Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Esther

What is a Safeguarding Adult Review (SAR)?

According to Part One Section 44 of the Care Act 2014 Safeguarding Adult Boards (i.e. Cambridgeshire and Peterborough Safeguarding Adult Partnership Board) must undertake a Safeguarding Adult Review (SAR) when:

1. An adult in its area with care and support needs (i.e. an adult at risk) has died as a result of abuse or neglect whether this was known or suspected before the adult died and there is concern that partner agencies could have worked more effectively to protect the adult.
2. An adult in its area with care and support needs (i.e. an adult at risk) has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

The purpose of a Safeguarding Adults Review is to **learn the lessons** about how professionals and organisations work together, and to consider how the learning can be used to improve practice for others in the future.

(Adapted and Taken from Care Act 2014 and Cambridgeshire and Peterborough Safeguarding Adult Partnership Board Website)

This briefing is written to support the learning for professionals with a view to improving future safeguarding practice

Esther

The name Esther is a pseudonym used within this briefing to anonymise and protect both the identity of the adult at risk and her family members.

Background

Esther was a white female aged 51 years in 2020. Until November 2016, she had been living a somewhat chaotic lifestyle owing to her drug and alcohol use and resulting homelessness. She had been an independent person but following a spinal abscess resulting in spinal cord injury, Esther became paraplegic. As a consequence, she was non-weight-bearing, spending the majority of her time in bed or her wheelchair, which she was able to self-propel. She required the use of a full body hoist and two care providers to support with all moving and handling manoeuvres, including the support of one care provider for formal repositioning. Esther had a long history of alcohol and drug misuse and a historic diagnosis of a personality disorder. She had also been a victim of domestic violence in the past.

At the time of her death she had been living with Joe for approximately three years. The nature of the relationship between Esther and Joe was unclear. He was described as her partner, ex-partner and carer interchangeably. On 18th May 2020 Esther was taken by ambulance from her home to hospital, where she was admitted with a suspected broken arm. Whilst in the ambulance, Esther disclosed that her partner Joe had assaulted her. Unfortunately, she died in hospital on 28th May 2020, from what is thought

to have been pneumonia. The cause of death remained undetermined at the time this report was being written.

Key Learning Points

Good practice identified:

- Evidence of Esther's voice recorded in hospital records
- Thorough assessment of Esther's care and support needs and evidence of significant efforts being made to meet both her needs and her wishes
- Multiple occasions where safeguarding concerns were raised relating to Esther: domestic abuse, financial exploitation and domestic abuse
- Single agency safeguarding discussions were evident
- Signs and indicators of domestic abuse and coercion and control were recognised
- Esther's vulnerability was recognised and support from statutory services was offered repeatedly
- Evidence of Esther's mental capacity being considered regularly and appropriately throughout the chronology.

Areas of learning:

- Missed opportunities to explore with Esther support for her mental health or her inability to care for herself as a result of her disability
- A lack of clear understanding of the relationship between Esther and Joe and therefore an incomplete picture of the possible risks
- Missed opportunities to explore with Esther what her desired outcome might be and what support she might be willing to accept to decrease her reliance on Joe and therefore reduce her vulnerability
- Limited consideration of support routes outside of statutory services, i.e. Adults Social Care or Police
- Missed opportunities for multi-agency information sharing. A holistic assessment may have drawn out the potential areas for concern and inter-linking risk factors such as Esther's drug use, self-neglect, and the risk of harm from domestic abuse
- A lack of clarity relating to the completion of Domestic Abuse, Stalking and Harassment (DASH) forms
- Missed opportunities, later in the timeframe of the review, to utilise the Multi-Agency Risk Management (MARM) process when Esther was refusing to accept support
- The principles of Making Safeguarding Personal could have been followed to a greater extent to support Esther in considering how her situation could be improved

Recommendations

1. The CPSAB should work with the Domestic Abuse and Sexual Violence Partnership to ensure that:-
   i. There is clear guidance to practitioners on the completion of DASH risk assessments.
   ii. That practitioners are aware of domestic abuse services in the area and what the services can offer.

iii. That practitioners and their organisations understand the process for referring a case to MARAC.
iv. There is awareness and training to practitioners to assist them to understand the necessity to consider how coercion and control may impact on a person to be able to make decisions on their wellbeing and protection.

2. The Police should ensure that consideration of previous information on individuals involved in an incident is routinely undertaken, when assessing whether a DASH risk assessment form is required.

3. The Local Authority should ensure that when an organisation undertakes a section 42 enquiry, there is a written request setting out the key lines of enquiry, the tasked organization is appropriately involved in the planning of the enquiry and that the enquiry is undertaken in a timely manner.

4. The CPSAB should work with partners from across the safeguarding adults workforce to develop information sharing guidance for practitioners involved in safeguarding adults to support practitioners in making referrals in safeguarding cases, particularly in situations where the person does not consent to information sharing.

5. The findings of this review should be used to continue to raise the awareness of the Multi Agency Risk Management (MARM) process and Self Neglect Guidance. In particular using these processes in complex multi-agency cases to effectively convene professional's meetings and the role of lead professional.

6. The CPSAB should task the Quality and Effectiveness Group to explore existing data and quality assurance activity relating to safeguarding adult referrals being reported to the MASH and how these are being triaged and decisions made on necessity for section 42 enquiry.

Further Information

Adult Safeguarding Partnership Board Website
http://www.safeguardingcambspeterborough.org.uk/adults-board/

Multi-Agency Safeguarding Training
http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Safeguarding Adult Reviews
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/sars/

Self-Neglect
https://www.safeguardingcambspeterborough.org.uk/adults-board/adult-abuse-and-neglect/self-neglect/

Leaflets, Resource Pack, Training slides, Virtual training and Useful Information
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/leaflets/
https://www.safeguardingcambspeterborough.org.uk/adults-board/resources-for-practitioners/

Multi-Agency Policies and Procedures

https://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/
http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/selfneglect/

The Lived Experience of the Adult
https://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/lived-experience-of-the-adult/

Domestic Abuse
https://www.cambsdasv.org.uk/web

https://www.womensaid.org.uk/

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