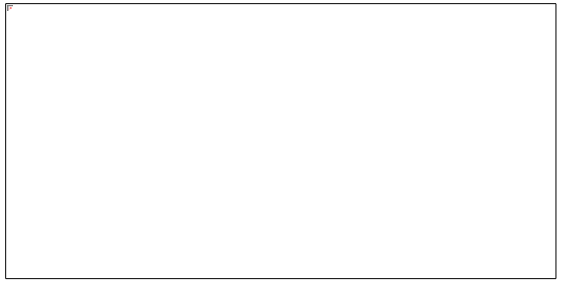
Managing and Assessing Risk in a Multi-Agency context



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Agenda

- Liz: Safeguarding Adults Reviews
- Ric: SAR National Analysis
- Liz: Multi-agency risk management featured in the recommendations of a SAR in North Somerset– What happened?
- Claire: What is Multi-agency risk management (MARM)

NSSAB

Safeguarding Adults Reviews (SAR)

The Law

- They are completely **different** to raising a Safeguarding Adults Concern to the Local Authority (S42 Enquiry by local authority).
- Safeguarding Adults Boards have a statutory requirement to undertake SARs (S44 Safeguarding adults reviews) when:
- SABs must arrange a SAR when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
- SABs must arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult experienced serious abuse or neglect, and there is concern that partner agencies could have worked more effectively to protect the adult.

SABs may arrange for a SAR in any other situation involving an adult in its area with needs for care and support where it believes there is value in doing so. Cases for a SAR not involving death or serious abuse or neglect may be selected by the SAB because they allow the SAB to proactively address issues of concern,

Purpose and Relevance of SAR

A SAR is a multi-agency review process which looks at what relevant agencies and individuals could have done differently to prevent harm or death from taking place.

The purpose of a SAR is **not to apportion blame**.

It is to promote effective learning and to prevent future deaths or serious harm occurring again.

The purpose of a SAR is not to hold any individual or organisation to account. **Other processes exist for this.**

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them.

If individuals and organisations are fearful of SARs, their response will be defensive, and their participation guarded and partial.

What do we know from the national analyses of SARs re risk assessment and management?

First (April 2017 – March 2019)

- In direct work, Risk assessment was the 2nd most prominent poor practice theme and most prominent source of SAR recommendations.

Second (April 2019 – March 2023)

- In direct work, risk assessment and management was the most prominent practice shortcoming (82%)

Risk assessment and management – key shortcomings from 2nd SAR analysis

Multiple SARs noted shortcomings in relation to risk. Absence of risk assessment was a common theme, with examples across a range of services:

- lack of due diligence in a care home's risk assessment relating to use of a bed rail
- failure to assess suicide risk in hospital, despite evidence that the individual tied ligatures
- risks of pressure ulcers from failed equipment not recognised
- the implications of coercion and control not integrated within risk assessment in practice
- lack of risk assessment in primary care, despite concerns expressed
- lack of attention to gaslighting and vulnerability in an individual's accommodation
- failure to recognise the interface between self-neglect and neglect by family carers
- lack of assurance around infection control and prevention measures resulting in the living environment being unsafe
- no comprehensive risk assessment undertaken when an individual was not eating, refusing support with incontinence and not taking medication
- failure to appreciate the seriousness of the risks being faced
- practitioners' reliance on individuals' self-report when refused access to their property
- failure to seek information from other agencies when undertaking risk assessment
- poor recognition of certain aspects of risk, for example, self-neglect relating to health needs not identified within an overall picture of self-neglect.
- risk assessments were sometimes static rather than dynamic and were not regularly reviewed when an individual's circumstances changed.

Failure to recognise fire risk

There were multiple examples of failure to recognise fire risk, e.g.

“Practitioners were aware that X was a heavy smoker, and of her physical and cognitive decline, but missed opportunities to identify and respond to the risks that this posed to X and others living in the accommodation block.”

Shortcomings in addressing Suicide risk

Shortcomings in addressing risk of suicide also featured in multiple SARs, with failure to piece together multiple indicators common:

“The risk of suicide was not fully understood in either case. Both said they had no suicidal intent but risk factors were present: they both struggled with emotional control; they had been looked after children who had survived adverse childhood experiences, perhaps as a result they used drugs and alcohol, lived nomadic lives with few fixed points and had little stability, economically, socially, or of accommodation. Both had experienced recent and ongoing trauma through loss of loved ones and friends, relationship breakups, homelessness and physical and sexual assaults. Both had made previous suicide attempts. These factors could have been fully appreciated through history taking and information gathering.”

