

7 Minute Briefing – Safeguarding Adult Review ‘Eric’

1. Introduction

Safeguarding Adults Boards have a statutory duty to conduct Safeguarding Adult Reviews (SAR) in certain circumstances. Concerns were identified regarding Eric, an adult who had care and support needs and appeared to have died as a result of neglect. In addition to this, there was reasonable cause for concern about how agencies worked together to safeguard him.

Salford Safeguarding Adults Board felt that the criteria were clearly met and therefore commissioned this review.

2. About Eric

Eric had lived in Salford all his life, he was married, had a daughter and passed away in hospital age 81, with the cause of death being starvation.

He is described by his family as someone who ‘lived life to the full’. He was passionate about classic cars, motorbikes and he enjoyed watching and playing various sports. He also enjoyed spending time outdoors and socialising. Eric was a private family man who perhaps struggled with getting older, the loss of friends and experienced episodes of depression.

3. What happened?

Eric took to his bed and began to refuse food, water, personal care and treatment.

He was seen by various professionals over a few weeks. Eric did not always engage, making it difficult to determine what care and support was needed. The review panel felt that there was a lack of confidence in applying the principles of the Mental Capacity Act or Mental Health Act and escalating serious concerns about self-neglect.

4. What happened next?

Eric was determined by some professionals to be ‘end of life’. A Safeguarding concern was raised as Eric did not have a medical diagnosis to support this. He was later assessed as lacking mental capacity to refuse care and treatment and was eventually admitted to hospital. Unfortunately, this was too late for any acute care and treatment to be provided and soon after he passed away.

5. Learning

- Be mindful that seeing a case through a particular ‘**perspective**’ can have a significant influence on what happens – **be open to other possibilities**
- Always consider **legal options** where a person is putting themselves at risk and won’t engage with a mental capacity assessment.
- **Escalate concerns**, especially where there are ongoing risks present.
- **Multi-agency working is crucial**. Familiarise yourself with and use the [Self Neglect Policy](#) and [safeguarding process](#) to trigger a multi-agency discussion if someone is putting themselves at risk of harm due to self-neglect.
- Ensure that **carers** are fully supported and [carer’s assessments](#) offered so they can access support available to them.
- Ensure staff can access support / debrief when dealing with complex situations.

6. For more information, please see:

Read the [full report](#).

SSAB [Safeguarding Policy and Procedures](#)

[Make a safeguarding Referral via the SG1 Form](#)

[Information and resources on the Mental Capacity Act](#)

[Salford Council – Information on Mental Capacity Act](#)

[Gaddum](#) – Carer's Support Service

Contact Details:

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