of themselves as continuing to 'sow the seeds of doing something about the abuse':

> *"You're often sowing the seeds and it's the next time or the next time after that [that the victim will disclose abuse and ask for help] // it's about people knowing that there is support out there, perhaps the next time that they come into hospital they will want to do something about it, or perhaps the next time the district nurse sees something or tries to speak to them about it, they will want to do something".*

The report highlights the importance of consistent dialogue about an older victim's experiences and persistent encouragement to accept help. The hospital based Independent Domestic Violence Advocate worked with an older woman who advised her to:

> *"keep on ringing me and eventually the time will come [where I will inform the police of the abuse and accept further support], but I'm not there yet".*

[1] Spotlights Report # Hidden Victims. Safe Later Lives: Older people and domestic abuse. Safer Lives: October 2016. **https://safelives.org.uk/sites/default/files/resources/Safe%20Later%20Lives%20-%20Older%20peoonple%20and%20domestic%20abuse.pdf**

The disincentives that have been identified in research for older women to do something about their abuse also impacted on the subject of this SAR, Katherine. She had been married for 60 years and up until her death, despite the option of going to live with her son; she did not want to leave her husband, despite his progressively controlling behaviour that saw her isolated, unable to leave the house, speak in confidence to her children, listen to the radio or sleep at night undisturbed. Her faith played an important part in her view that she could not leave him (see Finding 5). While practitioners from a range of different agencies were involved with Katherine, the extent to which they played a role in sowing the seeds that she might one day want to do something about her husband's abuse varied significantly, reducing the extent of it and its potential impact.

The GP practice knew both Katherine and her husband well and had, 4 years earlier, played an active role in enabling Katherine to meet with domestic abuse specialists. Since then, Katherine's situation had become normalised, her husband's behaviour did not appear to be seen as coercive and controlling, and no efforts were made to talk to her about it. The two key practitioners, a Carer's case worker and a volunteer coordinator from Age UK, played a hugely supportive role to Katherine and actively ameliorated her husband's controlling behaviour. They were, however, restricted in their ability to 'sow the seeds' of Katherine doing anything about her abuse, by their knowledge (or lack of knowledge?) of what services were available. Lastly, community health practitioners in contrast had no knowledge of the abusive relationship past or present; there was nothing on the referral for their services to indicate this.

At the practitioners' workshop run as part of this SAR, there was strong feedback that the notion of 'sowing the seeds' was useful, and a good way to think about what you could do in what can otherwise feel like a 'stuck' situation.

Questions for the SAB and partners

- Is there a role for the SAB in promoting across agencies the notion of 'sowing the seeds' with older domestic abuse victims, of doing something about the abuse?
- Is there clarity across agencies about good practice in seeking consent to share information about domestic abuse from victims who do not want to leave their partners, but the abuse is on-going?
- What does the SAB know about any efforts to enable GPs who may have long standing relationships with their patients who are living with domestic abuse, to maximise the role they can play in sowing the seeds of doing something about it?
- How easy is it for staff across agencies to know what services are available for domestic abuse victims, and older victims in particular?

FINDING 2: Recognising coercive and controlling behaviour in old aged married men

Systems finding

If a long-term relationship is marked by domestic abuse including coercive controlling behaviour, how does that dynamic develop in older age? In general, people's worlds start to shrink, opportunities to leave the house and to see other people reduce, physical illnesses progress, depression and anxiety often rise and the complex inter-dependency of caring roles are layered over earlier relationship dynamics and

behaviour patterns. Such a set up requires sensitivity to appreciate what might be going on beneath the apparently settled surface of an older, long-married couple.

Katherine's case provides a distressing example of such a picture. The self-centred, controlling behaviour of her husband was exacerbated by his increased anxiety, in turn exacerbating her own health needs, and so her reliance on him, making her even more vulnerable. Yet what also surfaced through the SAR is the potential for professionals either to deny the possibility of abusive behaviours and/or to minimise their impact on the victim, due to a benign, if infantilising, view of men in older age. The evidence of this dynamic fell mostly outside the time frame set for the SAR. This means there has not been the opportunity to explore the pattern in more detail, particularly with the police.

Questions for the SAB and partners

- How much does the SAB and SAB partners know about domestic abuse by old aged people in long-term relationships?
- Is there a role for the SAB in opening discussion among partners about potential discrimination against domestic abuse victims stemming from a benign view of older people?
- Is there good practice elsewhere on this issue that the SAB might draw on and promote?

FINDING 3: Availability of specialist domestic abuse support for practitioners working with victims of domestic abuse who decline specialist Domestic Abuse services and where domestic abuse is on-going

Systems finding

The disincentives for older people who have been living with domestic abuse over years, to do something about it, are many. Specialist domestic abuse services will often be declined, even though the domestic abuse continues. A safe system therefore cannot rely only on domestic abuse expertise coming directly through specialist domestic abuse service staff. There is also a need to provide domestic abuse expertise indirectly to professionals engaging with an older victim in other roles. This could be located with safeguarding or be an expansion of a domestic abuse service. It would have the additional benefit of building on positive relationships that already exist between the older victim and particular professionals.

