Safeguarding Adults Review (SAR)

Case Study Exercise

SUGGESTED FOR USE IN LEARNING AND DEVELOPMENT ACTIVITIES, TRAINING, TEAM MEETINGS, SUPERVISION

What is a Safeguarding Adult Review (SAR)

One of the core duties of a Safeguarding Adults Board (SAB), under Section 44 of the Care Act 2014, is to review cases in its area

The Safeguarding Adults Board will review cases where an adult with needs for care and support:

- Has died and the death resulted from abuse and neglect, or
- Is alive and the SAB knows or suspects that they have experienced serious abuse or neglect.

Importantly, safeguarding adults reviews are about how agencies worked together to safeguard adults; they are in their nature multi-agency reviews. For a review to be mandatory in legislation, there must be reasonable cause for concern about how the Safeguarding Adults Board, its members (or others with relevant functions) worked together to safeguard the adult.

Aim of the exercise

Using the Case Study you will have the opportunity to reflect on the complexity of single and multi-agency working where Domestic Abuse, Mental ill health and Neglect may be present

Case Study

This exercise is based on a recently published review

Some of you will know 'Mary and Graham' and the agencies involved

It is important to note that in this case study exercise we have included information relating to Mary and Graham that only became known through the review process and may not have been available to practitioners at the time

https://www.leicester.gov.uk/media/186335/mary-and-graham-executive-summary-safeguarding-adults-review.pdf

https://www.leicester.gov.uk/media/186336/mary-and-graham-overview-report-safeguarding-adults-review.pdf

Case Study

Prompting Questions

1. What factors would cause you concern in this case?

2. How might you engage with someone who is difficult to engage with?

3. To demonstrate ‘professional curiosity’ what would you be doing?

4. How might issues of Mental Capacity be a factor and how might these be addressed?

5. What would be the benefits of working together in a case such as this? how ‘creative’ could you be?

What might impact your assessment (skills, knowledge, attitudes)?

Feedback

Safeguarding Concerns

- Mary expressing delusional beliefs and exhibiting unusual behaviour
- Anti-social behaviours reported
- Health concerns in respect of Graham
- Concerns over coercive control/potential domestic abuse from Mary to Graham, including preventing engagement with the GP
- Lack of utilities at property as gas and electricity disconnected
- Risk of homelessness due to tenancy breaches and non-payment of rent

Overall Findings

- The VARM process did not work in this case
- Possibility that interpersonal domestic abuse against elderly male victim was missed by some practitioners.
- Mary and Graham were not seen separately despite domestic abuse / coercive control being a potential (but unconfirmed) factor in their relationship.
- Housing went above and beyond their responsibilities in trying to help this couple over a long period of time and in trying to see Graham separately from Mary
- Individual agencies and the partnership struggled to engage with this couple.
- Key information not passed across and/or not recorded. Key information not included in professional referrals.
- Mary's previous diagnosis of mental ill health was not passed on.
- Risk wasn't assessed.

Things to consider in practice

- Coercive control – It happens in elderly couples
- Consider Male victims of domestic abuse
- See people separately (we need to know the lived experience of those involved)
- Engaging with people we find difficult to engage –non engagement increases risk (be creative, look to the community, who is the best person to make contact)
- VARM – if you think you have tried everything – escalate for independent review

Things to consider in practice……

- Assessing risk (professional curiosity of multiple issues, what increases or lowers risk)
- Practitioner access to historic records (assess the relevance for now)
- The need to understand how a Mental Health diagnosis and Mental Capacity impact on Self Neglect
- Agency thresholds and working together (Understanding roles, responsibilities)
- Are referrals of good quality to aid decision making
- What information is available that can be shared to assist in assessing risk and harm
- Good quality recording (planning , agreed actions, defensible decision making)

Actions from the Review

- Review published January 2020

- VARM guidance updated
- Escalation to 'independent review' process
- Meetings to include agencies who could potentially offer support

- Meetings
- Minutes of meetings sent to non attenders
- Consider holding meetings in venues that will maximise the attendance of key people

- Sharing learning (next Safeguarding Matters in April)

Actions from Review

- Training
- Including male older victims in case examples
- Training Group to consider future training/learning activity
- Promoting across the safeguarding adults partnership, the benefits of a 'problem-solving' or 'creative thinking' way of working with people we are struggling to engage with
- Promote the use of professional and appropriate challenge across the safeguarding adults partnership (including use of the 'Resolving Practitioner Disagreements and Escalation of Concerns' policy).
- File retention and information sharing – Historical data needs to be made available. In next financial year a statement to be requested from partner agencies on file retention and what information can be shared