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Plymouth Adult Safeguarding Partnership

Report to PSAP

Date	09.06.21
Name	[redacted]
Agency	NHS Devon CCG; Chair of SAR sub group
Report subject	SAR sub group recommendation
Strategic Plan ref:	N/A
SAB Sub-Group	SAR

Purpose of report:	To provide a recommendation to the Plymouth Safeguarding Adults Partnership (PSAP) following a referral for a Safeguarding Adult Review (SAR)
Content:	Context: Once in receipt of a referral, the purpose of the SAR sub-group is to review the information held by agencies and make a recommendation to the Independent Chair of the PSAP as to whether a SAR should be commissioned, in line with the Care Act 2014 statutory guidance and the SAR sub group policy. Decisions for referrals must gain the support of a majority of the SAR sub-group members. Should they not be able to reach a majority decision, reasons for not agreeing are recorded and the decision referred to the PSAP Chair. In the event of the referral for a SAR not progressing, the SAR Sub-group will ensure the reasons will be recorded in writing, decision shared with the referrer and other stakeholders as appropriate. In addition, the SAR Sub-group may make alternative recommendations to the referrer. Referral for Glenn MacMartin: The NHS Devon Clinical Commissioning Group (CCG) was asked to chair the group for this referral in order to provide independence for the decision process, as both the usual chair of the SAR subgroup and Devon and Cornwall Police had been involved in the Coronial process. The SAR sub-group received a referral in respect of Mr MacMartin, and the Chair can confirm that 2 sub-group meetings were held to discuss in depth the relevant information. All 3 statutory partners were represented, Plymouth County Council, NHS Devon CCG and Devon

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	and Cornwall Police; therefore the meeting was quorate, and the decision unanimous. Following review of all of the relevant information, it was agreed by the SAR subgroup that this referral did not meet the criteria for a SAR for the reasons stated below: • There was evidence of good multi-agency working in order to protect the adult with care and support needs, though there were some gaps in communication identified. • The events prior to Mr MacMartin's death were thoroughly investigated by Devon & Cornwall Police, who found no evidence of a crime or abuse or neglect. This was reviewed and all agreed with the decision made by the police. • All safeguarding concerns and enquiries raised prior to Mr MacMartin's death were reviewed and the group concurred with there being no abuse or neglect identified in them. • The whole service concern process regarding the care home in which he resided was reviewed, and it was clarified that whilst the parallel CQC process resulted in the home later being closed, this was a result of the lack of ability to comply with the requirements of the process, rather than any indication of neglectful care. • There was evidence that his care provider sought appropriate medical support in the days leading up to Mr MacMartin being admitted to hospital. • There was evidence of a timely and appropriate health response to the requests from the care home for a health assessment. • After his initial good response to treatment received in the hospital he sadly deteriorated and despite all their efforts to treat him, he very sadly passed away. • The pathologist's report does not indicate any signs of abuse or neglect. • The group acknowledged there was a lack of communication between the care home and Mr MacMartin's family. While the recommendation is that a SAR is not the appropriate response to this referral, there is recognition of an opportunity for learning and this will be taken forward as a multi-agency response to the HMCO Regulation 28 request.

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Formal response from PSAP Independent Chair	Following the initial discussions at the PSAP Executive Group meeting on 1 June 2021, I have now received the SAR referral decision for the case of Mr Glenn MacMartin. I note the recommendation of the SAR sub group, under the Chair of [redacted], not to commission a SAR process. This decision was based on a full and thorough multi-agency analysis of the circumstances and contextual factors surrounding Mr MacMartin's death, including a police investigation and post mortem examination. I endorse the recommendation not to proceed to a SAR process based on the detailed rationale set out above. However, I fully support the commissioning of a multi-agency learning review, independently facilitated, to ensure that multi-agency learning is identified in terms of strengths and weaknesses, and subsequently translated into improved ways of working across the system. This should be a transparent process involving the engagement and participation of Mr MacMartin's family, with the learning shared as widely as possible. I understand that planning for the learning review is underway, and the following details of this will be communicated to Mr MacMartin's family and to HMCO as the response to the Regulation 28 request. • Inform relevant partner agencies of the proposal, and secure engagement • Agree Terms of Reference and scope with partners • Identify and commission an independent facilitator (IF) • IF to set out plan to family, accept questions, parameters etc • IF meet before and after with family • Capture learning/record, feedback, report to the Coroner • Share learning [redacted] Independent Chair Plymouth Safeguarding Adults Partnership