LEARNING FROM SERIOUS CASE REVIEWS & SAFEGUARDING ADULTS REVIEWS IN THE SOUTH WEST 2013-2017

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Care Act 2014: statutory duty to review serious cases

- SABs must arrange a Safeguarding Adult Review (SAR) when:
    - An adult dies as a result of abuse or neglect, or experiences serious abuse or neglect and
    - There is concern about how agencies worked together to safeguard them
- The purpose:
    - To identify lessons to be learnt from the case and apply those lessons to future cases
    - To improve how agencies work, singly and together, to safeguard adults

The focus of the study

Key questions	The approach

• What learning themes emerge from SCRs & SARs conducted in SW?
 	
• How do the learning themes help us understand what goes wrong?
 	
• What changes are recommended in order to prevent recurrence?
	• Sample
	  • 26 SCRs & 11 SARs
	  • Only completed reviews included
	
	• Two forms of analysis
	  • SCR/SAR characteristics: type of case, type of review, type of recommendations
	  • SCR/SAR content: factors contributing to the case outcome

The cases

- Demographics
  - Across the life span (unlike the London sample); 41% of cases age not specified
  - Slightly more cases involved men (as in the London sample); 30% of cases gender not specified
  - Ethnicity usually unspecified (as in the London sample) – only 11% record ethnicity
  - 27% of reviews involve some form of group living.
  - 54% of reviews involve death of subject (in line with other reviews of specific types of cases – London was higher at 76%)
- Type of abuse
  - Organisational abuse (31% SCRs; 27% SARs)
  - Self-neglect (23%; 55%)
  - Combined – 3 SCRs, two involving self-neglect with neglect and/or organisational abuse; 2 SARs, one involving self-neglect with financial abuse
- Almost all were statutory reviews
  - Did not routinely indicate source of referral
- Much less reference than in the London review to reticence or defensiveness.
- Increasing tendency for reviews to make recommendations just to the SAB, from 35% to 45%

A range of methodologies

- Scrutiny of key documents: chronologies and reviews of each agency's involvement (50% and 10%)
  - Useful where multi-agency involvement has been long-term
- Systemic approach – "learning together" (15% and 10%)
  - Useful for promoting participation by those directly involved with the case
- Significant incident learning process (8% SCRs)
  - Useful where key episodes can be identified
- Significant event analysis
  - Useful where a key single event can be identified
- Hybrid approaches are increasingly common (8% and 64%)

Referral and review period	• Unclear how referral originated – 46% & 73% • 41% length of time taken not stated
Independence	• Questionable in 2 cases
Family involvement	• From 35% SCRs to 64% SARs • Family contributions to reviews
Individual's involvement	• Where individual alive, 22% did not indicate how their involvement had been considered
Length of review process	• Unclear how long process had taken – 41% • Very few completed within 6 months • Delays: parallel processes, poor quality or untimely information provision, scale & complexity
Length of report	• 24% ten pages or less • 16% more than 50 pages • No discernible trend
Recommendations	• 4-44 (SCRs) and 3-15 (SARs) with increasing tendency to limit the number & and to direct to the SAB (35% to 45%) • 35% of reviews make recommendations to unnamed agencies; very few to national bodies

Best practice research evidence	• 58% SCRs and 55% SARs utilise research evidence
References to other reviews	• 42% SCRs and 18% SARs draw on other reviews; missed opportunity to embed prior learning
Publication	• Majority published in some form (unlike in London sample)
Publication	• 88% SCRs and 91% SARs (only 45% in the London sample)
14 SABs in SW	• 13 submitted SCRs, ranging from 1 – 5 • 5 submitted SARs, ranging from 1 -5 • One SAB did not submit any reviews • How do we explain the variation?

Quality markers	• Transparency of process, as in
	   • decision-making about commissioning
	   • not all delays explained
	   • choice of methodology

Quality markers	• Accessibility, as in
	   • use of unexplained acronyms
	   • typographical and grammatical errors