Cumulative risk and the normalisation of risk

In some cases, there was a failure to appreciate cumulative risk, where combinations of risk features that in themselves were not acute but together added up to picture involving a much higher-level of risk, e.g:

“X was in frequent contact with a number of agencies, making 41 999 calls in the eleven months prior to his death. This, combined with his alcohol use, appeared to result in the normalisation of risk, missed opportunities to identify self-neglect and the risk of harm from others and the inability to see him as a whole person or to recognise how vulnerable and isolated he was.”

But, how do we know whether there are a combination of risk features if we are working in silos?

Observations on recommendations from First Analysis

- The first SAR analysis highlighted that *“all types of abuse and neglect require a multiagency response, which itself should draw on research on best practice to be evidence-informed”*
- Communication and coordination regarding risk is key
- There was a clear focus on the importance and value of multiagency risk management meetings and/or high-risk panels, for protection planning and mitigation of risks.

Observations on recommendations from Second SAR Analysis – has much changed?

Direct practice - "Findings and recommendations on direct practice continue to highlight concerns about making safeguarding personal, expression of professional curiosity, **the robustness of assessments and reviews, risk management,** use of safeguarding, and support for carers. SABs have a statutory mandate to seek assurance about the effectiveness of adult safeguarding."

Interagency practice – "SARs reveal repetitive findings on poor understanding of agencies' roles, duties and powers, **lack of communication and information sharing between agencies, silo-working and an absence of case coordination, including use of multi-agency meetings.** Recommendations that aim to enhance how services work together to prevent and to safeguard individuals from abuse/neglect also reflect these familiar themes."

2nd Analysis of SARS – Building on good practice

Reviews found evidence that professionals had made persistent and determined efforts to identify, assess and manage risk:

- The police found positive ways of managing difficult community situations and 'went the extra mile' to safeguard the individual in risky situations.
- Call handling staff showed professional insight in identifying serious concerns underlying a call about a neighbourhood dispute.
- Good triage of NHS 111 calls was noted when an individual's call was transferred to 999 and resulted in ambulance attendance.
- Good risk assessments were carried out by ward staff.
- Risks of self-neglect and pressure ulcers were recorded in a care plan.
- The signs of safety model worked effectively in identifying and managing risk.
- A day centre recognised and raised concerns about issues in relation to Percutaneous Endoscopic Gastrostomy feeding (use of a feeding tube) and put a risk management plan in place;
- A community mental health nurse's risk assessment took full account of past incidents of violence and aggression;
- Paramedics managed to gain access to an individual's home and gave a good account of the risks they witnessed;
- Risks from an individual keeping her back door unlocked were recognised and raised with her.

Learning from SAR recommendations

Direct Practice

- Involve the person who is at risk in risk assessment and management by consulting with them directly (Making Safeguarding Personal).
- Expressing concerned professional curiosity is part of prevention and protection – including suicide prevention.
- Partners must work together to identify themes and cumulative risk, and consider the need to refer an adult safeguarding concern.

Interagency Practice

- Collaboration is more effective when all those services either involved or with a potential contribution to make come together in multi-agency (risk management) meetings to share information, and to develop and then review agreed plans to mitigate risk, to prevent and to safeguard individuals from abuse/neglect.
- Clearer focus on use of multiagency meetings, ensuring that they are embedded in practice and that procedures for convening, recording and reviewing their outcomes are in place.
- Information-sharing is also central to counteracting silo working. Recommendations focused on raising awareness about the importance of sharing information, reviewing information-sharing protocols, and encouraging use of available policies, including on escalation of concerns.
- Information-sharing is closely linked with the accessibility of records and the adequacy of their contents.

North Somerset SAB

Thematic Review: Self-Neglect

- 3 adults at risk
- Over 2019 – 2021 (Covid)
- Engagement
- Relationships
- Misunderstanding
- Acceptance of self-reporting
- No lead agency or worker was apparent
- Management oversite of complex situations

Recommendation 7

NSSAB should consider reviewing and revising existing guidance on pathways into and procedures for multi-agency risk management meetings, disseminating expectations about multi-agency and multi-disciplinary working, and auditing outcomes.

Multi-Agency Risk Management (MARM) | Adult Safeguarding Board

"Professionals seem willing to attend under the banner of MARM, where prior to this it was difficult to get the right people around the table. MARM provides gravitas that was challenging for providers to garner before."

