Hillingdon Safeguarding Partnership

Newsletter, April 2025

The Safeguarding Partnership Vision

For every child and young person to be and feel safe, enjoy good physical, emotional and mental health, have pride in their unique identities, feel that they belong and have opportunities to thrive.

For adults, irrespective of age, race, gender, culture, religion, disability or sexual orientation to be able to live with their rights protected, in safety, free from abuse and the fear of abuse.

All previous newsletters can be accessed here.

This newsletter is a special issue focusing on learning from Hillingdon's recently published Safeguarding Adult Reviews. Much of the learning is similar to Child Safeguarding Practice Reviews and is widely applicable across the children's and adult's workforce.

- **Mairead**
- **Rachel**
- **Safeguarding Adults from Pressure Ulcers - watch the webinar**
- **Ms. Stitch**
- **Thematic Learning Across Local SARs - watch the webinar**
- **Appropriate Use of Language**
- **Lived Experience**
- **Legal Literacy: Mental Capacity Act 2005**
- **Legal Literacy: Care Act 2014 and the Care and Support Statutory Guidance**
- **Partnership Working**
- **Professional Curiosity**

Partnership News:
LBH Cuckooing and Exploitation Protocol, New Adult Neglect Strategy, Safeguarding Partnership Information Webinars, Partnership Training Offer

Subscribe to the Safeguarding Partnership mailing list here - it only takes a minute! You will receive new briefings and newsletters as soon as they are published.

Local Safeguarding Adult Reviews

Safeguarding Adults Reviews (SARs) take place when an adult with care and support needs has died, or suffered serious harm, as a result of abuse and neglect. These reviews look at the work of all involved agencies and professionals to identify learning that can be used to improve practice for other adults at risk.

Three SARs recently published in Hillingdon are Mairead, Rachel and Ms. Stitch. The SARs and their key learning are set out below.

Mairead

Mairead was a 70-year-old white female open to secondary mental health services with a diagnosis of schizophrenia. Mairead saw a psychiatrist periodically and attended a psychiatric medication clinic regularly. She was in supported accommodation with a low level of floating support attached.

In June 2021 she was taken to hospital by ambulance very mentally unwell and physically frail. She sadly died in hospital.

Executive Summary

Practitioner briefing

Key Findings:

Throughout May and June 2021 professionals who saw her documented recurrent concerns about deteriorating mental state and difficulties engaging her in face-to-face contact. She was described on multiple occasions as appearing "unwell". However, opportunities to intervene in response to these concerns were missed until she was in crisis.

Key Messages for Practice:

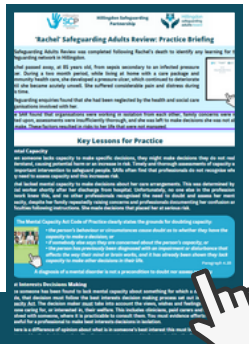
- **Assessments should be holistic and take account of all available information.**
- **Assessments of any health or social care needs must involve information gathering from all involved professionals, including any care or support providers.**
- **Support, treatment or care provided should be kept under review, and reviews should involve everyone involved.**
- **It is important to listen carefully to family members and proactively ask their views on their loved one's needs and risks.**
- **When someone does not attend appointments, be curious about why, risk assess through discussions with other involved professionals and family, and follow your organisation's policies.**
- **If you are concerned someone is deteriorating on physical or mental health - promptly talk to the person, their family, and the other organisations involved. Do not assume someone already knows.**

Rachel

Rachel passed away, at 85 years old, from sepsis secondary to an infected pressure ulcer. During a two month period, while living at home with a care package and community health care, she developed a pressure ulcer, which continued to deteriorate until she became acutely unwell. She suffered considerable pain and distress during this time.

Full Safeguarding Adult Review

Practitioner briefing



Key Findings

Organisations were working in isolation from each other, family concerns were not acted upon, assessments were insufficiently thorough, and she was left to make decisions she was not able to make. These factors resulted in risks to her life that were not managed.

Key Messages for Practice

- **If someone is at high risk of skin breakdown, everyone involved must take preventative action - sufficient care, continence management, appropriate equipment - and ensure everyone involved understands the risks and how to manage them.**
- **If someone is making choices which put them at risk, you should doubt their mental capacity, explore their reasoning, support them to understand the risks, and assess their mental capacity.**
- **If you determine someone lacks mental capacity about something, tell other involved professionals and informal carers.**
- **If someone lacks capacity to make a decision, you must make a best interests decision on their behalf, following the lawful process in section 4 Mental Capacity Act - you MUST consult other involved professionals and their family and friends.**
- **Differences of opinion must be resolved before a best interests decision is made - if not resolved, you may need to go to approach the Court of Protection. No one except a judge has the power to override family members views or other professionals.**
- **Assessments of social care needs must involve consultation with involved health professionals, care providers and family members.**

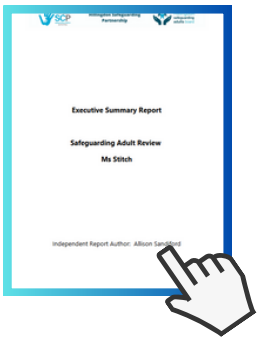
This pre-recorded webinar shares key lessons for all professionals about safeguarding adults from pressure ulcers.

