

Safeguarding Adults Review:

‘Richard’ (Pseudonym)

Confidentiality Statement: This review is confidential and is not to be shared further with any party.

Pseudonyms are used in the report to protect the identity and privacy of the individuals’ referenced in the review. (The pseudonyms used within the Domestic Abuse Death Review have also been used within the SAR).

Pseudonym	Relationship
Richard (28)	The subject of the review
Keith	Stepbrother
Mandy	Stepbrother’s partner

Lead Reviewer - Cherry Collison

Date: Oct 2025

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1. Introduction

- 1.1 This Safeguarding Adults Review (SAR) concerns a young man with a learning disability and autism, called Richard who had lived in Staffordshire with his stepbrother Keith and Keith's partner Mandy, since 2015. Keith and Mandy were the tenants of the property, which was rented from the local borough council.
- 1.2 Richard's first contact with adult social care (ASC) was in April 2015 whilst he lived with his parents when a safeguarding concern was raised that he was possibly not being adequately fed and in May 2015 when a disclosure of childhood sexual abuse was raised. At this later point, Richard had moved in with Keith and Mandy. ASC had not initiated the move, but a case record suggests that the social worker involved was concerned about Keith and Mandy's motivation for offering support and the sustainability of the arrangement, but after sending a letter to support a housing application for Richard ASC closed their involvement. Alternative options were not discussed with Richard and his capacity in this area of decision making was not formally assessed.
- 1.3 From May 2015-2017 Richard had input from the Community Learning Disability Team (CLDT- Midlands Partnership NHS Foundation Trust (MPFT) and was enrolled in a local college, until July 2017, supported by a mentor, but then had no direct contact with services until an assessment by the Adult Learning Disability Team (ALDT) in October 2022. However, from 2019 onwards several agencies became aware of concerns relating to Mandy's deteriorating mental health, indicators of carer stress, the difficulties she reported in relation to Richard's behaviour, and a proposed eviction, but this did not lead to a coordinated multi-agency response.
- 1.4 It is known that both Keith and Mandy have long term health conditions, poor mental health and a history of using substances.
- 1.5 In the last week of November 2022 whilst Richard's father was visiting him at Keith and Mandy's home, he was found very ill and was taken to hospital. On admission Richard was found to have multiple fractures, presented as emaciated and physically neglected. The Police became immediately involved.
- 1.6 Richard died less than a week later in hospital and a criminal investigation was opened which has not yet been concluded as the Police are still awaiting the outcome of a pathology report to determine the cause of death.

2. SAR Referral

- 2.1 Queen Elizabeth Hospital made a referral to consider a Safeguarding Adults Review (SAR) on 3rd February 2023. This was initially discussed at the SAR sub-group meeting on 8th March 2023 however, following initial enquiries there was a decision to defer action whilst the police investigation continued and to await the outcome of the Domestic Abuse Related Death Review (DARDR) process. The referrer was informed of this decision.

- 2.2 In July 2024, the Police confirmed that screening against the SAR criteria could be progressed without interfering with any criminal process. Staffordshire and Stoke-on-Trent Safeguarding Adult Partnership Board (SSASPB) SAR sub-group screened the case on 2nd September 2024, postponed from 22nd August, and agreed this should progress as a review because of the concerns identified at the time of death, contact with agencies and an apparent lack of professional curiosity applied.
- 2.3 This was proposed as a discretionary SAR ¹ due to not being able to confirm a direct correlation of abuse to Richard's death. The SSASPB Independent Chair agreed that the SAR criteria was met, and recommended the review should be planned in consultation with the police.
- 2.4 The SAR was commissioned in May 2025, following the completion of a Domestic Abuse Related Death Review (DARDR), arranged by Tamworth Community Safety Partnership (CSP).

3 Methodology

- 3.1 A copy of the draft DARDR (February 2025) was shared with Staffordshire and Stoke-on-Trent Safeguarding Adult Partnership Board (SSASPB) and the independent author prior to the first SAR panel meeting which helped to inform the terms of reference for the SAR due to the detailed chronology provided within the DARDR.
- 3.2 At the first panel meeting on 19/05/25 the proposed terms of reference were discussed and agreed. It was agreed that where possible information provided to support the DADR would be used. However, additional information has been requested from agencies to support the SAR analysis.
- 3.3 The review focusses on the time between May 2015 – November 2022, which is Richard's first point of contact with adult services, up to his admission into hospital however, background history is provided outside this period that is considered relevant to the SAR analysis and overall learning.
- 3.4 An adapted 'action learning' approach was applied within the SAR, informed by the SCIE Learning Together Model, with a specific focus on:
 - a. Understanding the context at the time of the review and gaining practitioner/operational perspectives.

¹ The statutory mandate for SARs resides within section 44 of the Care Act 2014: This section states that a mandatory SAR should be undertaken when an Adult who has needs for care and support (whether or not the Local Authority was meeting any of those needs):

dies and the Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the Adult died) Or

does not die but the Board knows or suspects that the Adult has experienced serious abuse or neglect

- b. Considering the areas of learning, understanding current practice and any developments required.
- 3.5 Two SAR panel meetings have been held, and liaison has taken place outside panel processes with agencies involved.

4 Terms of Reference

- a. The effectiveness of transitional planning and information sharing arrangements between children and adult services.
- b. Responses to safeguarding concerns, evaluation of risks and the effectiveness of multi-agency working.
- c. Application of the MCA, Care Act, Human Rights Act (wider legal frameworks and legal literacy).
- d. Professional curiosity and Making Safeguarding Personal (MSP).
- e. 'Health' interventions & reviews.

5 Family Involvement

- 5.1 The independent author contacted the Police Family Liaison Officer (FLO) involved at the start of the review process to advise that a SAR had been commissioned. The FLO assisted in delivering a letter to Richard's mum and dad which explained the purpose of the review but so far, they have declined further contact.
- 5.2 An approach had also been made within the DADR process, and they had indicated that they did not want to talk about what had happened as it would "bring their nightmares back".
- 5.3 Due to the ongoing police investigation into the circumstances of Richard's death it is not appropriate currently to speak to Mandy or Keith.

6 Relevant background information prior to the time in scope

- 6.1 Before moving in with Keith and Mandy at the age of 21 years Richard lived with his parents and siblings. Richard was the subject of a Child Protection Plan as a very young child between 1997-1998 under the category of neglect and Children's services received referrals in 2005, 2008, 2009 and 2010 due to concerns about the welfare of Richard, his siblings and the home environment but he was not assessed as a 'child in need' ² and transitional planning was not initiated. It was judged by Children's Social Care that Richard was receiving a good level of support when they were last involved in 2010 and the school could offer direct work and monitoring.

