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### Safeguarding Adult Review

Section 44 of the Care Act 2014 stipulates that the Safeguarding Adult Board (SAB) has a responsibility to authorise the commissioning of a Safeguarding Adults Review (SAR). A review is required to be undertaken if the Board considers that there is significant learning to be gained across partner agencies.

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### Background

Erik was a 72 year old man who died of natural causes. Concerns were raised after his death about the quality of health care received by Erik. A multi-agency panel made decision that although the criteria for SAR had not been reached there was learning identified which could benefit agencies in their practice.

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### Implementing Change

- Reflect on the findings and discuss the implications for your service/practice.
- Identify and outline the steps you and your team will take to improve practice in line with the findings and recommendations.

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### Recommendations

- Consider use of MARM for all adults who have been identified as being in need of care and support but who do not lack mental capacity.
- Safeguarding strategy meetings need to occur at a timely point of the service user's journey of care.
- The assessment of risk of harm to individuals from domestic abuse should not be influenced by the gender of either the perpetrator or the victim.
  - Carers' assessments need to be undertaken
- Team around the adult care plans need to include the wishes and feelings of carers including their understanding of what is required of them and their willingness to undertake the role.
  - Practitioners need to use professional curiosity in their practice.

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## Safeguarding Adult Review Erik

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### Safeguarding Concerns

Erik did not lack mental capacity to make decisions about his life. He was not always compliant with care and on occasions refused hospital admission. Erik moved into the accommodation of his partner 6 months prior to his death. There was no assessment of his partner as a carer of Erik.

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### The Review

- The review looked at the following themes:
- Self-Neglect and use of Multi agency Risk Management Tool (MARM)
  - Lack of professional curiosity about alleged domestic abuse and substance misuse
    - Working with carers
  - Multi agency working including information sharing.

### The findings

- Agencies failed to work with partners to review suitability and willingness to undertake caring role with Erik.
- Self-neglect was not assessed and the MARM tool was not implemented.
  - Expectations of Erik's partner and her willingness to care for Erik was not included in care plan
    - Agencies worked in silos
  - Failures to assess Partner as a vulnerable person
  - Team Around the Adult not in place

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### The Incident

There was no specific incident which prompted concerns about safeguarding. Reflection by practitioners, however, after the death of Erik prompted agencies to review information sharing, working together, response to allegations of domestic and alcohol abuse, assessment of partners as carers and working with vulnerable people who do not lack capacity.

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## 7 Minute Briefing

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