SAR content: whole system understanding

Direct practice with the adult
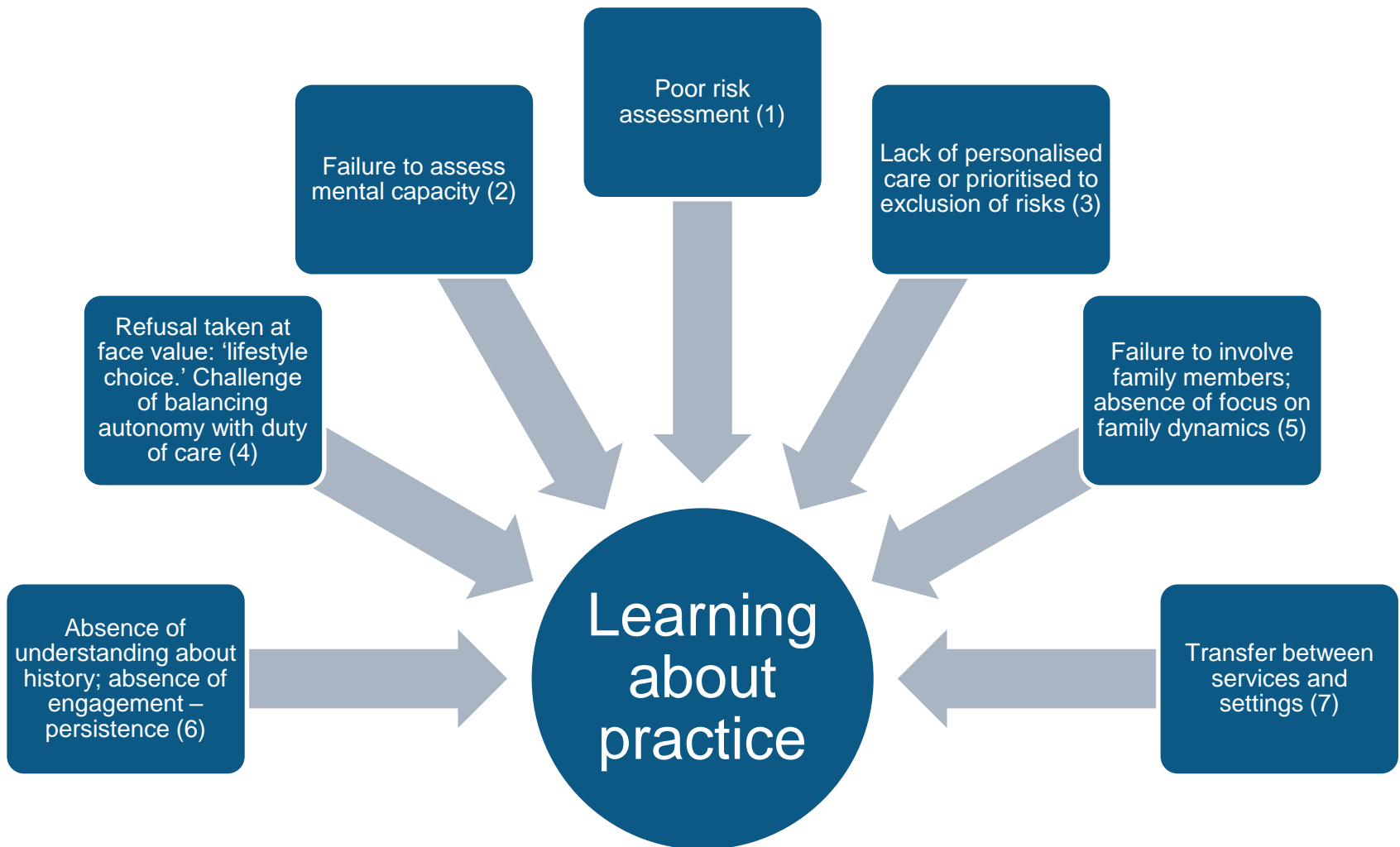
Risk
- Assessments absent or inadequate
- Failure to recognise and act on persistent and escalating risks

Mental capacity
- Assessments missing, poorly performed or not reviewed
- Absence of detail about best interest decision-making

MSP
- Insufficient contact with the individual
- Unclear focus on individual's wishes, needs and desired outcomes
- Focus on autonomy excludes consideration of risks to others and duty of care