7 Combined Chronology - Review Period - May 2015 - November 2022

² Children Act 1989 (s17)

- 7.1 In April 2015, a safeguarding concern was raised by the police following contact from an RSPCA inspector who had been called to complete an animal welfare check. The concern was that Richard was possibly not being fed adequately. Richard was living with his parents at this time.
- 7.2 A joint visit was completed by a Social Worker from the Independent Future's, now known as the Adult Learning Disability Team, with Staffordshire Police, but there is no further detail regarding the outcome of the safeguarding enquiry.
- 7.3 In May 2015 Adult Social Care (ASC), Learning Disability Team also completed an assessment, following a referral received in April 2015. The assessment describes Richard as underweight, but he was said to eat regularly. It is recorded that Richard had told the social worker he had bought a sandwich at a local supermarket and had a large bag of sweets in his bag. His mum had also mentioned that the family would be buying a meal from the local chip shop the same day. The property was described as of "a very poor standard" with "grave hygiene issues". The assessment refers to Richard saying that he did not want to live with his parents, because of them telling him when he should be home each night and that he did not get on well with his siblings as he sometimes fought with them, but no further detail is provided. It is documented that Richard said he maintained his personal care, but his appearance suggested otherwise but the reason for this or his need for support in this area is not addressed within the assessment.
- 7.4 A referral was made to the Community Connect service to explore community activities and to support Richard with a housing application and a referral was made for a health facilitator to establish if there was any underlying health condition or if weight issues were linked to Richard's living conditions. Concerns about the conditions of the property were reported to the Borough Council and a referral was made for a benefits check for Richard.
- 7.5 The independent futures service became involved with Richard in May 2015. A community worker from this service described the home as "uninhabitable" with dogs locked in the living room. This was not referred as a safeguarding concern.
- 7.6 ASC have a record of an e-mail received from Staffordshire Police to the allocated Social Worker on 9th May 2015. This refers to Richard telling staff he knew from a local shop that he didn't want to live with his mum anymore.
- 7.7 On 11/05/15 ASC have a record of conversation between the Social Worker and Richard's father. Richard's father said the Social Worker was putting ideas in Richard's head and encouraging him to move out when he was not ready. The Social Worker advised that Richard had discussed wanting to move out and they were exploring his options. It was explained that if a property was found, support would be offered to help Richard manage in his own home.
- 7.8 On 19/05/15 ASC were notified that Richard had moved out of the family home that day to live with Mandy. The reason given for this was because Richard's parents were separating and his mother was planning to move abroad. Mandy said that Richard had been given a choice about where he wanted to live and had asked to live with her and she was happy for Richard to stay "until this is sorted out". Richard

had apparently also confirmed that he wanted to stay with Mandy. Keith is not mentioned.

- 7.9 On 20/05/15 A well-being check was carried out at Keith and Mandy's home by the Social Worker; Community Connect Worker and Police. It is documented that Richard said that he was happy to stay with Keith and Mandy. Following this visit the Police had informed Richard's parents that he was happy staying with Keith and Mandy and that they should not be putting pressure on him to return home.
- 7.10 On 21/05/15 the social worker & Community Connect Worker met with Richard and he said that he felt safe living with Keith and Mandy.
- 7.11 On the 26/05/15 ASC had further contact with Mandy. At this time, Richard and his brother were both staying at the address. (ASC hold no information regarding when Richard's brother had moved into or out of the property and wider agency timelines do not reference this either). Richard had an appointment with the Community Connect Worker on 01/6/15 to complete a housing application form and an appointment with Housing Options on 06/06/15.
- 7.12 On the 29/05/15 the Social Worker spoke to a Tenancy Sustainment Officer; Tamworth Borough Council and they suggested that a supporting letter could be provided to support the housing application. The supporting letter was completed on the same date. Within the letter it is stated that Richard had chosen to move out of his parents' address. There is reference within this to the safeguarding concern that had been raised on 20/05/15- as detailed below.
- 7.13 The letter goes on to say that whilst Richard, Keith and Mandy are indicating they are happy with the situation, "I am not sure how long this arrangement will be sustained for or how genuine the support is. I am advised that at this current time Richard is sleeping in the living room on the sofa. I have been told that they have a spare bedroom but no bed for Richard". Richard's (middle) brother is also living at the property."
- 7.14 Only a few weeks after this ASC closed their involvement.
- 7.15 In late May 2015, a further safeguarding was raised by the Community Connect Service (the County's information gateway to local area services) following a disclosure of historical familial sexual abuse and concerns that Richard's parents were withholding his benefits. Richard was living with Keith and Mandy by this point.
- 7.16 A safeguarding strategy meeting was not arranged at this time. The report of sexual abuse was referred to the Police to investigate who opened an investigation and completed two interviews with Richard however, following consultation with Crown Prosecution Services the investigation was closed without charges due to 'evidential difficulties.'
- 7.17 Police interviews were informed by an achieving best evidence approach, and Richard's vulnerabilities were noted however, a registered intermediary was not used within the first interview but was in the second. The Police had no flag within their system (Niche) to identify a learning disability but Police and Criminal Evidence Act (PACE) 1984 makes provision for the use of intermediaries and appropriate

adults based on the observations of the officers or feedback from family etc, and if in doubt provision should be made within an interview. The Local Authority screened the safeguarding referral of historical sexual abuse as “not a current risk” due to this occurring within childhood.

- 7.18 The concern relating to financial abuse was signposted to Independent Future’s to conduct a safeguarding enquiry. A practitioner from this service planned to undertake a mental capacity assessment to determine “Richard’s understanding of money” and documented that Local Authority appointeeship would be considered, if he lacked capacity. However, this assessment was not completed, and an enquiry outcome cannot be located.
- 7.19 A complaint was made by Richard’s father who did not want social care staff to talk to him without a parent being present. Richard’s father was concerned that his son did not understand what was being said to him as he was not an adult “in his head”. This did not lead to a capacity assessment being initiated.
- 7.20 In June 2015 a community connect worker visited Richard at Keith and Mandy’s home and noted that he “looked as if he had gained some weight”. Mandy reported that “everything was fine” and that Richard was going to work and managing his daily care needs. The worker talked to Richard about returning to college and becoming involved in community activities. The same service also recorded a contact from a local school (identified in the records) reporting that Richard had been “stalking” one of their female students however, the contact record does not include any detail about the referrer other than a first name and further enquiries were not undertaken.
- 7.21 There is conflicting information about whether an advocate became involved from July 2015. According to ASC records the community connect worker met Richard’s advocate in the summer of 2015 and there was an email from the advocate in July 2015 however advocacy services have no record of involvement. A copy of the advocacy referral cannot be located by ASC therefore it is not possible to establish any detail about a request for support or information shared with this service.
- 7.22 In July 2015 Richard had an appointment with a Learning Disability Psychiatrist from MPFT, supported by Mandy. Mandy advised that Richard had stopped taking risperidone (an anti-psychotic medication) 2-3 months previously. This was a regular prescribed medication. No concerns were identified in relation to this but the doctor signposted Richard to the Community Learning Disability team for ‘emotional/relationship’ support, due to the disclosure of historical sexual abuse. This was a positive action which recognised the likely impact of abuse and trauma.
- 7.23 Brief psychological intervention was provided by the Community Learning Disability Psychologist, and an IQ test was undertaken which concluded significant cognitive deficit indicative of a mild learning disability. The Psychologist identified that Richard’s verbal communication was poor. Referrals were made for Speech and Language Therapy input and Occupational Therapy (OT) but Richard did not want to engage with an OT assessment.