Ms. Stitch

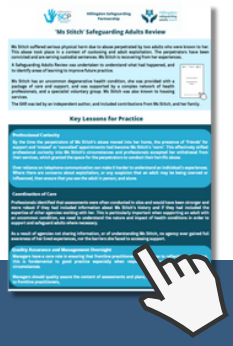
Ms Stitch has a rare neurodegenerative health condition, she was provided with a package of care and support, and was supported by a complex network of health professionals, and a specialist voluntary group. Ms Stitch was also known to housing services.

Ms Stitch suffered serious physical abuse perpetrated by two adults who moved into her home. This abuse took place over several months in the context of cuckooing and exploitation.

Executive Summary



Practice Briefing



Key Findings

Professionals worked in isolation from each other, did not pick up signs and indicators of exploitation and cuckooing, and did not arrange sufficient care and support to meet her needs, leaving her dependent on others to help. Her abusers were considered informal carers, yet no attempts were made to explore their ability and willingness to provide care, nor their identities or social circumstances. The impact of deteriorating executive function wasn't considered in any assessments. Poor engagement with a range of services was assumed to be a choice rather than a consequence of being physically unable to attend, deteriorating cognitive function or being held captive in her home by abusers.

Key Messages for Practice

- **Assessments should include consultation with other involved professionals and family members as well as the subject adult.**
- **Take account of degenerative conditions in your assessments and reviews - if you don't know about the condition, look it up and ask questions. Degeneration means the person's needs will increase over time.**
- **Many neurodegenerative conditions affect cognitive function - understand how a condition could affect someone's ability to plan, make decisions and assess risk.**
- **If anyone comes forward as an informal carer ensure you know who they are, and explore their ability and willingness to provide care. If they say they are providing support establish what they are doing and whether it is meeting the person's needs.**
- **Pay attention to the dynamics between informal carers and the cared for person.**
- **If someone has debts or reports financial abuse, consider their mental capacity and their cognitive ability to manage their finances.**
- **If there is a concern that an adult is being exploited, ensure that you speak to them alone and in person**
- **Follow the LBH Cuckooing and Exploitation Protocol**

Thematic Learning Across all Local SARs

Rachel, Mairead and Ms. Stitch had different stories and very different experiences and needs. However, a number of themes emerged across all three SARs. These themes also appeared in previous Hillingdon SARs and are common themes across SARs from other areas.

Use of Language

Clearer language, avoidance of victim blaming or dehumanising language, and avoidance of euphemisms, can improve overall professional responses to adults at risk.

Lived Experience

Greater focus on the lived experience of adults at risk can improve professional recognition of and response to need and risk. Asking questions and giving weight and value to the wishes, feelings and views of adults and risk and their family and friends can aid assessments of needs and risks. Pain, distress, and fear expressed to professionals should be taken seriously and used to inform professional decision making about risk management. Sometimes trauma in someone's past can impact significantly on their needs, safety and behaviour in the present - it is important to think about how someone's past affects the present. A person's history and the use of chronology of previous concerns and events are important for contextualising any current concerns.

Management Oversight and Supervision

Effective quality assurance of assessments, recording, and interventions by managers supports the quality and effectiveness of practice to support and safeguard adults at risk. Good supervision, which challenges assumptions, explores legal requirements, and helps professionals pay attention to the lived experience of the people they are supporting is an important part of good safeguarding practice.

Legal Literacy

When professionals, across all organisations and disciplines, understand the laws and statutory guidance underpinning their responsibilities, particularly the Mental Capacity Act 2005, the Care Act 2014 and GDPR, their efforts to support and safeguard adults at risk are more effective. If you are not sure, read the primary legislation, be familiar with statutory guidance, and ask for legal advice.

Partnership Working

Professionals and organisations working together in partnership, communicating openly, seeking and sharing information, and making joint plans together can improve risk identification and risk management for adults at risk. Working in silos makes it much harder to support and safeguard people. If you don't know who else is involved, find out.

Professional Curiosity

Increased willingness and confidence to ask questions, seek out information, look beyond the superficial information, and reality test information provided can improve the identification of and response to risks and better enable professionals to support and safeguard adults at risk.

