

From the Somerset Safeguarding Adults Board (SSAB)

Thank you for taking the time to read this briefing sheet. It is one way by which we are supporting multi-agency professionals working with adults at risk, or families to learn from practice.

This briefing sheet pulls together key messages arising from local case reviews.

We ask that you take time to reflect on these issues and consider, together with your team/s, how you can challenge your own thinking and practice in order to continuously learn and develop and work together to improve outcomes for adults.

This document includes a feedback sheet to capture how you have used this learning.

The practice briefing will also be disseminated to training providers to ensure content is included within, or informs, safeguarding adults training.

What is a Safeguarding Adults Review?

The SSAB, as part of its Learning and Improvement Policy, undertakes a range of reviews and audits of practice aimed at driving improvements to safeguard and promote the welfare of adults at risk. A key duty is for Boards to commission Safeguarding Adults Reviews (SARs), when:

- an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is a concern that partner agencies could have worked more effectively to protect the adult.
- an adult in its area has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.

Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again.

Juliet

The SAR was undertaken using the SSAB Local Learning Review and the key messages contained in this briefing reflect the learning to emerge from this.

How you can make a difference

Take some time to think about what these key messages mean for your practice. Ask yourself:

- Does my organisation have robust policies and processes in place to support people who with autism?
- Do I feel confident to arrange a MARM and who should attend?
- What support is available for those with alcohol dependency?
- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Juliet's Case

Juliet was 63 years of age and had been living primarily at her partner's address for several years. She also had her own tenancy in Taunton, but she stayed in this property only intermittently. Partner agencies became concerned that Juliet was experiencing domestic abuse in the form of violence which often arose when she refused his demands for sexual intercourse. There was also concern that Juliet was experiencing coercion and control and it also appeared that she was being financially exploited.

Juliet had been dependent on alcohol for several years which appeared to be a factor in her self-neglect. At times, her alcohol dependency also perceived to be a barrier to Adult Social Care acknowledging that she may have care and support needs. In addition to alcohol dependence, Juliet experienced depression, was a heavy smoker and was diagnosed with Chronic Obstructive Pulmonary Disease, was registered partially sighted in 1995.

The Police obtained a Domestic Violence Protection Order which prevented her partner from abusing Juliet for a time. However, Juliet tended to gravitate back to him and the risks which arose from her relationship with him continued until her death.

Key considerations for practice arising from the review:

Participation of relevant organisations/services in multi-agency meetings

- MARAC should consider the option of requesting a professionals meeting to be held in complex cases, particularly where a victim with complex needs is repeatedly being referred back to MARAC.
- A professionals meeting would increase the likelihood of all relevant risks to the victim – and the intersecting impact of those risks - being fully considered.
- MARM is intended to empower all agencies (in their management of risk) to feel confident to instigate multi-agency risk management meetings in relation to people with complex needs or circumstances
- Somerset One Team process is a forum where concerns about individuals may be raised to agree the most appropriate pathway.

Decisions about Juliet's care

- Self-neglect research emphasises the importance of a relational approach in order to help professionals 'find the person'.

- The management of chronic dependent drinkers recommended by Safeguarding Vulnerable Dependant Drinkers should be considered when working with those experiencing alcohol dependency.
- Practitioners should consider referral to Somerset Drugs and Alcohol Service (SDAS) for support.
- There needs to be more awareness of the support available to perpetrators of domestic abuse and how to refer or encourage self-referral to the *Engage Programme*.

Records management

- In Primary Care, dedicated time should be assigned to discuss adult patients about whom there are safeguarding concerns, these are robustly recorded and that a register is kept to ensure ongoing monitoring of such cases.
- Guidance on what happens after a safeguarding referral, advises a planning discussion to share and consider information across agencies to ensure a join up approach, which is documented.

Further information

Somerset Safeguarding Adults Board:

[Multi-agency Risk Management \(MARM\) Guidance](#)

[Risk Decision Making Tool](#)

[Vulnerable Dependent Drinkers](#)

[How to use legal powers to safeguarding highly dependent drinkers](#)

Somerset Council:

[Information for those causing harm](#)

Feedback Sheet

Please return completed feedback to: ssab@somerset.gov.uk

Your name	
Organisation	
Date	
This briefing was cascaded to:	
(e.g. all district nurses; duty social workers etc.)	
This briefing was used in:	
(e.g. supervision with X number of staff; team meeting; development event etc.)	
Action taken as a result of the learning:	
Other feedback / discussion points	