- 7.24 Between August 2015 – Oct 2015 a health facilitator (MPFT) was involved. MPFT have been unable to locate any further details regarding this. MPFT indicate that there was a change in trusts merging at this time and some services used paper records which have not been uploaded onto the RIO (computerised system).
- 7.25 In February 2016 Richard attended his GP Practice with Mandy for the issuing of a sick note. Following this, annual invites for Learning Disability annual health reviews (LDAHC) were sent by the Practice from 26/09/16 - Oct 22 but appointments were not attended, and the Practice took no further action.
- 7.26 In February 2017 the CLDT closed their involvement with Richard.
- 7.27 There is then a gap in agency information until November 2018 when it is known that Mandy's son was killed in a road traffic accident (RTA).
- 7.28 In March 2019 Mandy was made Richard's appointee to deal with the Department Work Pension and benefits.
- 7.29 In May 2019 Mandy was referred to the Mental Health Access Team (MPFT) suffering from low mood following the death of her son. She is recorded as having a history of substance use. Appointments were scheduled in June and July, which Mandy did not attend, and she was discharged back to the care of her GP.
- 7.30 In August 2019 Housing service spoke to Mandy about rent arrears and the prospect of eviction processes starting. Mandy reported that Richard was not contributing to the household finances and was described by her as "gambling" and being "loud and violent". Agencies involved with Richard have no record of any prior issue relating to Richard gambling.
- 7.31 During 2020 unsuccessful attempts were made by substance misuse services to engage with Mandy and housing support service identified concerns about hoarding in the property: In December 2020 a warrant for possession of the property was granted but possession action was postponed until May 2021.
- 7.32 The Borough Council have advised that as intermittent payments were received against rent arrears a more active process of eviction was not initiated.
- 7.33 In August 2021 Police responded to neighbour complaints about Keith and ongoing issues with neighbours. Mandy reported being concerned about Keith's mental health and erratic behaviour and she is "signposted to relevant agencies".
- 7.34 In May 2022 a further court application for possession of the property was made due to the accruing rent arrears. In June 2022 Mandy informed a housing official during a telephone call that Richard had been sexually assaulted by family and had been accused of sexually assaulting two girls. The Police have no record of this allegation in 2022. She stated that she did not want Richard living in her home but there is no record of this being referred to any other service.
- 7.35 In July 2022 the court granted a warrant for possession of the property in August 2022.

- 7.36 In early August 2022 the Borough Council income support service raised a safeguarding referral with ASC for Mandy due to the imminent risk of Mandy becoming homeless (through eviction).
- 7.37 In the referral it is documented that an adult with LD (Richard) lived in the same household. Mandy had reported to the income support officer that Richard's behaviour in the community was causing concerns. This included looking at girls on the street, urinating in the street and looking down Mandy's top. The income support officer described Mandy's poor health which included COPD (chronic obstructive pulmonary disease), emphysema and heart problems. Mandy said that she did not have a bank account and that the benefits for Keith and herself were paid into Richard's bank account. The household was due to be evicted within 7 days.
- 7.38 ASC screened the referral as not meeting the criteria to be progressed as a Section 42 (s.42) enquiry under the Care Act 2014. A referral was made for a carer's assessment for Mandy and Richard was signposted for a Care Act assessment.
- 7.39 On the 02/08/25 the case of the household was discussed within a Vulnerability Partnership meeting (Housing) with a record that all partner agencies were aware of the circumstances.
- 7.40 The Borough Council indicate that within the period of their involvement they had limited opportunity to view the property as Mandy preferred to have telephone contact. Therefore, it was difficult to assess the home circumstances, and they recalled only one occasion when they had met Richard.
- 7.41 On 02/08/22 a Care Act Preliminary Assessment was completed by ASC, First Contact. At this time Mandy said that Richard was doubly incontinent and was not showering/ bathing. She said that Richard was texting "schoolgirls to send pictures of private parts" and Mandy said that she was struggling with Richard's sexualised behaviour. On 04/08/22 after a phone conversation with Mandy and brief conversation with Richard the case was closed as "no further input was required".
- 7.42 It is not documented within the assessment whether this was reported to the Police however, Police information verifies that a 3rd party (professional) concern was received which related to concerns about Richard's inappropriate behaviour in the community and towards Mandy but there is no record of the allegation of texting. This was tagged for the harm reduction hub and a Police officer visited and spoke to Mandy who reported concerns about Richard's inappropriate behaviour in the home, but not the wider issues and she did not want to make a complaint. The officer suggested that Richard could be asked to leave, and the incident was closed as no offence was disclosed.
- 7.43 The Police officer did not liaise with the referrer and a public protection notice was not raised. The officer recalls that Mandy directed conversations outside the house rather than inside, at the time of the visit.
- 7.44 A further Safeguarding concern was made for Mandy by Humankind on 4th August 2022 due to the concerns she raised about Richard's inappropriate sexualised behaviour. Mandy said that Richard was very threatening to her mentally and emotionally, he asked her to buy scratch cards, and would ask her to buy him things.

Following contact with Mandy the safeguarding was closed again as this did not meet the s.42 enquiry criteria, but a recommendation was made for the Adult Learning Disability Team to complete a face-to-face assessment, and a carers assessment should be offered.