Competing moral imperatives

Respect for autonomy and self determination

Duty of care and promotion of dignity
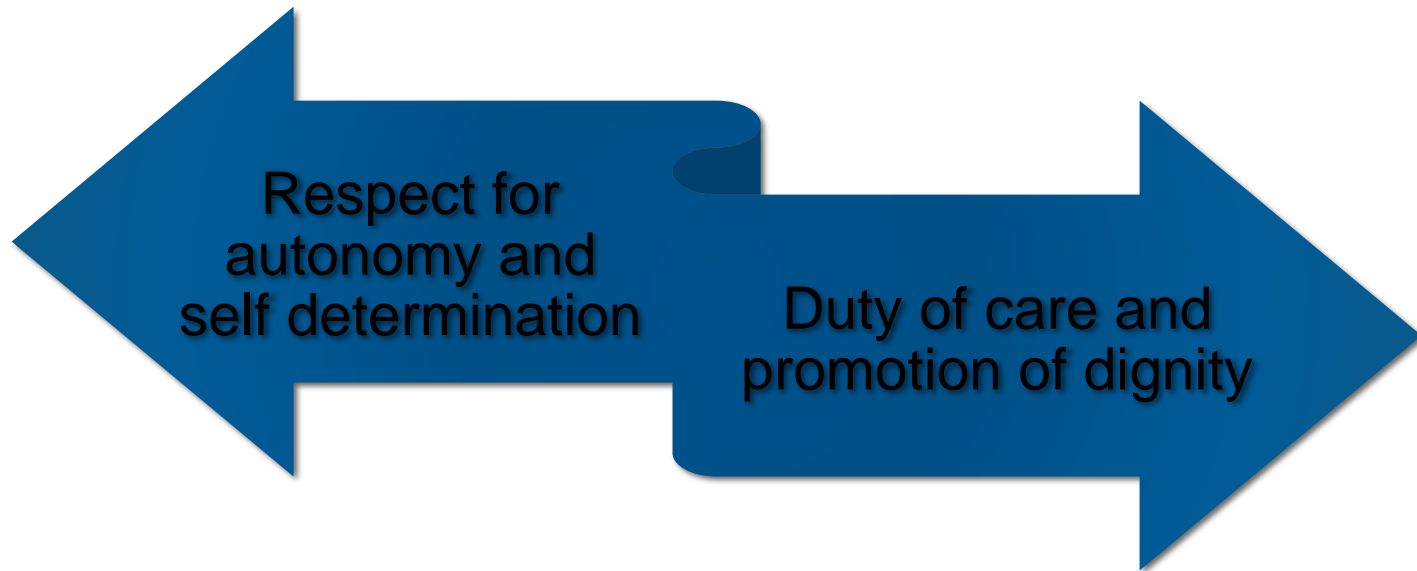
The key dilemma: competing imperatives

Respect for autonomy

- Right to make decisions others think unwise (MCA 2005)
- Limits to the power of the state (Magna Carta, the unwritten constitution)
- ECHR articles 5 and 8
- Policy context of personalisation & making safeguarding personal

Duty of care

- The state has a duty to protect citizens from foreseeable harm
- Extreme self-neglect compromises wellbeing & human dignity – "surely someone could/should have done something"
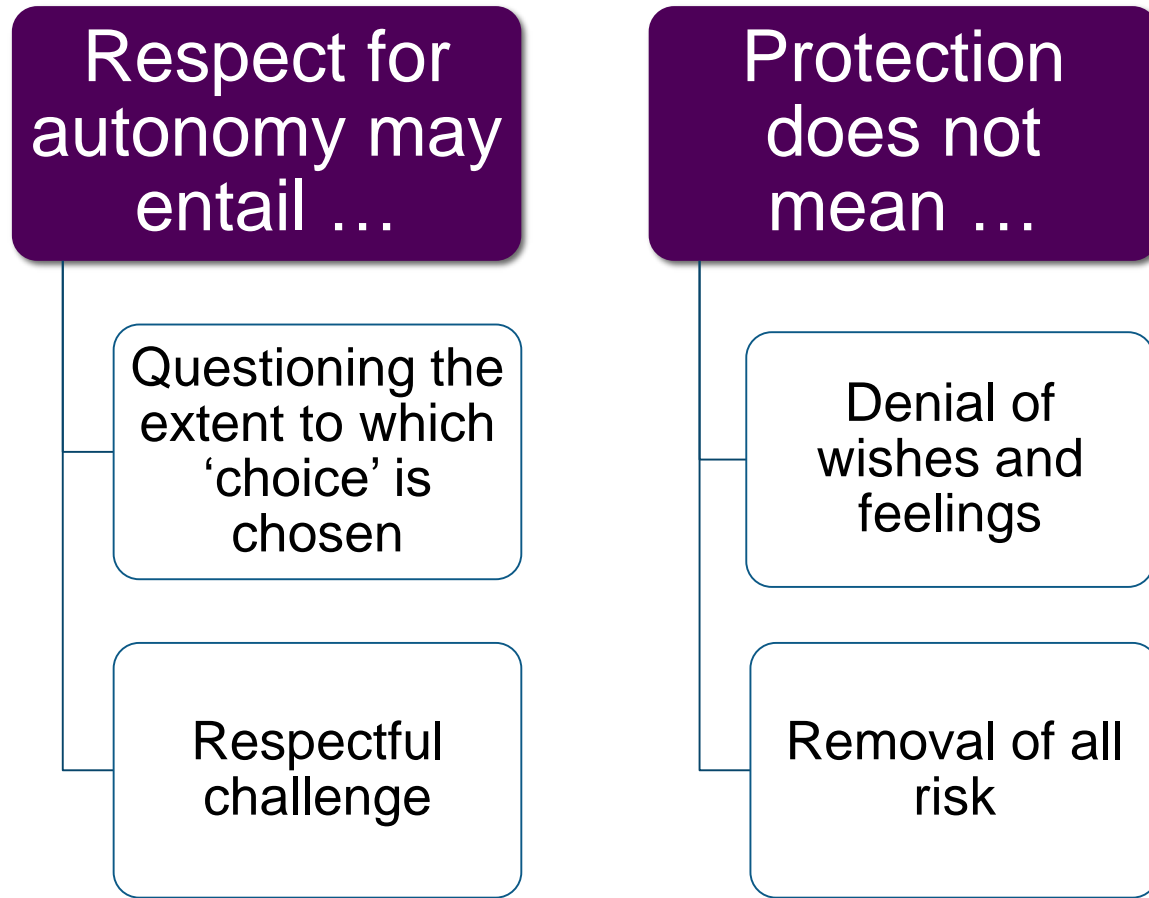- ECHR articles 2 and 3
- Others may be at risk