This Safeguarding Partnership webinar covers learning from these three local SARs

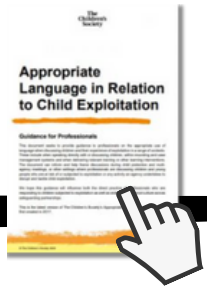
Appropriate Use of Language

Our choice of words and phrases can influence the way people think about what is happening in abusive or neglectful situations, our perceptions about who has the power to effect change, and the way professionals perceive risk and responsibility.

Language implying a vulnerable adult is responsible in any way for abuse or neglect to which they are subjected, must be avoided to ensure we initiate a safeguarding response when needed, and appropriately acknowledge our power and responsibility and that of any perpetrators.

This language guidance has been developed and agreed by a multiagency group of professionals from across the health, social care and policing network in Hillingdon.

There is also a language guide from the Children's Society to support work with children and young people at risk of exploitation



Lived Experience

This briefing is based on the wisdom and experiences of people in Hillingdon with lived experience of safeguarding interventions. Children and adults were asked about their experiences and about what helped them feel listened to.

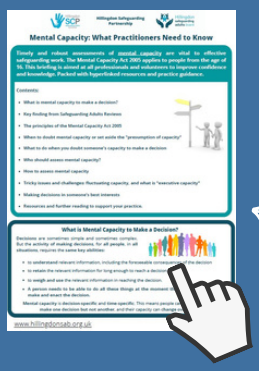
It includes short videos co-produced with adults and children with lived experience of safeguarding support.

The Safeguarding Partnership has commissioned training for a multiagency audience on how to work in a trauma informed way with adults and children. You can access this through Learning Zone.

Legal Literacy : Mental Capacity Act 2005

When someone lacks capacity to make specific decisions, they might make decisions they do not really understand, causing potential harm or an increase in risk.

Timely and thorough assessments of capacity are an important intervention to safeguard people. SARs often find that professionals do not recognise when they need to assess capacity and this increases risk. The Mental Capacity Act 2005 is relevant for people over the age of 16.



Use this briefing *Mental Capacity: What Practitioners Need to Know*

Once someone has been found to lack mental capacity about something for which a decision needs to be made, that decision must follow the best interests decision making process set out in Section 4 Mental Capacity Act. Make sure you understand the lawful process.

Familiarise yourself with the Code of Practice you must follow

Legal Literacy: The Care Act 2014

Make sure you know what the Care Act 2014 says and understand its implications for you. Here are some key sections that were misapplied or overlooked in one or more of the local SARs.

Section 7

- **There is a duty on all professionals to work together to support adults who might have care and support needs.**
- **If a local authority requests co-operation of a health professional, or other relevant professional, to help in the assessment or support of an individual, they *must* cooperate, unless it is incompatible with their own duties. And vice versa.**

Section 9

- **The local authority has a legal duty to assess needs of people who appear to have care and support needs - this includes people who might need supported accommodation.**
- **People who are receiving support, including floating support, have the appearance of support needs and therefore are owed a duty of assessment.**
- **Anyone providing care to an adult, e.g. a family member helping with financial management or food shopping, or someone paid to provide care or support, *must* be consulted in an assessment of need or reviews of a care and/or support package.**

Section 10

- **Informal carers are people who provide practical or emotional support to an adult who needs care or support without being paid or an official volunteer. The adult's needs do not need to be eligible needs.**
- **Where a local authority thinks a carer might need support of any kind they must complete a carers assessment and assess whether the carer is able and willing to provide the care that is required.**
- **The local authority must not wait until a carer asks for help.**

Section 11

- **If there is reason to believe the adult might be at risk of abuse or neglect, including self-neglect, the local authority must assess their needs, alongside any safeguarding enquiries, *even if the adult refuses the assessment.***

Section 18

- **If a person has eligible care or support needs, the local authority must meet these needs if the person lacks mental capacity to make the arrangements, and there is no one else with the authority to do so on someone's behalf.**
- **Someone would need Lasting Power of Attorney or Deputyship to access an adults money to arrange care for them if the person lacks mental capacity to make decisions about arranging and funding care. If there is no LPA or Deputy, the local authority has to arrange and review the care and support.**

Section 27

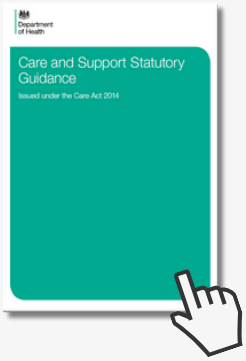
- **If the local authority has arranged support, it *must* review that support - even where an adult says they do not want their support reviewed.**
- **If someone makes a reasonable request on behalf of an adult for a review of their care or support, a review *must* be undertaken.**
- **If there is reason to believe a person's needs may have changed e.g concern from family or provider, or disengagement from support, the local authority should reassess needs.**

Section 42

- **Where an adult with care and support needs is experiencing, or is at risk of, abuse or neglect, and is unable to protect themselves because of the care/support needs, the local authority *must* make safeguarding enquiries.**
- **Safeguarding enquiries are to enable the local authority to decide what action should be taken to safeguarding or support the adult.**
- **There is no reference to consent in this section. The local authority must decide what enquiries are needed and what action should be taken.**

Legal Literacy: Care and Support Statutory Guidance

Statutory guidance tells us how we must apply the Care Act 2014. It is guidance all professionals must pay attention to in work with adults with care and support needs. Make sure you know what it says about assessments. This applies to all organisations involved in assessing and supporting adults with a range of care and support needs.