- 7.45 On the 5th August 2022 the Access Team also received a telephone call from Humankind. The service reported that Mandy was struggling with her mental health, and she was feeling suicidal. Again, Mandy reported physical, sexual and emotional abuse from Richard.
- 7.46 Between 05/08/22- 11/08/22 the Access Team had telephone contact with Mandy. During this time, Mandy said that she couldn't cope with Richard and wanted to move without him being part of the household. The Access Team were aware that the safeguarding referral had been closed but Mandy advised that a social care needs assessment was being progressed. She talked about continuing to struggle with her son's death and described Richard as never stopping eating and being awake all night.
- 7.47 The Access Team attempted to contact on two further occasions but as these were unanswered Mandy was discharged from the service, in mid-August 2022. Mandy had previously been advised to speak to her GP regarding an increase in medication.
- 7.48 A letter sent to the GP by the Access team said that Mandy had "kicked and punched walls to relieve stress and that she broke a knuckle punching a brick wall". This had originally been reported to Humankind. There is no other information about what had triggered the incidents of stress or whether Richard had been within the house at the time. There is no record of this information being shared with Adult Safeguarding to support the risk to Richard being considered.
- 7.49 On 21/09/22 a further safeguarding concern was raised for Mandy by the Borough Council income support team, due to concerns about Richard's behaviour, financial arrangements and the impending court action to evict the household due to rent arrears.
- 7.50 On 23/09/22 a Care Act Preliminary assessment was undertaken by a telephone conversation with Mandy. In the assessment it is documented that Mandy said she wouldn't let Richard out on his own as she feels he is capable of a sexual assault and that caring for Richard was affecting her well-being. A risk appraisal was not undertaken, and this did not result in an urgent assessment being progressed.
- 7.51 In mid-October 2022 a social worker from the Adult Learning Disability Team visited the home to complete an assessment. The assessment completed documents 'no significant concerns' although there is reference within this to Mandy reporting Richard's inappropriate sexual behaviour at home, in the community and she described an incident where Richard had slapped and bit her, but no context is provided. There is reference to Richard's history of childhood sexual abuse but a possible link between Richard's history and the issues presenting was not explored.
- 7.52 Richard is described by Mandy as neglecting his personal care, but in the assessment, Richard is described as 'quite clean' 'not dishevelled'.

- 7.53 At the time of the visit, Mandy is noted to answer on Richard's behalf, but it appears he was not seen on his own. Richard said he wanted to continue living with Keith and Mandy.
- 7.54 The assessment makes no reference to the impact of Richard's learning disability or potential vulnerability and a Mental Capacity Act assessment was not undertaken or planned. Although GP records note a diagnosis of autism this is not referenced within the assessment or the previous 2015 assessment. The outcome of the assessment was that a referral would be made to the CLDT requesting an assessment about relationships, an understanding of risks and developing 'appropriate relationships.' (An appointment was offered from this service following Richard's death - Dec 22).
- 7.55 Following Richard's admission into hospital police officers who attended the property submitted a PPN (Public Protection Notification) which described the very poor and inadequate conditions of the home. The PPN also raised significant concerns about the ability of Mandy or Keith to care for Richard.
- 7.56 It is unclear why these issues were not identified by the social worker at the time of visit and as the practitioner has now left the Local Authority it is not possible to gain their perspective.

8 Analysis against the terms of reference

The effectiveness of transitional planning and information sharing between children and adult services.

- 8.1 The chronology has identified that Richard was not supported through a planned transition process although Children's services were involved and completed a Core Assessment in 2010 linked to a section 47 enquiry which had considered development needs, family and environmental factors. Therefore, a planned approach to sharing assessments and relevant background information between children and adult services would have been valuable.
- 8.2 The assessment completed by ASC in May 2015 makes no reference to the previous involvement of CSC or Richard's history, although it is recorded in the case notes that there were concerns about historic sexual abuse which would be within CSC records. Within the assessment Richard's childhood is described as "dysfunctional" which does not support any understanding of the nature of the concerns or provide insight into the possible impact of adverse childhood experiences. ASC practitioners were unable to access CSC records at this time and ASC have no record of contact with children's services.

Learning

- 8.3 The assessment completed by ASC offers limited insight into Richard's history and the possible impact of adverse childhood experiences was not explored: Good transition preparation and planning ensures information regarding an individual's history, safeguarding concerns, risks and assessments (including specialist) are

shared to support trauma informed assessments, interventions and planning effective support for adults with learning disabilities.

- 8.4 Children's Services held valuable information which was pertinent to transitional planning and to inform contextualised adult assessments.
- 8.5 **Current Practice:** As part of the review process Staffordshire and Stoke-on-Trent provided details of the current transitional practice guidance: Joint Children and Adult Social Care Practice Guidance- Preparing for Adulthood: Children's to Adult's Social Care and Referral Process (25/04/25) which suggests that a clear process for transitional planning is now in place, and this details the requirements to coordinate Care Act and MCA assessments, to identify safeguarding issues, the impact of trauma and to apply trauma- based practice where this is appropriate and to consider the need for advocacy.
- 8.6 Multi-agency triage meetings have also been introduced to support effective transitional planning across health and social care.
- 8.7 It is understood that a transitions strategy has also been developed with a corporate policy project monitoring the effectiveness of this. This suggests that clear transitional planning guidance is in place and appropriate pathways have been established subject to ongoing monitoring.

Responses to safeguarding concerns, evaluating risks and the effectiveness of multi-agency arrangements/ working.

- 8.8 The Care Act 2014³ which came into force in April 2015 is the statutory framework that legislates the responsibilities towards adults with care and support needs. The local authority has a statutory duty to undertake section 42 (safeguarding) enquiries and consider appropriate action where an adult with care and support needs (adult at risk), is experiencing, or is at risk of, abuse or neglect, and as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
- 8.9 The Care Act stipulates that 6 key principles should underpin adult safeguarding interventions:
- 8.10 Empowerment, prevention, proportionality, protection, partnership and accountability.
- 8.11 When the first safeguarding concern was raised in May 2015 although a joint visit was carried out by Adult Safeguarding with Staffordshire Police, there is no further detail regarding the outcome of the enquiry and the subsequent ALDT assessment does not adequately explore indicators of possible 'neglect' and possible wider factors of risk.
- 8.12 Although referrals were initiated to housing due to environmental concerns and for health facilitation due to the concerns regarding Richard's weight, the outcome of referrals was not established prior to closure to ASC therefore it is unclear if the risks indicated were addressed. Within the assessment there is also limited

³ Care Act (2014)

exploration of the reason why Richard did not want to continue living with his parents, he was not asked whether he felt safe and well cared or what his views and wishes were regarding his living arrangements at that time or in the future which suggests a lack of application of the principle of making safeguarding personal.

