Bexley Safeguarding Adults Board

7-minute Learning Summary

SAR - Mary

1. Rationale for Safeguarding Adult Review (SAR):

The BSAB regularly carries out SARs. They are extensive pieces of work, that look in details at cases when an adult at risk of abuse dies or has experienced serious neglect or abuse, and there is concern that partner agencies could have worked more effectively to protect them. This SAR was carried out so that the agencies involved in providing services to Paul could learn lessons and improve practice.

Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight.

The overall aim of a SAR is to improve services because of that learning. **What do you do?** Make sure you embed the learning and can evidence to the BSAB especially if you work for an agency that was involved in this SAR.

The full report can be found here –

https://www.safeguardingadultsinbexley.com/wp-content/uploads/SAR-Mary.pdf

2. What happened in the case of Mary?

On the night of Mary's death, her daughter-in-law, Hayley, called the London Ambulance Service (LAS) having found Mary in the in the early hours of the morning with no signs of life. The LAS called the MPS to request their attendance as this was an unexpected death. On arrival, the LAS noted that Mary's family were on scene performing cardiopulmonary resuscitation. Following examination, the ambulance team noted that Mary had no signs of life and the onset of rigor mortis. An electrocardiogram indicated that Mary's heart rhythm was in asystole (no electrical activity present). Recognition of "life extinct" was recorded by the ambulance Staff in the presence of the police and the family at 02:51h. Over a 10-year period – Mary had over 10 different Home Care Agencies providing Care in the home as well as Multiple health & social Care agencies. The SAR Identifies 18 learning Points.

3. What were the Key Questions for the Review?

A. What Was The Post Incident Response & Was Adequate?

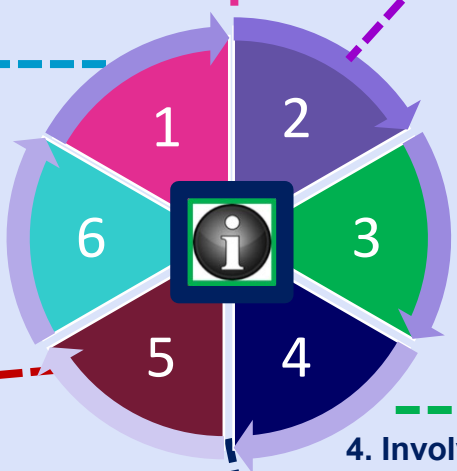
B. Safeguarding Concerns Raised?

C. Working In Partnership?

D. Evidence Of Making Safeguarding Personal?

E. Information Sharing & Confidentiality

F. Previous Safeguarding Adult Reviews Evidence of Learning



4. Involvement of Family and significant others:

Mary's family were sent a letter of invitation to engage with the SAR. No response was initially received as the family had moved to a new house. A new letter was arranged to be hand delivered by a professional engaged with the family at their new address which was received. As a result, the Independent Chair and the BSAB Practice Review & Learning Manager met with Mary's son, Ian, over video conference (we were unable to meet face to face due to Covid-19 control measures preventing unnecessary gatherings and travel). The review has benefitted from the input from Ian, who not only offered his views but was also able to confirm that the findings of the report resonated with his own experience.

5. Findings:

4 Key Domains found in SAR-Mary:

A. Direct Practice with Mary -

Recognising and Responding to Specific Forms of Abuse and Neglect

B. The Team Around The Adult / Interagency Working –

How do professionals work as a team, colleague and network to safeguard families.

C. The Agencies Around The Team / Organisational Behaviour –

Organisational behaviour in the agencies involved contributed to the practice observed in both direct work with the individual and in interagency working in Domains A and B above.

D. SAB Governance –

Oversight by the BSAB and to ensure the findings, recommendations, and action plans are completed and updated as per the 6-Safeguarding Principles that govern the work of the board.

6. SAR Assurances & LA Oversight:

BSAB to seek updates from partners regarding the embedding of this learning through the BSAB SAR Sub Group.