"Just to say that I have been impressed by the agency engagement in MARM. It won't be able to resolve all situations but does demonstrate that all considerations have been made to reduce or remove risks - this might be particularly relevant should a case reach a safeguarding adult review meeting."

"The monthly meetings are effective at assessing and sharing risk. They have good attendance from senior representatives."

Multi-Agency Risk Management (MARM)

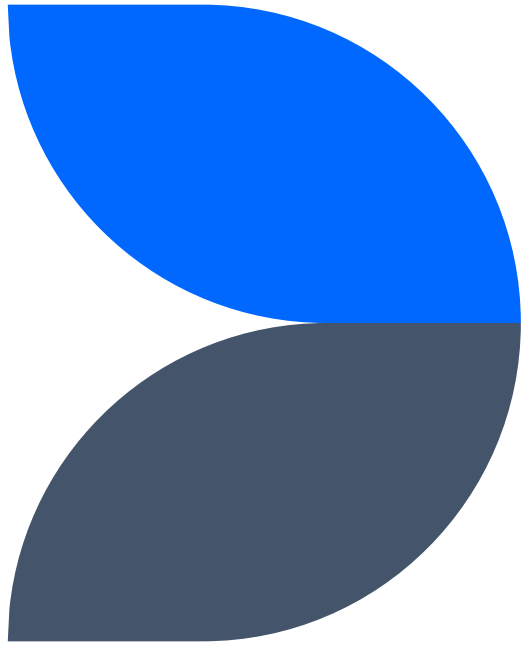
Photo taken from ‘Care Learning’, 2025 (online)

What is MARM?

- Research suggests that multi-agency working is a key part of safeguarding.
- MARM is a pathway to support a person where there is escalating risk and the risk falls outside of the statutory adult safeguarding framework (referred to as Section 42 of the Care Act 2014).
- MARM brings together multiple-agencies to support a person who is living with high levels of risk.
- The agency should attempt to mitigate the risk using their usual safeguarding procedures before requesting a MARM meeting.

MARM and the Law

- The Care Act 2014 emphasises multi-agency collaboration to safeguard adults.
- MARM is not a legal requirement but it is seen as best practice.
- MARM does not replace existing legislation or frameworks for managing risk.



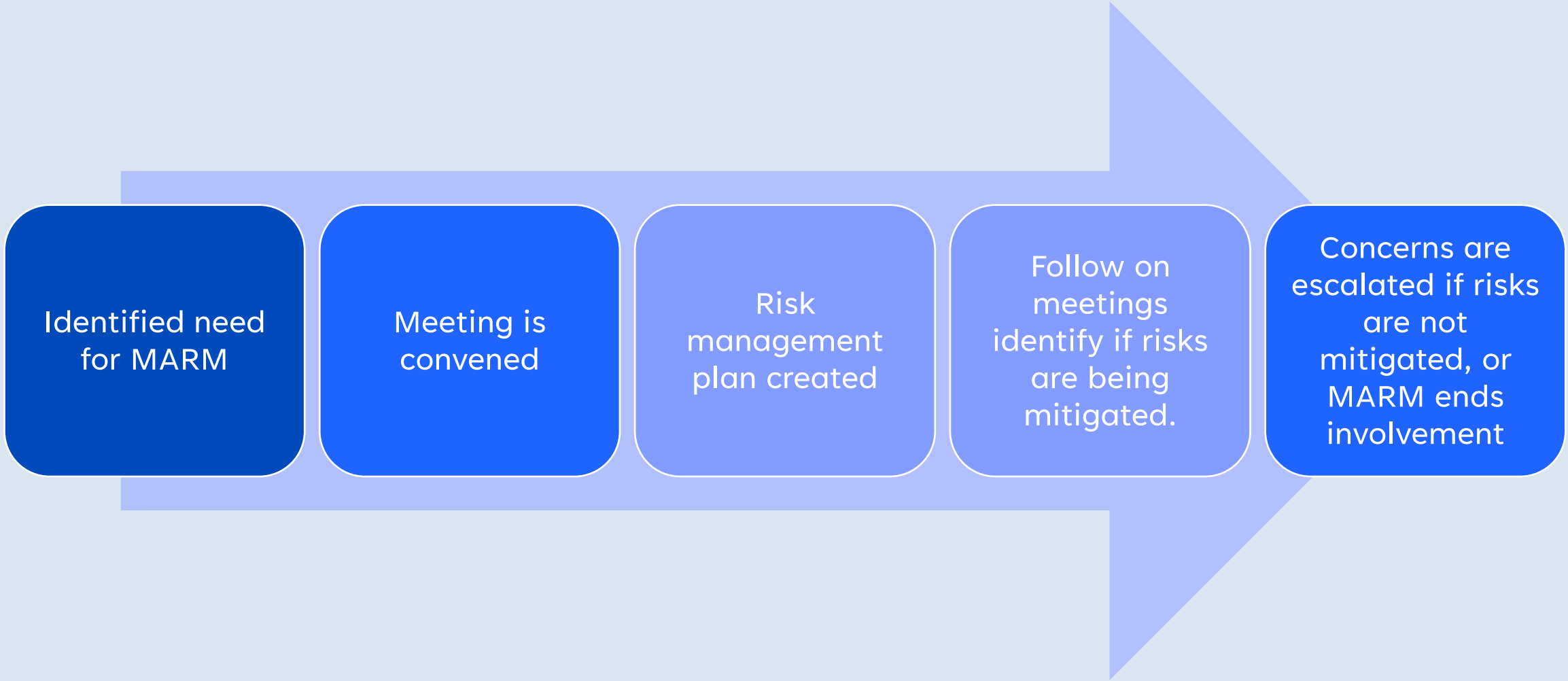
What concerns could trigger a MARM?