Learning

- 8.13 When safeguarding concerns are raised it is important that appropriate safety planning / risk assessments take place and the outcome of referrals is established to ensure any risks identified have been addressed and to coordinate a multi-agency approach, if required.
- 8.14 Following the disclosure of childhood sexual abuse and concerns that Richard's parents were withholding his benefits, a multi-agency strategy meeting was not arranged, but may have been beneficial.
- 8.15 Due to its historical nature, the issue of sexual abuse was not appraised as a risk, but this approach does not recognise the impact of abuse and a wider need for support for example through psychology, therapy, specialist learning disability, mental health or advocacy.
- 8.16 The risk of possible future contact with the perpetrator and determination of Richard's wishes, views and capacity in this area of decision making was also not considered.
- 8.17 A multi-agency strategy meeting involving the Police, Local Authority, appropriate health agency and advocacy would have been valuable at this point to consider the risks and Richard's needs more broadly and to support a more trauma informed response.
- 8.18 Within the previous DARD process, Staffordshire Police promoted the proactive use of a flag within their Niche (system) to identify when adults have a learning disability to ensure registered intermediaries are used. As the public protection unit now have dedicated officers dealing with child and adult victims the Police indicate that the use of intermediaries has increased hugely since the time of the review.
- 8.19 In relation to the financial abuse concern, it is unclear why the mental capacity assessment was not completed as planned. As this did not occur Mandy was later designated by DWP to become an appointee for Richard's benefits, but a formal mental capacity assessment was not undertaken by the DWP as this was not a requirement under relevant law or operational procedure. However, the DWP guidance at this time did stipulate that a DWP officer should carry out a face-to-face visit and must satisfy themselves that the individual cannot manage their benefits, and they could seek medical evidence, social worker input, or carer feedback ⁴ which did not take place.
- 8.20 A review of DWP current Appointeeship Guidance indicates that more structured safeguarding questions are now included within the appointee process, mandatory

⁴ Social Security Administration Act 1992: <https://www.legislation.gov.uk/ukpga/1992/5>

checks should be made against the Adult Safeguarding Risk Register (where available) and the option to involve a third-party advocate is also recommended (e.g. Independent Mental Capacity Advocate) ⁵

- 8.21 SCIE (2020) ⁶ and ADASS (2021) ⁷ guidance emphasises that any financial control arrangement should be proportionate, reviewed regularly, and transparent.
- 8.22 It is unclear why advocacy was not considered at the point of safeguarding referrals. Under section 67 of the Care Act Local Authorities are required to consider independent advocacy during safeguarding enquiries if an individual has substantial difficulty participating and if there is an absence of an 'appropriate' person to represent them.

Learning

- 8.23 Using advocates is an important mechanism of support - to promote an individual's rights, empowerment and protection within safeguarding interventions.
- 8.24 Ensuring appropriate background checks are undertaken by DWP before appointeeship is arranged is an important mechanism to safeguard individuals with who may be at risk of financial abuse.
- 8.25 Since this review, Advocacy Practice Guidance has been introduced for Adult Social Care which clearly sets out the statutory duties and responsibilities to offer advocacy in accordance with The Care Act (s67 & 68) and MCA 2005 and Assist Advocacy are commissioned to provide this.
- 8.26 There has also been significant work in Staffordshire to improve advocacy rates which SSASPB have been sighted on in 2024/2025. This has included training across Adult Social Care and the establishment of regular interface meetings between the advocacy service and the Principal Social Worker. The Advocacy service are also a member of the SSASPB.
- 8.27 Between May 2019 – July 2022, significant concerns are raised across several agencies, but a multi-agency meeting was not arranged by any agency involved to support cross agency information sharing, gaining a better understanding of the risks emerging and to inform a co-ordinated approach. Within this time a referral for a carers assessment and social care needs assessment was not initiated but may have supported an earlier statutory intervention and prevention focussed approach in accordance with the requirements of the Care Act.
- 8.28 Staffordshire do not currently have a formal multi -agency risk assessment management process (MARAM) alongside safeguarding arrangements to support a prevention focussed approach by identifying and mitigating risks.

⁵ DWP Appointeeship Guidance (2024): <https://www.gov.uk/become-appointee-for-someone-claiming-benefits>

⁶ SCIE (2020): Adult safeguarding: Financial abuse:
<https://www.scie.org.uk/safeguarding/adults/practice/financial-abuse>

⁷ ADASS (2021): Guidance on Financial Exploitation and Safeguarding

- 8.29 Between August 2022 - Sept 2022, 3 safeguarding referrals were raised for Mandy due to concerns about her mental health, the risks of housing eviction, financial issues, and issues she was reporting in relation to Richard's alleged behaviour. However, referrals were closed due to the s.42 criteria not being indicated with signposting for social care and carers assessments.
- 8.30 At this time wider issues were highlighted regarding Richard neglecting his personal care and wetting the bed and a further concern about possible financial abuse was also suggested.
- 8.31 It is unclear why greater professional curiosity was not applied to appraise the issues presenting at this time linked to carer stress, poor mental health, housing eviction, concerns about Richard's behaviour and possible indicators of trauma, neglect or self-neglect.

Learning

- 8.32 Professional curiosity is the foundation of good safeguarding practice; without it, agencies may fail to see the wider picture, complexity and hidden harms.
- 8.33 In August 22, when an allegation of inappropriate sexual behaviour was raised liaison did not take place between the Police and ASC which was a further missed opportunity to consider the wider circumstances through a multi-agency approach and to seek earlier input from the Community Learning Disability team (MPFT).
- 8.34 A review by Public Health England in 2015 ⁸ highlights that people with disabilities are more vulnerable to domestic abuse, experience more severe and frequent domestic abuse for longer periods of time, than non-disabled people. This research also highlights that people with disabilities encounter differing dynamics of abuse, which may include more severe coercion, financial, economic abuse or control from carers. At points of contact the possibility that Richard was a victim of domestic abuse does not appear to have been considered.
- 8.35 At this point in August 2022, a letter was sent by the mental health Access team to the GP indicating that Mandy had reported she had "kicked and punched walls to relieve stress and that she broke a knuckle punching a brick wall". However, this information was not shared with the Local Authority to support the risk being considered.
- 8.36 The second national analysis of Safeguarding Adult Reviews ⁹ which compares the percentages between the first and second national analysis of SARs identified cases featuring concerns relating to partners, relatives, friends or unpaid carers increasing from 19% to 25%.
- 8.37 The second finding in the national analysis entitled 'safe care at home' also identified instances where situations are seen through the lens of carer stress rather than curiosity about the relationship dynamic between the carer and the cared for

⁸ Disability and Domestic Abuse: Ann Craft Trust <https://www.ann.crafttrust.org>

⁹ Second National Analysis of Safeguarding Adult Reviews <https://www.local.gov.uk/our-support/partners-care-and-health/safeguarding-resources/analysis-safeguarding-adults-reviews-4> published 12 June 2024

person, and whether there is evidence of abuse or neglect. Coupled with an absence of professional curiosity and an avoidance of difficult discussions this may result in risks not being recognised or addressed.

- 8.38 The report highlights two priorities for Safeguarding Adult Boards: The first being that the performance data on carers assessments should be obtained and assurance about levels of oversight of care at home, with actions to evidence partnership working operationally and strategically between community safety, adult safeguarding practitioners and managers.

