Somerset Safeguarding Adults Board:
PRESS RELEASE
Review recommends improvements following death of Somerset resident

A series of recommendations have been made by the Somerset Safeguarding Adults Board (SSAB) following the death of a Somerset resident.

The recommendations are shared in a report published today 1 October 2024, which documents an elderly lady's life leading up to her death from a COVID-19 infection whilst being treated for injuries arising from an accident. There is evidence that the lady's life was controlled for some years before her injury, which occurred partly in the context of the restrictions of the COVID-19 pandemic. There were also concerns about how money was being used. Neighbours heard unrest and shouting at the home and there were indications of coercive control.

Highlighting weaknesses in the way agencies were able to communicate with the lady has been assessed and the information recorded and shared across the health and social care system, the report makes various recommendations, including:

- Seeking assurance that the Safer Somerset Partnership develops the guidance and development opportunities below.
    - Specific guidance on working with older people experiencing domestic abuse including additional risk assessment tools that work alongside the standard generic DASH assessment
    - A development programme which addresses child to parent abuse when children or grandchildren are adults.
    - Guidance that supports practitioners to effectively address the needs of older adults at risk who do not meet the threshold for MARAC.
- Working in partnership with the Safer Somerset Partnership to ensure that the guidance and development opportunities are promoted and embedded within all health and social care organisations across Somerset.
- Extending the current guidance on professional curiosity to include the concepts of respectful uncertainty and safe uncertainty and to extend the guidance beyond the current conversation-based model.
- Reviewing the MARM guidance in the light of learning from this review and consider whether best practice guidance in multi-agency or 'professionals' meetings is required.
- To re-launch the updated "Resolving professional differences" protocol with a view to encouraging confident and consistent use of escalation in a range of circumstances, for example organisations not contributing to multi-agency approaches or potential high impact risk remaining unmitigated, as described in this SAR.

- Including the necessity to address the assumption that if an ambulance called, a person is not always conveyed to hospital, in all learning materials and discussions related to this SAR.
- Asking SC Adult Social Care for assurance that there will be full co-operation with future SARs.
- Developing a process to address non-compliance with s45 by any organisation or team.
- Using this SAB to contribute to the DHSC as evidence of the need and framework around a Power of Entry in adult safeguarding in England.
- Auditing a range of s42 decisions to ensure that the statutory criteria of 'at risk of' abuse or neglect is considered in decision making and to consider the implications of audit findings for guidance revision or practice development.
- Reviewing arrangements to support staff who feel intimidated or are threatened by the people they are serving. Particular attention may be needed for services, like GPs, who are not employed but have a key role in identifying risk and working in situations that pose a risk to them.

The learning from the review will be shared with the NHS Integrated Care Board (ICB), housing employees within local authorities and housing associations, employees of Somerset Council's Adult Social Care Service and all members of the Board.

Professor Michael Preston-Shoot, Independent Chair of the SSAB said:

> "The Somerset Safeguarding Adults Board exists to protect vulnerable people, and to make sure lessons are learned so that necessary improvements can be made. I want to take this opportunity to offer the family my sincere condolences for their loss.
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> There is much to learn from this SAR to inform how we work with older people who are being controlled by a relative. It highlights how communicating with someone who we are attempting to safeguard, where there is a high degree of obstruction to agencies, is an extremely challenging, so requires all agencies to be professionally curious and have a person-centred approach, even when we are unable to spend time with the person, together. We will work with our partners to address the aspects highlighted within this SAR and investigate how the SSAB and Somerset Safer Partnership can work together to produce guidance for practitioners on older people experiencing domestic abuse in the context of child to parent abuse when children or grandchildren are adults."

The Safeguarding Somerset Adults Board is made up of all the organisations which have a role in preventing the neglect and abuse of adults, including: Somerset Council, Somerset NHS Integrated Care Board, Avon & Somerset Police, Somerset NHS Foundation Trust, Somerset, Our members (somersetsafeguardingadults.org.uk)

For more information about the SSAB and a copy of the report visit www.ssab.safeguardingsomerset.org.uk

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Notes to editors