Paragraph 6.14:
Where an adult has a need... the local authority... must... consider whether their need(s) have... consequences on their... personal health. ... The local authority must also consider whether the individual's needs impact upon their wellbeing beyond the ways identified by the individual.

Paragraph 6.77:
Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times.

Paragraph 6.78:
Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a high quality, coordinated assessment.

Partnership Working

Preventing, recognising and managing risk of harm to adults and children requires a range of professionals and organisations working in partnership. This means active communication between professionals, seeking and sharing information between professionals and resolving differences of opinion through discussion and, where necessary, escalation. This should happen regardless of whether a formal safeguarding enquiry has begun.

Local SARs have highlighted a range of situations in which safeguarding partners struggled to work in partnership in a way consistent with the law, statutory guidance and local policies and best practice. Here are some local resources intended to support partnership working.

Information Sharing: Advice for Professionals

Escalation Policy: Resolving professional Differences

Best Practice in Safeguarding Adult Enquiries

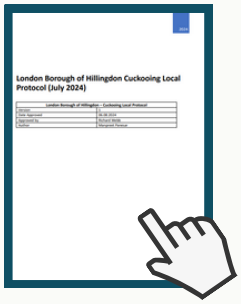
Professional Curiosity

Professional curiosity in safeguarding refers to the proactive approach taken by professionals to explore and understand the underlying factors and contexts of a situation, especially when it involves the safety and well-being of individuals, particularly children and vulnerable adults. It involves asking probing questions, seeking clarity, and not taking information at face value.

A curious mindset helps in identifying potential risks and safeguarding concerns that might otherwise be overlooked. By maintaining an inquisitive and open-minded attitude, professionals can better protect those at risk, ensuring that all aspects of their circumstances are considered and addressed comprehensively. This approach is crucial in creating a culture of vigilance and responsiveness in safeguarding practices.

Hillingdon Safeguarding Partnership

Partnership News



London Borough of Hillingdon Cuckooing Local Protocol

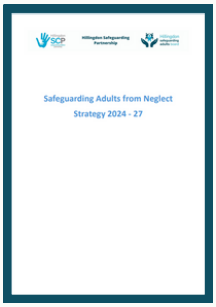
This protocol is for frontline staff who work with vulnerable adults and is a source of information and advice to support individuals, families, carers, and members of the public. The protocol supports an effective multi-agency response, and provides a risk assessment tool, to prevent, disrupt and reduce cuckooing in Hillingdon.

Community MARAC is an appropriate place for discussing cuckooing.

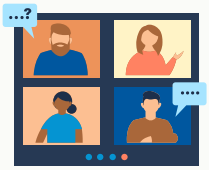
If the victim may have care and support needs also make a safeguarding referral.

Adult Neglect Strategy

Neglect of adults is the most common safeguarding concern brought to the attention of the local authority. It can carry significant risk of harm for those adults at risk. This new Adult Neglect Strategy aims to: prevent neglect, identify it when it occurs, and support effective safeguarding responses to promote the safety and wellbeing of adults at risk. All members of the Safeguarding Adult Board commit to working in accordance with this strategy. Use it for your learning, supervising others, and aiding discussions in team meetings.



Safeguarding Partnership Information Webinars



The Safeguarding Partnership deliver webinars through the year to provide you with information about our roles, responsibilities, priorities, and relevant legislation. These sessions are for professionals working with children and adults across all local services. This includes social care, housing, education, policing, probation, health, voluntary and private sector organisations. New staff or people who want to refresh their knowledge are welcome.

Book your place through Learning Zone

Safeguarding Partnership Training Programme 2024-2025

The Partnership commissions a range of safeguarding training relevant to working with children and adults. This training is free to staff in the organisations that jointly fund the Safeguarding Partnership: NHS, Police, and Local Authority. Book on to any of our training at Hillingdon Learning Zone: Safeguarding Partnership. Some courses are chargeable to organisations that do not contribute financially to the partnership, and some courses are free to all.

The courses are for professionals working with children or adults across all local services. This includes: social care, housing, education, policing, probation, health, and voluntary and private sector providers.

You'll need a Learning Zone account to access our training. If you don't have one, click this link to create a new account

https://hillingdonsafeguardingpartnership.org.uk/ https://hillingdonsab.org.uk/