- Disengagement from services, which leaves the person at high risk of harm.
- Self-neglect and hoarding.
- Significant substance abuse.
- Significant mental health concerns.
- Person not attending to their health needs.
- Homelessness where the person has additional needs that escalate the risks.
- Complex or diverse needs which either fall between statutory responsibilities or eligibility criteria
- On-going needs or behaviour placing the person and/or others at significant risk.

MARM Across the Country

- Not all local authorities (L.A) have a MARM framework but most L.A's have a multi-agency process in place.
- MARM can be known by different names.
- There may be a MARM Officer that coordinates the process, or agencies may be expected to follow MARM guidance, convene and facilitate the meetings themselves.
- Whilst the MARM process can differ between local authorities, essentially the principles of MARM remain the same.

Typical MARM Process



MARM and Risk Management

Case example

Photo taken from ‘The Atlantic’, 2017 (online)

Resources

Multi-agency risk management different regions.

North somerset: Multi-Agency Risk Management (MARM) | Adult Safeguarding Board

Somerset - https://somersetsafeguardingadults.org.uk/wp-content/uploads/2024/10/SSAB-MARM-v1.2-july-2024-fv-.docx

Bristol Adult MASH - Rob.Byles@bristol.gov.uk
South Glos – all staff can call a multi-agency meeting. No set process.
BANES - Bath & North East Somerset Community Safety and Safeguarding Partnership (BCSSP) (BathNES) –

SAR Resources

List of 15 Safeguarding Adult Reviews Quality Markers - SCIE

Care and support statutory guidance - GOV.UK

SARs where MARMs has been identified as needed:

SAR Erik - Devon Safeguarding Adults Partnership

SAR Craig Learning Briefing

RSAB-SAR-Caleb-Overview-Report-May-2024.pdf

RSAB-Thematic-SAR-Self-Neglect-Deborah-and-David-May-2025-Final.pdf

Susan Learning Brief.pdf

7MBAlan.pdf

Resources Cont...

North Somerset: Safeguarding adult reviews (SAR) | Adult Safeguarding Board
Bristol: Welcome to the Keeping Bristol Safe Partnership website.
South Glos: Safeguarding Adults Reviews (SARs) | SafeguardingSouth Gloucestershire Safeguarding
Somerset:

- Safeguarding Adult Reviews
- https://somersetsafeguardingadults.org.uk/wp-content/uploads/2025/01/Appendix-1-Safeguarding-Adults-Review-SAR-Referral-Form.docx

BaNEs: Bath & North East Somerset Community Safety and Safeguarding Partnership (BCSSP) (BathNES) - Safeguarding Adult Reviews

This is the relevant legislation: https://www.legislation.gov.uk/ukpga/2014/23/section/44
Section 7 Care Act imposes a duty on relevant partners to cooperate - https://www.legislation.gov.uk/ukpga/2014/23/section/7
Care Act 2014.
SAR Analysis: https://www.local.gov.uk/publications/analysis-safeguarding-adult-reviews-april-2017-march-2019