The tricky concept of lifestyle choice

- Is it really autonomy when:

- You don't see or recognise how things could be different for you?
- You don't think you're worth anything different?
- You never made a conscious choice to live this way but found yourself there without knowing how you got there?
- Your executive functioning is impaired?

"I used to wake up in the morning and cry when I saw the sheer overwhelming state... My war experience in Eastern Europe was scary, but nothing compared to what I was experiencing here."

"Well I don't know to be honest. Suddenly one day you think, 'What am I doing here?' "

"I put everyone else first – and that's how the self-neglect started."

| Respect for autonomy may entail …	Protection does not mean …
Questioning the extent to which 'choice' is chosen	Denial of wishes and feelings
Respectful challenge	Removal of all risk

- This can require persistence rather than time-limited involvement that looks to achieve 'independence' before all else: respect for autonomy does not mean abandonment
- The policy and organisational context strongly influence the feasibility of relationship-based approaches

Resolving the tension

- Personalisation is an approach offering both opportunities and constraints, depending on how it is implemented
- Self-neglect calls for a facilitated approach based on dialogue and interaction
- The separate, parallel agendas of safeguarding and choice (Fyson & Kitson 2007) can be blended
- It does not have to be the case that "'*care and protection*' is the booby prize if people can't exercise '*choice and control*'" (Barnes 2011: 160)