Learning

- 8.39 Recognising the interplay between structural inequality and the additional risk of abuse and neglect for adults with a learning disability is an important consideration and point of learning.
- 8.40 **The requirements of the MCA, Care Act, Human Rights Act (wider legal frameworks and legal literacy), application of professional curiosity, Making Safeguarding Personal and 'Think Family'.**
- 8.41 The Care Act 2014 is a fundamental piece of legislation in England that reformed the legal framework for adult social care. Its ethos, values and principles, are centred on wellbeing, person-centred care, prevention, and empowerment.
- 8.42 Assessments under the Care Act should follow a clear, strengths-based, and inclusive approach which involves the individual, considers the whole picture and looks beyond physical needs to consider a person's individual's abilities, goals, social opportunities and informal support networks.
- 8.43 Within the two Care Act assessments completed in 2015 and 2022 there is limited evidence of this approach: In the 2015 assessment, Richard said that he did not like living at his parents' home, but this was not explored further, there is limited insight gained of his lived experiences, impact of past history or exploration of his future wishes regarding where he wanted to live.
- 8.44 Following Richard moving in with Keith and Mandy although a letter was sent by ASC to support a housing application no alternative options were discussed with Richard at this time, despite the social worker being concerned about the move and whilst it was considered that Richard had made a choice, the context suggests he lacked any real choice.
- 8.45 At both points of assessment in 2015 and 2022, Richard was not signposted for independent Care Act advocacy support despite the concerns presenting, his learning disability and lack of voice.
- 8.46 Prior to the assessment in October 2022, significant concerns had been raised: Mandy had said that she was unable to cope, she did not want Richard living in the household, had made allegations relating to Richard's inappropriate sexual behaviour in the community, at home, there was an imminent risk of eviction and it was reported that Richard was neglecting his personal care. However, the assessment does not look beyond what is reported by Mandy or the immediate

circumstances of what is presented, to adequately appraise the risks, explore the impact of previous abuse, trauma and learning disability.

- 8.47 As Richard was not seen on his own this was a missed opportunity to undertake a safe enquiry into the possibility of abuse, neglect or coercion and to engage appropriately with Richard within the assessment process.

Learning

- 8.48 It is important to ensure the voice of the adult is heard within assessment processes.
- 8.49 Seeing people on their own allows safe enquiries to be undertaken and may prevent family members speaking on behalf of the person.
- 8.50 It is important that factors of risks and needs are adequately appraised within assessments and coordinated multi-agency approaches support holistic assessments and risk appraisal.
- 8.51 Within safeguarding enquiries and social care assessments there is limited indication of an application of professional/ concerned curiosity or Making Safeguarding Personal (MSP). However, during the period of this review 2015-2022 and since this time, the SAB and partner agencies has carried out significant activity to raise awareness and embed MSP through policy, practice and audit activity.
- 8.52 Across agency interventions, there is also limited evidence of a 'Think Family' approach, despite the concerns and risks, as detailed, and it is unclear whether Keith had a role in Richard's care or the nature of their relationship, as little is documented: "Think Family" emphasises the importance of considering the whole family, rather than focusing only on an individual when providing support as the needs and circumstances of one family member (often a child or vulnerable adult) are often closely connected to those of the others in the household.
- 8.53 In practice this means, that services should look beyond an individual's immediate needs and consider the broader family context, including parenting/ carer capacity, family relationships, and household dynamics. For example, as within the circumstances of this case, whether a carer's mental health, substance misuse, financial or housing issues could impact on the adult with care and support needs or those of the wider family.

Learning

- 8.54 The key messages for practice include:
- 8.55 Promoting early intervention and prevention rather than reactive interventions.
- 8.56 The importance of multi- agency collaboration and coordinated joint working.
- 8.57 Section 10 of the Care Act 2014 gives anyone who is looking after an adult with care and support needs the right to an assessment and section 20 of the Act places a duty on local authorities to meet carer's needs in accordance with the national eligibility threshold.
- 8.58 The assessment should consider the carer's mental and physical health, their ability and willingness to provide care and their relationships with others. In this case,

Mandy expressed on several occasions that she did not want Richard living in the household, she reported increasing difficulties coping and had known mental, physical health and substance misuse difficulties but a referral for a carers assessment was only initiated in August 2022 and this was not actioned until early October 2022.

Learning

- 8.59 The offer of a carer's assessment should have been made at a much earlier point. This was possibly a missed opportunity to identify carer stress, to offer appropriate support and potentially to identify / escalate any issues of concern.
- 8.60 The Mental Capacity Act (2005) provides a clear legal framework for assessing capacity and making decisions to both protect and empower individuals. When applied appropriately it promotes an individual's rights and protects those who might not be able to make decisions due to illness, disability, or impairment. Together, the MCA and Care Act promote the safety and well-being of individuals and due regard must always be given to the Mental Capacity Act 2005 within safeguarding interventions.
- 8.61 Despite Richard's learning disability, and the potential difficulty he could have making specific decisions formal mental capacity assessments were not completed.
- 8.62 Despite Richard's known learning disability, at the point Richard moved in with Keith and Mandy, there appeared to be a reliance on a 'presumption of capacity' (principle 1 of the Mental Capacity Act) rather than a determination of capacity applying the two-stage functional test set out within the MCA (section 2 & section 3), and the principle of 'supported decision making' (Principle 2) is not evident as alternative options were not discussed to enable genuine choice.
- 8.63 When safeguarding concerns were raised and the second Care Act assessment was completed in October 2022 assessments of Richard's capacity were not completed and the assessment to determine Richard's ability to manage his finances, to determine the need for appointeeship was not actioned as planned.
- 8.64 Mandy's interaction with agencies may have been indicative of coercive or controlling dynamics, possibly limiting Richard's right to privacy, voice, and independent assessment ¹⁰.
- 8.65 Richard was extremely vulnerable to abuse and neglect because of his learning disability, family circumstances, dependency, isolation, and lack of voice which underlies the professional responsibility to be curious and investigative in safeguarding adults ¹¹

Learning

¹⁰ Braye, S., Orr, D., & Preston-Shoot, M. (2015). Serious Case Review findings on the challenges of self-neglect: indicators for good practice. The Journal of Adult Protection.

¹¹ Department of Health and Social Care (DHSC). (2022). Care and Support Statutory Guidance under the Care Act 2014.

- 8.66 The findings of the SAR also highlight the importance of legal literacy: Understanding the requirements of the Mental Capacity Act, Care Act, Equality Act 2010 ¹², the Human Rights Act 1998 ¹³ and application in practice. Alongside, Making Safeguarding Personal, professional curiosity, effective multi-agency working and 'Thinking Family'.
- 8.67 Shortfalls in attention to mental capacity, recognition of abuse or neglect, absence of professional curiosity and lack of personalised approaches are common themes identified within the analysis of national SARs, as previously referenced.
- 8.68 This analysis suggests that it is rarely one single element of practice that is poor. More often there are multiple shortcomings that combine to result in a poor outcome, and this is particularly the case where checks and balances are also missing elsewhere in the system, such as within interagency, organisational or governance domains of safeguarding, adding up to system failure.

