# Learning On One Page (LOOP)

Derby Safeguarding Adults Board (DSAB): Audit – Domestic Abuse in Older Adults (November 2024 and March 2025)

## Description of audit context

In 2024, the QA Subgroup decided to revisit cases processed after April 2023, focusing on Domestic Abuse in Older Adults. The aim was to assess improvements in learning and practice from previous multi-agency audits on Domestic Abuse in Older Adults.

Some of the learning themes identified from the audits carried out in 2023 were:

1) Delays in making safeguarding referrals.
2) The voice of the Adult was not always considered where family members were involved.
3) The need to consider an advocacy referral.
4) The need to consider a Domestic Abuse, Stalking and Honour Based Violence (DASH) referral.
5) Involvement of relevant agencies during information exchanges.
6) The need to have a clear safety plan in place.
7) Accurate and up-to-date recording and information.

The DSAB completed a multi-agency audit in November 2024 and March 2025, reviewing seven case files where safeguarding concerns had been raised for Adults who were referred for Domestic Abuse in Older Adults.

The recent multi-agency case file audits were completed with support from a panel of practitioners who sit on the QA Subgroup. It was not possible to obtain feedback from adults as part of this audit.

## Good practice

- A high level of clinical curiosity was noted and the level of risk for a DASH was completed and considered appropriate in 6 (85.7%) cases.
- The Adults views and wishes were recorded in all 7 (100%) cases.
- 6 (85.7%) cases were triaged on the same day as the referral was received.
- Collaborative joint working with the Local Area Coordinator took place in 2 (28.6%) of the referred cases.
- Think Family approach was evidenced in 6 (85.7%) of cases.
- Making safeguarding personal was evidenced in 5 (71.4%) cases and views from the Adult/Representative were obtained.

## What didn't go so well

- In 5 (71.4%) cases, information sharing could have been extended to wider partner agencies.
- In 1 (14.3%) case, the adult referred for safeguarding was also missed as a carer for the perpetrator.
- A mental capacity assessment should have been undertaken in 4 (57%) cases.
- Equality, diversity and inclusion questions were not asked in 3 (42.9%) cases.
- For 1 (14.3%) case, Think Family approached could have been evidenced more clearly.
- In 2 (28.6%) cases, reviewing historical safeguarding referrals would have provided valuable additional information.
- In 1 (14.3%) case, there would have been a benefit in holding a Multi-Disciplinary Meeting.
- Professional curiosity could have been more clearly evidenced in 1 (14.3%) case.

## Key learning themes

- Accurate recording and submitting safeguarding referrals within a timely manner.
- Consideration of equality, diversity and inclusion.
- Recognise where Adults may be carers.
- Consideration of historic safeguarding referrals on systems.
- Carry out information exchanges with appropriate agencies.

## DSAB recommendations

- When submitting referrals, agencies to record and submit in a timely manner.
- All agencies to obtain customer demographic information and consider equality, diversity and inclusion.
- All agencies to ensure carers are identified in the safeguarding adults process.
- Adult Social Care should, where possible, review historical referrals and information to assign the correct RAG rating to the recent referral.
- Adult Social Care to ensure information is shared with all relevant agencies during a safeguarding enquiry.