Organisationally determined workflow patterns
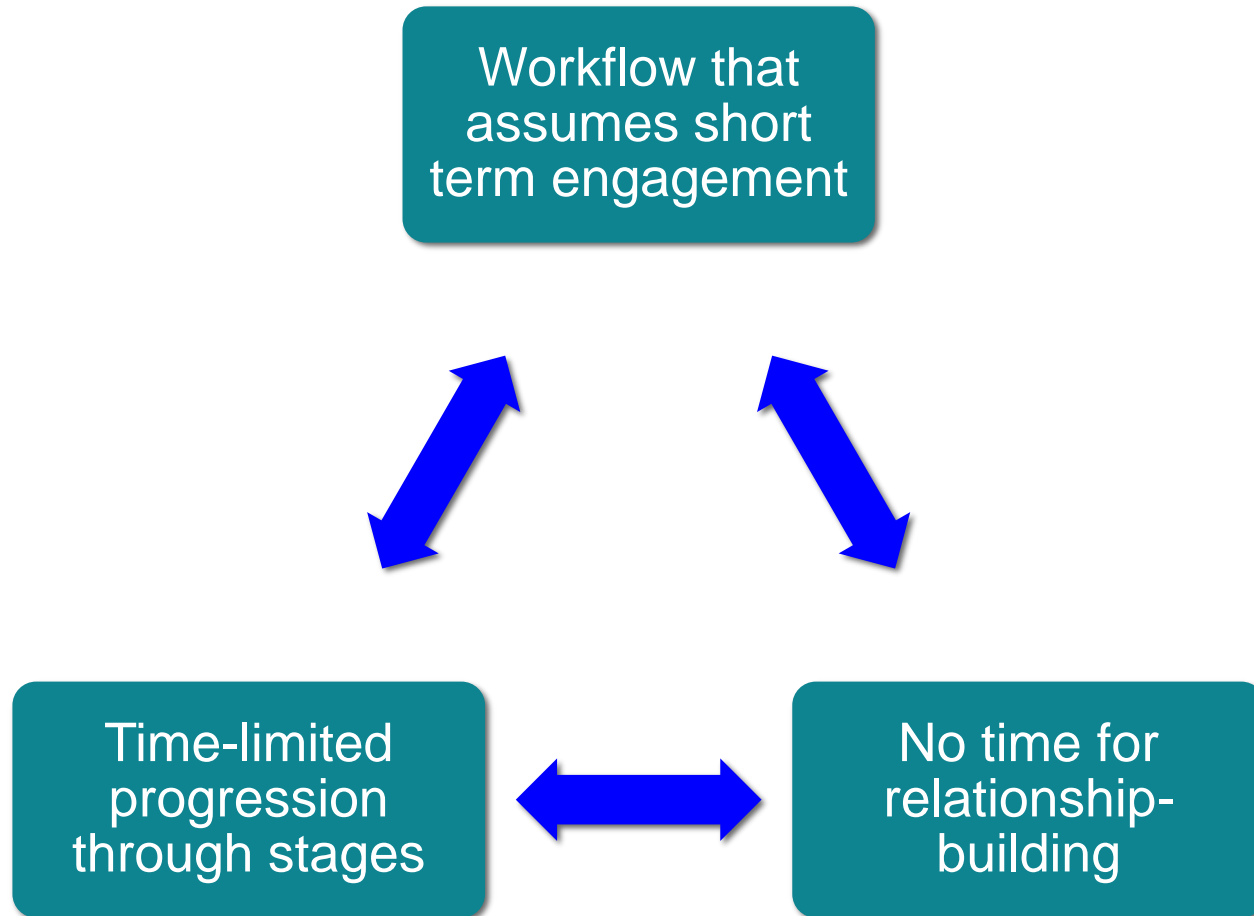