

# SSAB Briefing Document: Key Learning from the Safeguarding Adults Review (SAR) for ‘Nat’

## Purpose of the Briefing

This briefing summarises the key learning from the Safeguarding Adult Review from Nat, which has been commissioned by Salford Safeguarding Adults Board (SSAB). It is intended to support frontline professionals and managers across all agencies to reflect on practice, improve safeguarding responses, and ensure the voice of the adult is central to all decision-making.

The SSAB has decided that the full report cannot be published due to sensitivities with the review, however it has been agreed that a Briefing Document would be published to share the learning.

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## Why Was a Safeguarding Adult Review (SAR) completed?

The review was carried out to understand what happened in Nat’s life and how professionals and services supported him. The SAR aimed to identify the learn lessons to improve practice and future support for people in similar situations.

**It was not about blaming anyone.**

“We just want the learning to be shared, so no other family have to go through what we have gone through”

(Family of Nat)

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## Who was ‘Nat’?

Nat was an elderly man with significant health needs. He lived in his own home and his adult child moved in with him to provide additional support, they were also his paid carer via a direct payment and held Lasting Power of Attorney. Nat was described as sociable and community-minded, but over time became increasingly dependent on his adult child for all aspects of his care and support.

Nat made multiple disclosures to professionals of incidents involving his adult child which could have been an indication of domestic abuse within the home environment, but they were not fully explored, due to Nat stating that he wished to withdraw what he has previously said.

Nat had a number of episodes in hospital but then died at home in 2024.

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## Key Learning Themes

### 1. The Voice of the Adult Must Be Heard

- Nat's voice was often missing from support planning and safeguarding responses.
- Professionals sometimes accepted his adult child's view and decisions without confirming Nat's wishes, especially when access to him was restricted.
- **Learning:** Professionals must actively seek and document the adult's views, even when others speak on their behalf.

### 2. Risks in Direct Payments and Personal Assistants

- Nat's adult child lived with him and was also employed as Nat's personal assistant via a direct payment. No safeguarding checks were undertaken despite there being reported domestic incidents and tensions within the family.
- Professionals lacked confidence and clarity around managing direct payments.
- Practitioners need a clear process in place when family members who live with the cared for person request to be their personal assistant.
- **Learning:** Direct payments must be regularly reviewed, and professionals must be supported with clear guidance and training.

### 3. Missed Opportunities to Assess Carer Stress

- Nat's adult child showed signs of carer stress and declined support multiple times.
- No carer's assessment was offered during the scoping period of the review.
- **Learning:** Carer assessments are vital to understand the carer's needs, identified level of stress, obtaining their views and understanding what the caring role has on their own health and wellbeing.

### 4. Safeguarding Thresholds and Supervision

- Concerns were raised about Nat's adult child's ability to provide care, but safeguarding concerns were not always reported.
- Supervision systems across Health and Social Care Partnerships did not consistently support escalation.
- **Learning:** Safeguarding supervision must be robust, and concerns should be escalated even when previous concerns are ongoing.

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### 5. Domestic Abuse in Older Adults

- Nat disclosed abuse but later withdrew his allegations.
- Professionals focused on mental capacity without exploring coercion or emotional controlling behaviours.
- **Learning:** Domestic abuse in older adults must be recognised, and disclosures must be explored with curiosity and sensitivity. This has been the learning in previous SARs like [SAR Irene](#)

### 6. Family Involvement in Support Planning

- Nat had other adult children who were not involved in support planning.
- Professionals did not explore wider family dynamics or potential support in any great detail.
- **Learning:** Assessment and planning must include exploration of all family relationships, regardless of conflict or any tension/family dynamics.

### 7. Lasting Power of Attorney (LPA) – Risks of Coercion and Control

- Nat’s adult child held LPA, but professionals did not always confirm Nat’s capacity before accepting decisions made on his behalf.
- Current safeguards focus on donors who lack capacity. However, donors with capacity may still be vulnerable to coercive and control behaviours, especially in familial contexts. This gap was highlighted in the SAR for Nat, where concerns were raised about whether Nat was pressured into appointing his adult child as his attorney.
- **Local Learning:** LPA must be checked and understood. Decisions must be made by the adult unless capacity is clearly lacking.
- **National Recommendations: Clearer guidance** on when and how to challenge or report concerns about attorneys and **Review of LPA safeguards** for donors with capacity but who may be vulnerable.

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### Positive Practice

- There was evidence of compassionate end-of-life care by District Nurses, GP, Macmillan Nurses, and North West Ambulance Service (NWAS).
- The review noted that the GP Practice offered regular reviews and support.

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### Actions for the Workforce

- **Listen to the adult:** Prioritise their voice in all interactions.
  - **Be professionally curious:** Don't accept decisions at face value—explore context and risk.
  - **Know your safeguarding thresholds:** Escalate concerns even if previous concerns have been reported.
  - **Understand and feel confident with direct payments:** Access training and support to ensure you feel comfortable you understand what a Direct Payment is and isn't, how it should be used.
  - **Support carers:** Offer assessments and explore their wellbeing.
  - **Recognise domestic abuse:** Especially in older adults and those with disabilities.
  - **Check LPA status:** Confirm capacity and ensure decisions are legally valid.
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### Local Resources

- [Salford SAB 7-minute briefings](#) on Carers and Lasting Power of Attorney (LPA)
- [Salford SAB Domestic Abuse webpages](#) which provides a range of resources including a short videos on 'Hidden Harms' – this short animation explains domestic abuse and how it affects older people
- [Salford SAB Escalation Policy](#) – this can be used when escalating concerns when there is a difference of professional opinion.
- [Salford SAB Training and Development](#) webpages offers a range of resources, short videos, information about upcoming training and this is where you can subscribe to the SSAB Newsletter.
- For further information about support available in Salford for Carers, please visit [Information for Carers / Family members who provide care or support | Salford Safeguarding Adults Board](#)
- [Salford SAB website for Multi Agency Policies and Procedures](#)