NSSAB Safeguarding Adult Review (SAR) 7-Minute Briefing 'Dave'

Section 1: Introduction

A Safeguarding Adult Review (SAR) is about learning, it doesn't seek to lay blame but to understand what happened, and what could have been done differently. A SAR report will highlight anything that needs to change to make things better in the future. This 7 minute briefing summarises the key findings, learning points and recommendations from the SAR about Dave, more detail can be found in the full SAR Report. (ADD LINK).

Section 2 : Dave

Dave is a pseudonym chosen by his family; his ethnicity was White British. Dave was 73 when he died by suicide in February 2024. The SAR identifies the progression of Dave's increasingly concerning mental state and acute distress about his separation from and ultimate loss of his wife when she no longer recognised him because of Alzheimer's disease. Dave sought solace through an excess of alcohol and drugs, his loneliness made him vulnerable to exploitative 'friendships' and home invasion also known as cuckooing. Many concerns were raised about Dave and he came into contact with professionals from different agencies. The following areas of focus were identified for the SAR: Safeguarding Practice, Home Invasion/Cuckooing, Suicide Prevention and Partnership Working and Information Sharing.

Section 3 Safeguarding and Home Invasion/Cuckooing

- *There were operational pressures and organisational conditions that impacted on the effectiveness of the multi-agency safeguarding response.*
- *More professional curiosity about Dave would have helped to identify the risks he was exposed to.*
- *Engagement with Dave's family and people who knew him best would have been of benefit.*
- *There was limited partner knowledge of cuckooing/home takeover, exploitation and the victim – perpetrator relationship which can be complex.*

Section 4: Suicide Prevention

- *Dave would have greatly benefited from a collaborative response between partners to risk and suicide prevention.*
- *This would have brought partners together to work with Dave, and with his family, to develop a shared risk and suicide safety plan.*
- *New ways of working to prevent suicide that are focused on developing kind, compassionate and caring relationships and agreeing person -centred safety plans are now in place in North Somerset.*
- *There is scope to have a focus for learning on the increasing prevalence of suicide in older people.*

Section 7: Recommendations (Summary).

1. *A review of the protocol for multi-disciplinary meetings (MDTs) in hospital,*
2. *To progress as a priority Police/Adult Social Care safeguarding workshops*
3. *The NSSAB should seek assurance that partners have awareness, understanding and a working knowledge of the mental capacity act.*
4. *Adult Social Care advised to review and quality assure the previous and proposed changes to the revised safeguarding structure.*
5. *Partners advised to review Making Safeguarding Personal and Person Centred Practice to ensure that this includes a 'Think Family' approach and a recognition of the importance of trusted relationships and professional curiosity.*
6. *Establishing Cuckooing and Adult Exploitation awareness raising and practice guidance across the partnership.*
7. *The Care Home advised to capture the areas of learning from the SAR and progress an action plan that is monitored.*
8. *Suicide prevention to be strengthened across the partnership through awareness raising and accessible and flexible learning opportunities.*
9. *Partners advised to conduct a review of the Multi-Agency Risk Approach (MARM) in the light of this SAR. A review of sharing information pathways across the partnership.*

Section 6: *What's Changed and Changing*.

Positive changes have been made including the refreshed Mental Health Suicide Prevention practice approach, the introduction of the Multi-Agency Risk Management (MARM) approach and the Avon and Somerset Police review of the BRAG risk assessment to embed a more person centred way of working with adults who are at risk. Others are listed in section 5 of the full SAR report.

Section 5 – Partnership Working and Information Sharing.

There were a number of factors that impeded partnership working and information sharing:

- *Partners working and viewing information in isolation.*
- *Separate IT data systems.*
- *Low level concerns were note seen cumulatively identifying a pattern of sustained risk to Dave.*
- *Workload pressures, time constraints and increasing demand had an impact on response.*
- *A lack of confidence and uncertainty about partners approaching each other to access professional specialist support and expertise.*