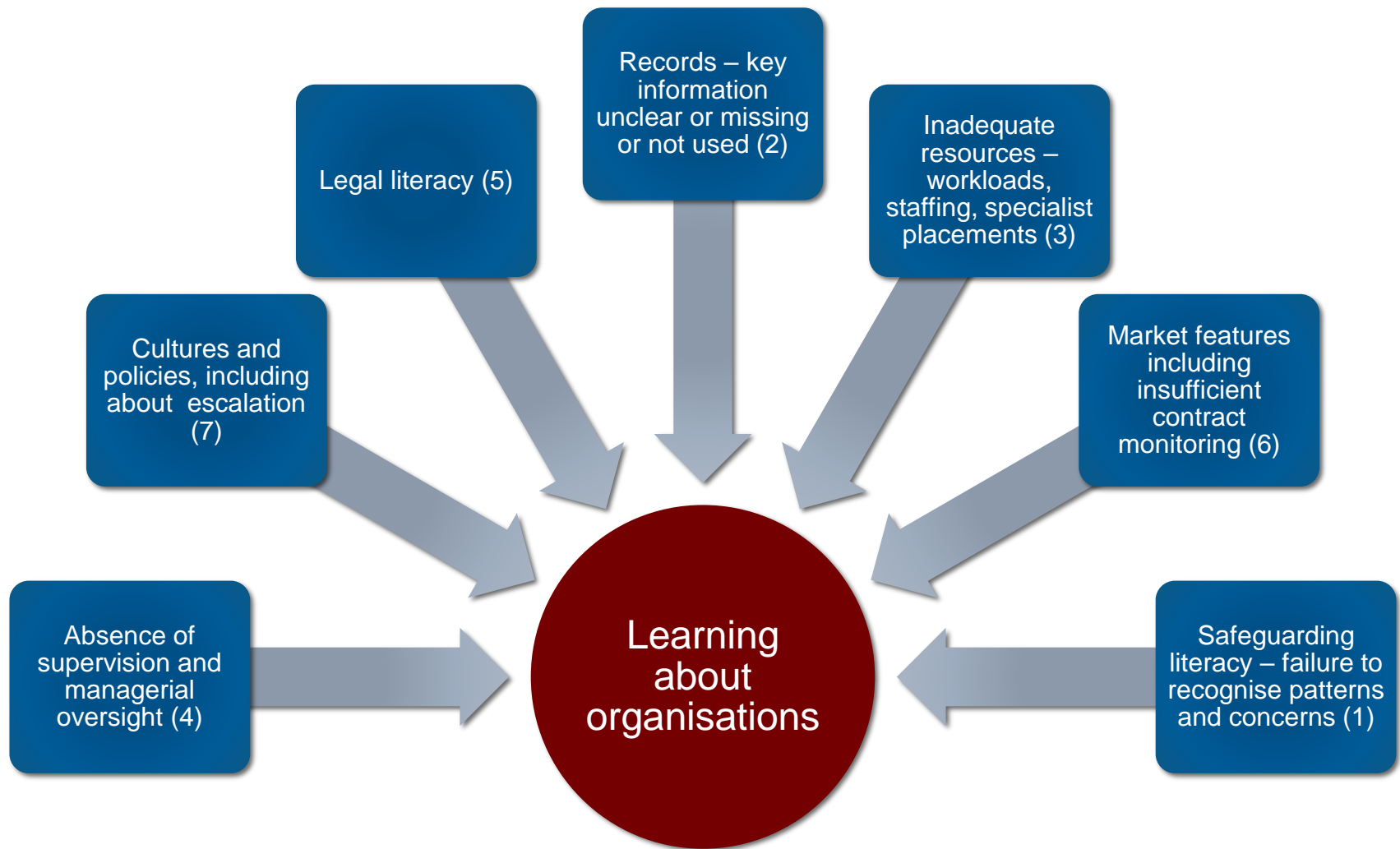
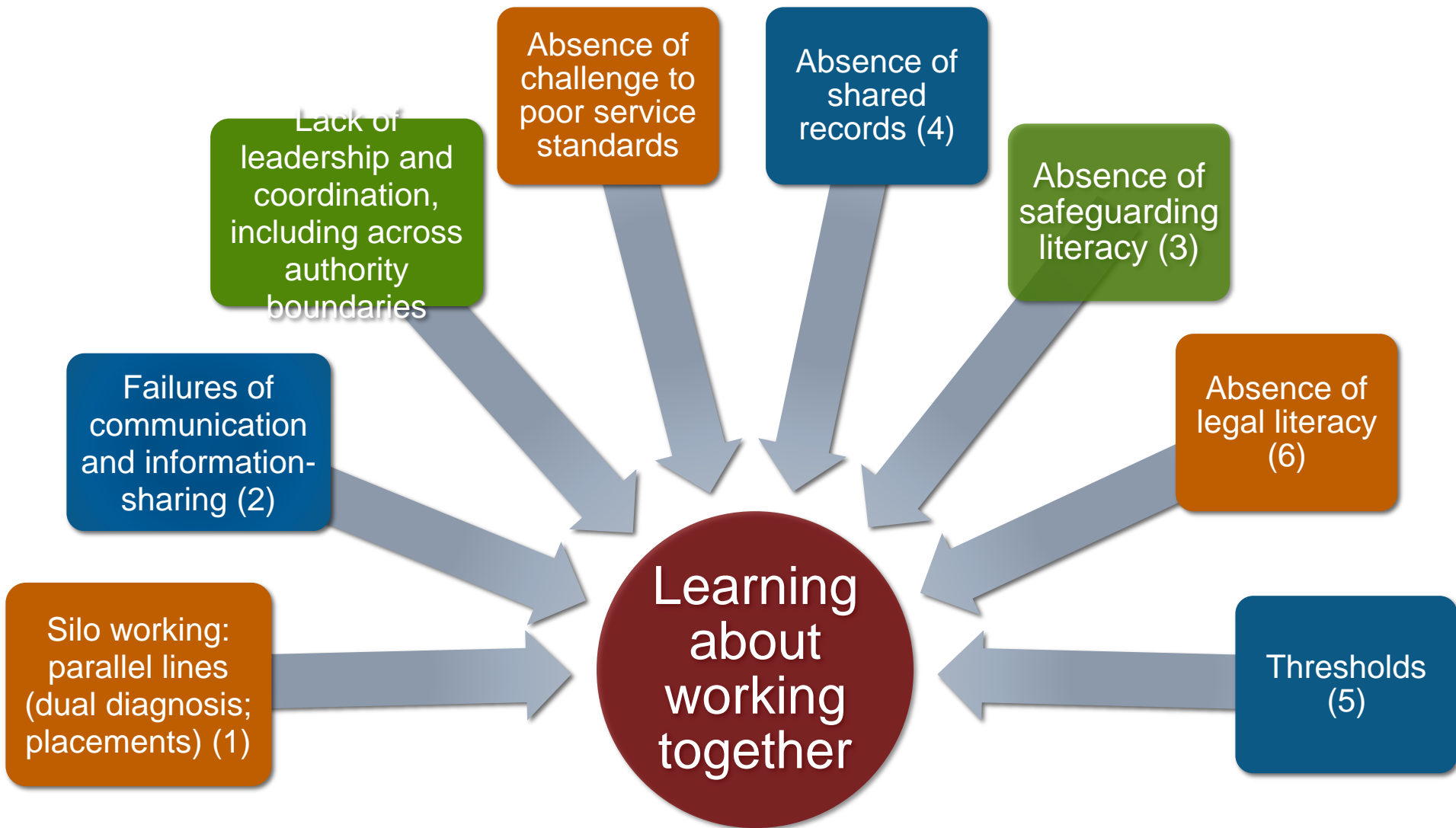# A perfect storm