The adequacy of 'health' interventions & reviews

- 8.69 There is significant narrative within the DARDR report which explains the requirements for GPs to keep a register of patient's who they know have learning disabilities, to maintain annual health checks ¹⁴ (LDAHC) and to ensure reasonable adjustments are applied due to the poorer health outcomes and health inequalities for people who have learning disabilities. Despite this, although Richard was on the GPs register of patients with a learning disability and invites for LD annual health checks were sent, when Richard did not attend appointments appropriate follow up did not take place, there was no consideration of whether reasonable adjustments were required, and this was not evaluated as a possible safeguarding issue. A diagnosis of mild learning disability was recorded in the GP record on 23.07.2015.

Learning

- 8.70 An LDAHC may have provided a valuable insight into possible indicators of neglect with particular attention to the issue of Richard's weight.
- 8.71 As an action following the DARDR, the GP Practice introduced a process to notify the community learning disability team when an annual health appointment has been missed so that support is provided to facilitate reviews for those who do not attend reviews. This is incredibly important as LDAHC provide preventative support, and this approach should be proactive and flexible to ensure any barriers to engagement are minimised.
- 8.72 At the time of this review the Practice did not have a "was not brought" or "missed appointments" Policy for adults who may require carer support to attend appointments due to care and support needs/ learning disability but this has since

¹² Equality Act 2010

¹³ Human Rights Act 1998

¹⁴ Annual Health Checks (AHC) are structured health assessments carried out by GPs and practices nurses with people with a learning disability and are known to uncover previously unknown conditions, reduce preventable hospital admissions (Carey et al 2017) and enable ongoing monitoring of existing conditions and foster continuity of care.

been put in place: This should support an appropriate evaluation of trigger points for evaluation of possible safeguarding risks, unmet health needs and to support information being obtained from other agencies working with the individual if required.

- 8.73 As detailed in the chronology, a letter was sent to the GP by the Access team to report that Mandy had “kicked and punched walls to relieve stress and that she broke a knuckle punching a brick wall” but no further information was provided about what had triggered the incidents of stress, or whether Richard had been in the house at the time. This information was not shared with the Local Authority, to support the risk to Richard being considered which has been recognised as a point of learning.

Additional area of consideration: COVID-19 and UK restrictions impact:

- 8.74 A period of this review coincides with the COVID pandemic, and associated lockdowns which commenced from March 2020, and which resulted in restrictions imposed by the UK government including three national ‘lockdowns’ during March – June 2020, November – December 2020, and January – March 2021. Prior to Covid Richard was not in regular contact with services or involved in any activity, however it is likely that the restrictions imposed at this time further increased his isolation and vulnerability due to his lack of visibility and may also have impacted on the wider family context.

9 Recommendations

1. The importance of Professional Curiosity is a key point of learning within this SAR: SSASPB may want to reflect on Professional Curiosity Practices and culture across the partnership, develop and embed resources to support application in practice.

The ‘CURIOUS’ framework lens is an example of a useful reflective tool- safeguarding, professional curiosity, rapid review — RiseStrong and resonates with the findings of this SAR as it highlights the importance of:-

- **Connecting with Compassion-** Understanding the person’s reality, even when families are reluctant to engage.
 - **Understanding the unspoken** by exploring the circumstances, presenting concerns and potential impact on the adult at risk,
 - **Recognising patterns and cumulative risks** rather than responding to latest incidents.
 - **Inquiring with integrity** rather than accepting surface level explanations.
 - **Observing home environments** to appraise the risks beyond what may be suggested.
 - **Understand the systems at play** by avoiding silo working.
 - **Sharing information across agencies** to close information gaps and ensure agencies have a shared understanding of risks.
2. Since this review, SCC and MPFT have introduced Trauma Informed Practice as an offer from the Social Work Learning Academy: Monitoring of take up across agencies would

therefore be valuable alongside an evaluation of how trauma informed practice translates within practice in Care Act and safeguarding assessments / interventions.

3. When multiple s.42 referrals are received but are evaluated as not meeting the Care Act criteria it is important that mechanisms of oversight are in place to evaluate decision making and ensure robust risk appraisal: If onward signposting has been initiated by the Multi-Agency Safeguarding team to area teams for Care Act/ carers assessments appropriate prioritization should take place, informed by the safeguarding evaluation and information shared: SCC advise that monthly audits of safeguarding contacts now take place alongside practice guidance which highlights the importance of considering previous safeguarding concerns when making decisions to provide assurance in this area.
4. Richard's safety was not the responsibility of a single agency or professional: It may be valuable for Staffordshire to consider developing a formalised MARAM (multi-agency risk assessment and management) process, alongside existing safeguarding arrangements, to support early information sharing and problem solving in a multi-agency context and to promote this across agencies (including Housing).
5. Formal Mental Capacity assessments were not completed by ASC during periods of involvement: Case records suggest there was a reliance on a presumption rather than a determination of capacity: Assurance has been provided by ASC that training is available to practitioners from awareness to advanced mental capacity training and audits of MCA are now routinely completed and reported on. This should support an evaluation of application in practice and help to inform any further learning and development initiatives indicated.
6. Raising awareness of supported decision making as a framework that helps individuals, especially those with a disability, to make their own decisions by providing the necessary support to understand options and make choices may also be valuable, and links with the requirements and principles of the Mental Capacity Act.
7. SSASPB may want to gain assurance that agencies are consistently signposting family/ informal carers for carers assessments through data analysis.
8. ASC may also want to gain assurance that the issue of carer stress/ need is adequately appraised within assessment and safeguarding interventions through audits of practice now established: SCC advise that changes have been introduced within assessment processes to capture the carer's willingness and ability to provide support, appraise factors of risk and to identify any early need for support.
9. Following the DARDR the GP Practice introduced a "Was Not Brought/ Did Not Attend Policy" for adults with care and support needs/ LD and a process to notify the community learning disability team when LD annual health appointments have been missed to support consideration of any reasonable adjustments required and proactive engagement. It is recommended that this should be an area monitored jointly between services (GP/CLDT) to support evaluation of unmet health needs / possible safeguarding risks and to seek information from other agencies individuals if appropriate.

