

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 Learning 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 with needs for care and support 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 with needs for care and support has not died, but the Board knows or suspects that the adult has experienced significant abuse or neglect.

In this case a SAR was not commissioned as it was determined that Kevin's case did not meet the above criteria for a SAR. However, it was agreed to instead undertake a review of Kevin's case to determine what, if anything, the relevant agencies and individuals involved in the case might have done differently. This was so that lessons could be learned from the case, and those lessons applied to future cases with the objective of avoiding similar circumstances reoccurring.

Kevin - Learning Review

While a SAR was not commissioned similar principles were applied to Practitioner Debrief and Learning Review sessions held with the individuals and organisations involved in Kevin's care and support that considered chronologies and other information relevant to his case. The key messages contained in this briefing sheet reflect the learning to emerge from these sessions, **these included learning from new safeguarding concerns that emerged after the SAR referral was received, with regard to which good practice was identified.** Kevin was invited to participate in this process but declined to do so.

How you can make a difference

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

- Can I make changes to my own practice?
- Do I need to seek further support, supervision or training?

Key features of Kevin's Case

- A referral for a Safeguarding Adults Review was received by the SSAB following an attempt by Kevin (pseudonym) to take his own life shortly after the death of his partner. This referral was not accepted, but it was felt that there was an opportunity to learn from the case.
- Kevin was middle aged when he attempted to take his own life, which had a life changing impact on his health.
- Kevin had a history of very high-intensity contact with his GP surgery, with often multiple contacts per day, and the Emergency Department at his nearest hospital.
- Kevin was not eligible for care and support from Adult Social Care at the time of the attempt to take his own life. This was because he was not considered to have care and support needs. This decision making was reviewed by a multi-agency panel as part of the process to decide whether or not to undertake a Safeguarding Adults Review, and it was considered to be compliant with the Care Act (2014).
- Kevin had made references about potentially wanting to end his life on occasions over the period of more than a year that was considered by the Review before he attempted to do so, but had consistently declined to engage with local mental health services.
- Prior to their death Kevin had made unsubstantiated allegations of domestic abuse by his partner. Professionals involved in Kevin's case felt that it was unclear whether abuse had taken place at all or, if it had, who the abuser was.
- No concerns were identified with regard to assessments of Kevin's capacity undertaken prior to his attempt to take his own life.
- A number of months later, while Kevin was a patient in hospital recovering after the attempt to take his own life, new concerns were identified regarding allegations of possible financial and material abuse of Kevin by a member of his family.

Key considerations for practice arising from the review

- A high intensity of presentations at one or more services is an indicator of an unmet need that should be explored and further understood, and this is often best done through a multi-disciplinary perspective.
- Meetings that discussed Kevin's frequent attendance at the Emergency Department of his nearest hospital did not include his GP surgery or other professionals from outside the NHS, nor did they consider his wider needs within the community in which he lived.
- Concerns raised with organisations prior to Kevin's attempt to take his own life were dealt with in isolation and, because of this, patterns were not recognised by any of the organisations involved.
- Kevin was not considered to be eligible for involvement from Somerset County Council's Safeguarding Service prior to the attempt to take his own life, however this did not mean that a multi-agency discussion could have not been arranged by one of the organisations that was involved in Kevin's case to discuss the concerns that professionals had.
- Professional opinions need to be respected by all when concerns are raised that someone may be acting out of character.

- The involvement of an Independent Domestic Violence Advocate (IDVA) may have been useful to help explore what the situation actually was regarding Kevin's allegations of domestic abuse by his partner prior to their death.

Examples of good practice identified

- It was noted that a Health Coach employed by Kevin's GP surgery was the primary point of contact for Kevin's frequent contacts with surgery, including the last contact before he attempted to take his life. The Learning Review identified that the support provided by Health Coach, over the period of over a year that it considered, was exemplary.
- The discharge process from hospital following Kevin's attempt to take his own life considered the ongoing safeguarding concerns regarding alleged financial and material abuse by a member of Kevin's family, recognised specific risks to Kevin in association with these concerns and took agreed actions with Kevin to mitigate them in line with the principles of [Making Safeguarding Personal](#) by ensuring that Kevin's home was a secure environment for him to return to.

Ensuring effective practice: Recommendations

Providers of Acute Hospital Services:

- Consideration should be given to GP surgeries being invited to attend any relevant sections of meetings that discuss people who are high intensity users of Emergency Departments and, regardless of attendance, consideration should be given to how relevant sections of the notes of such meetings can be appropriately shared with the patient's GP practice.

All organisations and professionals:

- Recognise that a high intensity of presentation at one or more public services may be a symptom of an unmet need that requires further exploration.
- Recognise that a concern **does not** require a safeguarding referral to have been made to, or accepted by, Somerset County Council's Safeguarding Service for a multi-agency meeting to be arranged, nor does the Safeguarding Service need to coordinate or be involved in such a meeting unless there are specific concerns of a nature that would suggest that involvement should be sought (please refer to the [SSAB Adult Safeguarding Risk Decision Making Tool](#) for guidance).
- Consider the involvement of an IDVA where domestic abuse may be a factor in the concerns that are held about an individual.
- Consider using a virtual meeting room approach, such as that offered through Somerset Choices, to assist in sharing information securely to avoid silo working.
- Consider how an approach based on the principles of [Making Safeguarding Personal](#), as seen in this case, can be utilised within discharge processes to facilitate a successful discharge where there are ongoing safeguarding concerns.
- Where an individual has expressed a wish to end their own life consider whether a [safety plan](#) could enable the person to keep themselves safe.

The SSAB:

- [To develop guidance on how organisations can work together where someone has multiple and/or complex needs but does not require a formal safeguarding intervention.](#)



Learning Lessons - Feedback Sheet

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

Your name	
Agency	
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	