Reluctance to engage

"The combination of people who are either terrified of losing their independence or terrified of state intervention, together with a state process that is desperate to apply eligibility criteria and find reasons not to support people, is just lethal.... It's just like: 'oh you're saying it's all fine, thank goodness, we can go away'".

Organisational pressures

Organisational context

Interagency cooperation

- Lack of leadership and coordination, including across authority boundaries
- Absence of challenge to poor service standards
- Absence of shared records (4)
- Absence of safeguarding literacy (3)
- Failures of communication and information-sharing (2)
- Absence of legal literacy (6)
- Silo working: parallel lines (dual diagnosis; placements) (1)
- Thresholds (5)

Learning about working together

SAB governance

Recommendations

Legal and policy context
SAB governance
Interagency collaboration
Organisations
Direct practice

Recommendations

Direct practice – (risk & capacity) assessments, person-centred practice, balancing autonomy & duty of care, legal literacy

Direct practice – thorough mental health and psychological assessments & support; developing understanding of safeguarding procedures; quality of reviews, especially of placements

Organisational – guidance, training, supervision, commissioning & care provision planning, case management, recording, referral & assessment practice

Inter-agency – information-sharing & communication, co-ordination of complex cases, clarifying professional roles & responsibilities

SAB governance – audit and quality assurance of practice standards, management & use of SAR

Recommendations

- Recommendations should
  - Clearly argue the case for change
  - Be learning oriented and evidence-based
  - Assign responsibility for action
  - Clarify the outcome desired & how it will be recognised
- Implementation more effective when recommendations are
  - Timely & engage practitioners/managers
  - Promote learning
  - Contribute to building relationships within & between agencies
  - Form part of a continuous programme of service development
  - Are regularly discussed and reviewed at all levels
- Attention to workplace as well as workforce development

Conclusions

- Unique and complex pattern of shortcomings
  - Learning rarely confined to 'poor practice'
  - Weaknesses in all layers of the system
  - Each alone would not determine the outcome
  - Taken together they add up to a 'fault line'
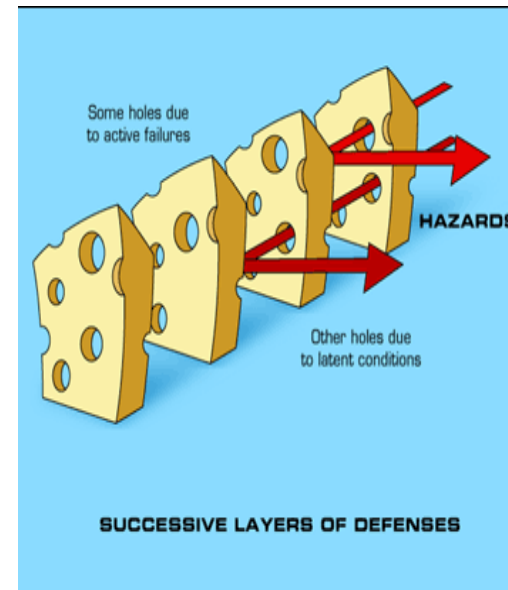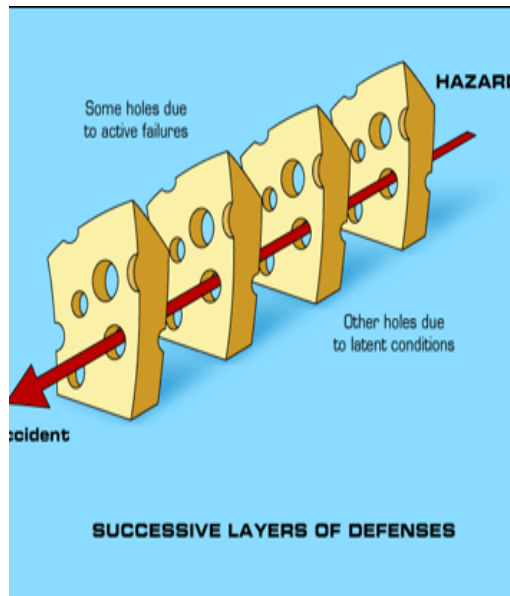
Impact of Care Act 2014?