10. The importance of Making Safeguarding Personal (MSP) is highlighted within this SAR as a key point of learning however, during the period of the SAR 2015-2022 and since this time significant activity has been undertaken: Making Safeguarding Personal (MSP) was an agreed priority within the SSASPB 2022-2025 Strategic Plan. Partners routinely reported on what they were doing to ensure professionals worked with adults to prioritise their views and wishes and empower adults to protect themselves. Individual partner activity is also reported in the SSASPB annual reports for this period, which includes assurances from training, development and audit activity, as well as changes implemented to systems, forms and tools to prompt engagement and capture adults' views. As such, there has been a drive across all agencies to raise awareness of Making Safeguarding Personal principles and what this looks like in practice, with case studies nominated for best practice examples. Training has also been promoted across all services, with additional focussed resources such as a MSP information leaflet for staff and patients and a seven-point briefing to support safeguarding supervision discussions. There are additional examples of consultation and coproduction, such as the Insight Academy's work with Expert Citizens to produce training resources produced by adults who had experienced the themes being discussed.

10 Contributors to the Review

The following agencies contributed to the review process within an outside panel process.

Midlands Partnership NHS Foundation Trust (MPFT)

Staffordshire Police

Staffordshire and Stoke-on-Trent Integrated Care Board (ICB)

Staffordshire County Council Adult Social Care Services (ASC)

Tamworth Community Safety Partnership (Homes Manager)

11 Independent Reviewer

SSASPB commissioned an Independent Reviewer to undertake this Safeguarding Adults Review. The Independent Reviewer is a qualified and registered social worker and best interest's assessor with over 25 years working across various health, social care and voluntary sector roles. Over the last 15 years this has been within Adult Safeguarding & Mental Capacity lead roles at both an operational and strategic level. The reviewer is completely independent of the SSASPB, and all agencies involved in this review.

Appendix 1

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Staffordshire and Stoke-on-Trent: Adult Social Care Practice Guidance: Advocacy 06/09/24

Glossary

Advocate	Advocates can be provided voluntarily or as part of legal processes such as under the Care Act the Mental Health Act (MHA) and the MCA. Advocacy is for people who find it difficult to get their opinions about themselves listened to and to ensure their opinions and concerns are heard by others, which may be because they have not been listened to or do not feel confident in speaking up or asking questions. Advocates have roles in assessments, care and support planning reviews and adult safeguarding: An advocate helps the person to understand processes, supports people to think about options so that people can make their own choices. Advocacy can make a difference to a person's life by supporting the person to be involved in decisions about their life. Working with an advocate can also help the person become more confident and can help other services to understand what people want and need.
ALDT	Adult Learning Disability Team (ALDT)

Appointee	An Appointee is someone who manages a person's benefits. Appointeeship is granted by the Department for Work & Pensions (DWP)
Best interest decision	If a person has been assessed as lacking capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests (principle 4 of the MCA).
Care Act assessment	An assessment under the Care Act 2014 is an assessment of needs for care and support, or an assessment of a carer's needs for support. It includes assessing any safeguarding concerns.
Carers assessment	Section 10 of the Care Act 2014 requires the local authority to complete an assessment where a carer may have support needs. This includes whether the carer is able or is likely to continue to be able to provide care for an adult requiring care.
DWP	The Department for Work and Pensions (DWP) is responsible for welfare, pensions and child maintenance policy. It administers the State Pension and a range of working-age, disability and ill-health benefits.
GP's learning disability register	People with learning disabilities have more difficulty than others identifying ordinary health problems and getting treatment for them. As a response to this, annual learning disability health checks have been a key part of NHS plans to improve health and reduce premature mortality since 2008. GPs are asked to keep a register of people known to have learning disabilities. These learning disability registers were established in 2006 as part of the quality incentive scheme called the Quality and Outcomes Framework (QOF). Up until 2014, QOF learning disability registers included only people aged 18 or over. In 2014, their scope was officially expanded to cover people with learning disabilities of all ages.
Learning disability	A learning disability is a reduced intellectual ability and difficulty with everyday activities. For example, household tasks, socialising or managing money affects someone for their whole life. A learning disability is different for everyone. No two people are the same. A person with a learning disability might have some difficulty: • understanding complicated information • learning some skills • looking after themselves or living alone A learning disability is different for everyone. Lots of people who have a learning disability can work, have relationships, live alone and get qualifications. Other people might need more support throughout their life.
Making Safeguarding Personal	Making Safeguarding Personal (MSP) is a sector-led initiative which aims to develop an outcome focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.

Mental Capacity Act	The MCA refers to a specific decision made at a specific time. The MCA sets out a two-stage test of capacity. Diagnostic Test (Section 2): - Does the person have an impairment of, or a disturbance in the functioning of, the mind or brain? - This includes conditions such as dementia, brain injury, learning disabilities, mental illness, etc. Functional Test (Section 3): - Can the person: - Understand the relevant information? - Retain that information? - Use or weigh that information as part of the process of making the decision? - Communicate their decision (by any means)? It is underpinned by 5 key principles: Principle 1 – A presumption of capacity. Principle 2 – The right to be supported when making decisions. Principle 3 – An unwise decision cannot be seen as a wrong decision. Principle 4 – Best interests must be at the heart of all decision making. Principle 5 – Any intervention must be with the least restriction possible.
Niche	A police records management system.
PPN	A public protection notification (PPN) is an information-sharing document used by the police to record safeguarding concerns by a police officer.
TBC	Tamworth Borough Council (TBC)
Transition planning	Transition planning refers to the process of moving into adulthood and the things that need to be in place to live independently. It also refers to the process of moving from child services to adult services. Transition planning normally starts around the age of 14 and can include everything from work experience and employment to housing and benefits. If a child, young person or their carer is likely to have support needs when they turn 18, the local authority must assess them if it considers there is a “significant benefit” to the individual in doing so. This is regardless of whether the child or young person currently receives any services.
ECHRA (1998)	The Human Rights Act 1998 incorporates the rights set out in the European Convention on Human Rights (ECHR) into UK law. This means UK courts can hear human rights cases

	directly without people needing to go to the European Court of Human Rights in Strasbourg. Key points: • Rights protected: The Act protects fundamental rights such as: ○ Right to life ○ Right to a fair trial ○ Freedom from torture and inhuman or degrading treatment ○ Right to respect for private and family life ○ Freedom of thought, conscience, and religion ○ Freedom of expression ○ Right to education ○ Prohibition of discrimination • Public authorities: The Act applies to all public bodies (government departments, police, local authorities, courts, etc.), which must act in accordance with these rights. • Judicial power: Courts must interpret legislation, as far as possible, in a way compatible with the ECHR rights. If a law cannot be interpreted in a way compatible with human rights, courts can issue a "declaration of incompatibility" but cannot strike down the law. • Individual cases: Individuals can raise human rights issues in UK courts, rather than having to go to the European Court of Human Rights.
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