Leicester Safeguarding Adults Board

WORKING IN PARTNERSHIP TO KEEP ADULTS SAFE

Safeguarding Adults Review

Executive Summary. August 2019

Safeguarding Adults Review (SAR)
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SAR Process

Leicester Safeguarding Adults Board (LSAB) commissioned a Safeguarding Adults Review (SAR) to learn from an incident when a married couple both in their 80s died approximately 2 weeks apart in the home they shared together in Leicester. There is no indication that either death resulted from abuse or neglect and there was no requirement under the Care Act 2014 to undertake a review of this case. Nonetheless, Leicester Safeguarding Adults Board (SAB) chose to undertake this review.

It was thought that this case could provide useful insights into the way organisations work together in Leicester in cases of self-neglect and with individual adults who are difficult to engage and who have needs for care and support. By promoting effective learning and improvement action, Leicester Safeguarding Adults Board (LSAB), aims to prevent future deaths or serious harm occurring.

The review work was undertaken over a period of 8 months from commissioning and involved a practitioners' learning event. The final report was agreed by LSAB in October 2019.

The scope of the SAR was to look at a number of issues: coercion and control in elderly couples; engaging with people we find difficult to engage; assessing risk; practitioner access to historic records; male victims of domestic abuse; mental capacity; self-neglect; mental health; agency thresholds; and working together.

Lessons learned and recommendations

The main learning and multi-agency recommendations address learning about*:*

- ***The Vulnerable Adult Risk Management Process***

Systems issues identified from this review included:

- Need for a clear escalation process
- Meetings to consider alternative possible pathways e.g. using the criminal justice system if appropriate.
- VARM offers a way of bringing people together to pool expertise and address difficult situations rather than simply bringing together people who have experience of the situation to share what they know. This suggests that statutory agencies should always be invited.

These points have been fed into the VARM review as the SAR has progressed and also address learning about risk assessment and good practice on behalf of Housing.

- ***Interpersonal domestic abuse/ coercive control***

Case findings: 1. Possibility that interpersonal domestic abuse against elderly male victim was missed by some practitioners.
2. The couple were not seen separately despite domestic abuse / coercive control being a potential (but unconfirmed) factor in their relationship.
System finding: Practitioners may accept (and not question) behaviours in older people that they would not accept (and would question) in younger people: there is a need to be alert to possible gender bias that may be exacerbated by generational and age issues.

Recommendation 1: Awareness-raising across the safeguarding adults partnership: Encouraging the representation of older people (including older male victims) in case examples for domestic abuse training and awareness-raising that takes place across the safeguarding adults partnership.

- ***Engaging with people we find it difficult to engage with***

Case finding: Individual agencies and the partnership struggled to engage with this couple.
System finding: People we find it difficult to engage with may need a particularly creative and flexible approach involving thinking 'outside the box'.
This is likely to involve using people they trust and are in contact with, and seeing them in places where they feel comfortable which may not be their home or the practitioner's office. It is also likely to involve continuity of relationship.
Recommendation 2: 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. Embed this way of working into multi-agency safeguarding adults work when we are finding it difficult to engage with people (including VARM).

- ***Information sharing***

Case findings: 1. Key information not passed across and/or not recorded. Key information not included in professional referrals.
2. One partner's previous diagnosis of mental ill health was not passed on.
System finding: 1. Referrers don't always know the language of their partner agencies, their thresholds for intervention / action, and what information is needed to meet the partner agency's thresholds.
2. Historical information is not always available, either (i) immediately or (ii) at all. Not all safeguarding partners are aware that this is the case. So when practitioners are told there is "no information" they are not aware that there could be historical information, but it is not available.
Recommendation 3: 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), and
Safeguarding adults partners to be reminded that important historical information needs to continue to be available long term across referrals and closures and across changes in personnel and systems. Where this is not possible, assurance to be sought that partners have a mechanism in place to identify this both internally and externally.

Multi-agency Action Plan

These findings/recommendations have been translated into outcome-focused actions to be undertaken by agencies involved in the case. The Action Plan will be monitored by LSAB.