- Positive – six principles, especially proportionality, empowerment (involvement) & accountability (publication)
- Positive – development of quality markers, methodologies & repositories
- No change – prominence of reviews on self-neglect and on organisational abuse & neglect, challenges in the care market, position & performance of CQC
- Context – financial austerity facing SABs & their statutory partners
- Challenge – demonstrating impact & added value

Recommendations to SW SABs

Safeguarding practice

- Review practice on implementing SAR findings
- Review safeguarding policies and procedures in the light of these findings
- Consider further work to track impact and outcomes of SARs
- Review protocols for cross-boundary working, especially care home placements & providers
- Develop practice standards on self-neglect and on prevention, detection and reporting of organisational abuse & neglect

SARs

- Expand use of quality markers in SAR policy & practice
- Facilitate discussion and development of guidance for SABs on
  - Commissioning SARs, methodologies, interface with parallel processes & other reviews
  - Monitoring of SAR referrals and outcomes cf. patterns of abuse
  - Family involvement
  - Panel membership (especially CQC)
- Consider further work on
  - Thresholds for SAR commissioning
  - Advantages/disadvantages of methodologies

Dissemination to DH and national bodies representing SAB partners

Taking learning forward

- 88% of SCRs and 91% of SARs published as whole reports or executive summaries (London – only 45% of SARs). What weighs in the decision-making here?
- Action plans, routinely monitored and updated, with outcomes reported to SABs
- Dissemination mainly within a locality but also regionally and nationally to promote learning and service development
- Briefing notes for a wide variety of audiences
- Learning and service development seminars & conferences
- But – how do we address current concerns about impact and effectiveness of the review system – learning the same lessons?
- Key themes – under-reporting of "low level" concerns; balancing autonomy with duty of care; effectiveness of placement monitoring and CQC; dual diagnosis; risk assessment
- What is NOT talked about – impact of public sector cuts, adequacy of market models of care, fragmentation of health and social care, adequacy of legal frameworks

Questions for Independent Chairs and Business Managers - Commissioning

- Organisational abuse and self-neglect also prominent in London survey but higher representation of other types of abuse/neglect in SW. What might influence the referral process here?
- Are referrals appropriate and do all agencies refer?
- How do we understand differences in the number of reviews being commissioned by different SABs (here and in London)?
- What are the explicit and implicit thresholds being used for commissioning different types of review?
- Statutory SARs and parallel SCRs dominate. What influences are at work here? How do we balance proportionality with commissioning the familiar? How do the six principles work here? Is the statutory guidance too restrictive? When might you use shared learning events?
- Finding reviewers?
- What influences or would facilitate choice of methodology?
- When does the six month timeframe commence – from the date of the decision to review or when the reviewers commissioned, or …?

Questions –Managing the Process

- What aspects of the statutory guidance on SARs have proved helpful or unhelpful?
- Family involvement – how explicitly do we clarify family expectations? What are we learning from an apparent increase in family involvement?
- Practitioner and manager involvement – SARs are about learning and not blame. Is that how the process is experienced? What is the SAB role here? Do we really reach an understanding of "why?"
- Panel membership – CQC? Care home owners or provider representatives?
- Parallel processes – how is it best to manage the interface with criminal proceedings, DHRs & SCRs, Coroner inquests, IPCC investigations, s 42 enquiries?
- Are SCIE and/or London ADASS quality markers being used to oversee the structure and content of the report?
- What is the panel's role on number and SMART content of recommendations?
- When is a review begun & completed?

Questions – Capturing Learning

- How useful have you found the different methodologies for understanding what influenced case processes & outcomes?
- What influences the decision about whether to publish and what to publish?
- Are web pages and annual reports compliant with Care Act requirements regarding publication of annual reports and their content with respect to SARs?
- There is no quality standard for recommendations – what might one contain?
- Do SABs consider it appropriate to direct recommendations to national bodies, including government? Very few recommendations about the legal, policy, financial and market contexts.

Questions – Embedding Learning

- Reviews rarely comment on SAB SAR procedures – increasing refinement? What about experience with thresholds and the six principles?

- Do all SABs have dissemination strategies – general or specific to individual cases?

- How do you know that learning is being sustained?

- What level of investment is feasible – cost/benefit analysis?

- What are you finding are the key differences between SCRs and SARs?

Further details

Reports

- **Braye, S. and Preston-Shoot, M. (2017)** *Learning from SARs: A Report for the London Safeguarding Adults Board*. London: ADASS.
- **Preston-Shoot, M. (2017)** *What difference does legislation make? Adult Safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews; A Report for SW Region Safeguarding Adult Boards*. Bristol: ADASS

Other resources

Articles

- **Braye, S., Orr, D. and Preston-Shoot, M. (2015)** 'Serious case review findings on the challenges of self-neglect: indicators for good practice', *Journal of Adult Protection* (17, 2, 75-87).
- **Braye, S., Orr, D. and Preston-Shoot, M. (2015)** 'Learning lessons about self-neglect? An analysis of serious case reviews', *Journal of Adult Protection*, 17, 1, 3-18.
- **Preston-Shoot, M. (2016)** 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work,' *Journal of Adult Protection*, 18(3), 131-148.
- **Preston-Shoot, M. (2017)** 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection,* 19, 2, 53-66.

Key contact

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