Details of Katherine's case indicated such a service does not currently exist in Dorset. Katherine had established relationships with a Carer's case worker initially, and latterly with the social worker who conducted a Care Act assessment. She also had a long-standing relationship with GPs at the local practice. But there was no source of domestic abuse support and advice for them, as distinct from the 'You First' service which would work with Katherine directly, or basic advice to complete a Domestic Abuse & Sexual Harm risk assessment and referral to the Multi Agency Risk Assessment Conference as appropriate. Without this, the situation became normalised on the part of involved GPs (not framed as domestic abuse), and it left the Carer's support worker grappling with an increasingly complex situation as Katherine's health declined, and her husband's controlling behaviour meant she had no rest and so no opportunity to recover.

Questions for the SAB and partners

- Has there been discussion locally about what the options are for enabling adequate domestic abuse expertise?
- Are there models of provision of such specialist expertise used in health that could be considered for social care?
- Is there a role for the SAB in championing the importance of domestic abuse work by non-domestic abuse specialists?

FINDING 4: Clarity about the distinctions between different multi-agency meetings and how they interface with each other

Systems finding

Multi-agency working is key to a safe system, with the potential to make the whole be something greater than just the sum of its parts. Multi-agency meetings are forums to bring different professionals involved with a person together, to share information, review progress, adjust plans and confirm relative roles.

Katherine's case highlighted the number of different forums there are to potentially bring professionals from different agencies together around a person, but none seemed to work to optimum effect for her:

- the Carer's case worker initiated a Multi-Agency Risk Meeting (MARM) but NHS services were not represented
- The Integrated Community Rehabilitation Team (ICRT) escalated Katherine's case to the 'Virtual Ward' meeting but there was no overlap with the MARM or with the allocated Social Worker or Carer's case worker
- There had also been the option of a referral of Katherine's situation to a Multi-Agency Risk Assessment Conference

In the practitioners' workshop, questions were raised about further work to clarify the role and remit of these different meetings, and how governance and oversight arrangements differ between them. Participants stressed the need to make each meeting count, and to recognise when a situation needs more than a particular forum can offer.

Questions for the SAB and partners

- Is the SAB assured that it has addressed how and whether agencies and partners have undertaken adequate work to address the distinction between these different forums and how practitioners can be supported to use them all appropriately and to best effect?
- Are there grounds to think through the roles and remits of different forums specifically for cases of domestic abuse against older people in life-long relationships?

FINDING 5: Enabling confidence across agencies about engaging with men about their abusive behaviours

Systems finding

A key part of tackling domestic abuse is engaging with perpetrators about their behaviours. This needs to be underpinned by a risk assessment due to the possibilities of escalating the person's abusive behaviour. These conversations can be led by anyone who has a relationship with the person concerned, dependent on the practitioner's skill and confidence.

In Katherine's case, conversations needed to be opened with Katherine's husband about how he was finding the relationship, his understanding of what a healthy marriage looks like, particularly in older age, etc.

In the practitioners' workshop the Age UK volunteer coordinator and the Carer's case worker described how they had tried to challenge him on some of his controlling and verbally aggressive behaviours, but he would always deny it. In contrast, input from the GP suggested a marked minimisation of his coercive controlling behaviour. ICTR practitioners noted that the referral to them did not come with any indication of the history of domestic abuse and coercive controlling behaviours, so they were unaware of the history. With more information they would have been more alert, but even then, would not have felt comfortable opening up a conversation about domestic abuse or coercive control.

Questions for the SAB and partners

- What does the Board and its partner agencies know about programmes and interventions locally for perpetrators of domestic abuse, including coercive and controlling behaviour, particularly for older men in life-long relationships?
- Is there a role for the SAB to enable discussion about the right balance between specialist roles and skills across all agencies for engaging with older men about coercive and controlling behaviour?

FINDING 6: Engaging with faith groups as important safeguarding partners

Systems finding

Faith leaders, staff or volunteers of faith organisations and community members can play an important role in ensuring that faith is a resource rather than a roadblock for people subject to domestic violence.[2] Faith leaders and community members can assist people in abusive domestic relationships as well as working to hold perpetrators accountable. Faith groups therefore are important safeguarding partners.

For older married women who identify with a particular faith and who have suffered a lifetime of domestic abuse, faith leaders and community members may help to challenge assumptions that it is against their religion for a wife to leave her husband when he is in need, regardless of the circumstances. For older men who identify with a particular faith and who have a lifetime of being violent, coercive and controlling toward their wives, faith leaders and community members may help to shape discussions about

[2] https://avaproject.org.uk/wp-content/uploads/2016/08/Praying-for-Peace-2008-3.pdf

domestic violence, to challenge and change attitudes to domestic violence and abuse. It is of course vital they have a good understanding of domestic violence in order to avoid inadvertently escalating situations and increasing risks.

Katherine and her husband belonged to a Faith Group. However, this information was not known across the professional network working with Katherine. There were also no established safeguarding links into this faith community that the professionals involved could have sought advice from, whilst maintaining client anonymity. Similarly, there was no professional expectation to encourage practitioners to explore Katherine's views about bringing in her faith group leaders or community for support.

Questions for the SAB and partners

- Is the SAB actively engaged enough with all faith groups active locally generally, and specifically about domestic violence in faith communities?
- Is there a role for the SAB in encouraging discussion about the role of faith as a roadblock or resource for victims of domestic abuse and professionals attempting to support them?