

WHAT CAN WE LEARN FROM COMPLETED SARS? FINDINGS FROM TWO THEMATIC REVIEWS

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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 studies

Key questions

- What learning themes emerge from SARs conducted in London and SW?
- How do the learning themes help us understand what goes wrong?
- What changes are recommended in order to prevent recurrence?

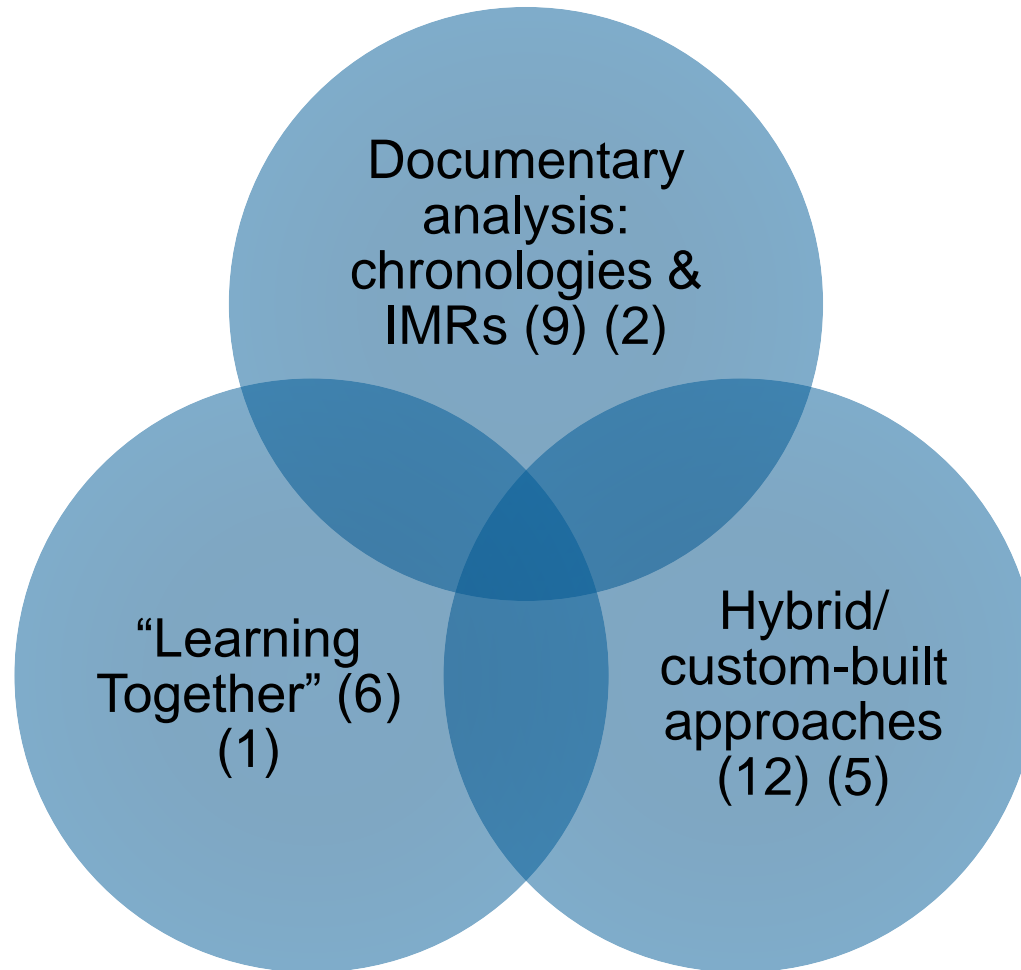
The approach

- Sample
 - 27 SARs (London), 11 (SW)
 - Not all SABs released full reports
- Two forms of analysis
 - SAR characteristics: type of case, type of review, type of recommendations
 - SAR content: factors contributing to the case outcome

The cases

- Demographics
 - All age groups represented, London emphasis on people 60+
 - Three-quarters involved individuals who had died
 - Almost half London sample related to group living situations
 - More cases involved men
 - Ethnicity usually unspecified
- Type of abuse
 - Organisational abuse (9 – London) (3 – SW)
 - Self-neglect (7) & (6) with several more since the studies
 - Combined(5) & (2) often involving neglect with self-neglect
- Almost all were statutory reviews
 - Did not routinely indicate source of referral

SAR characteristics: methodology

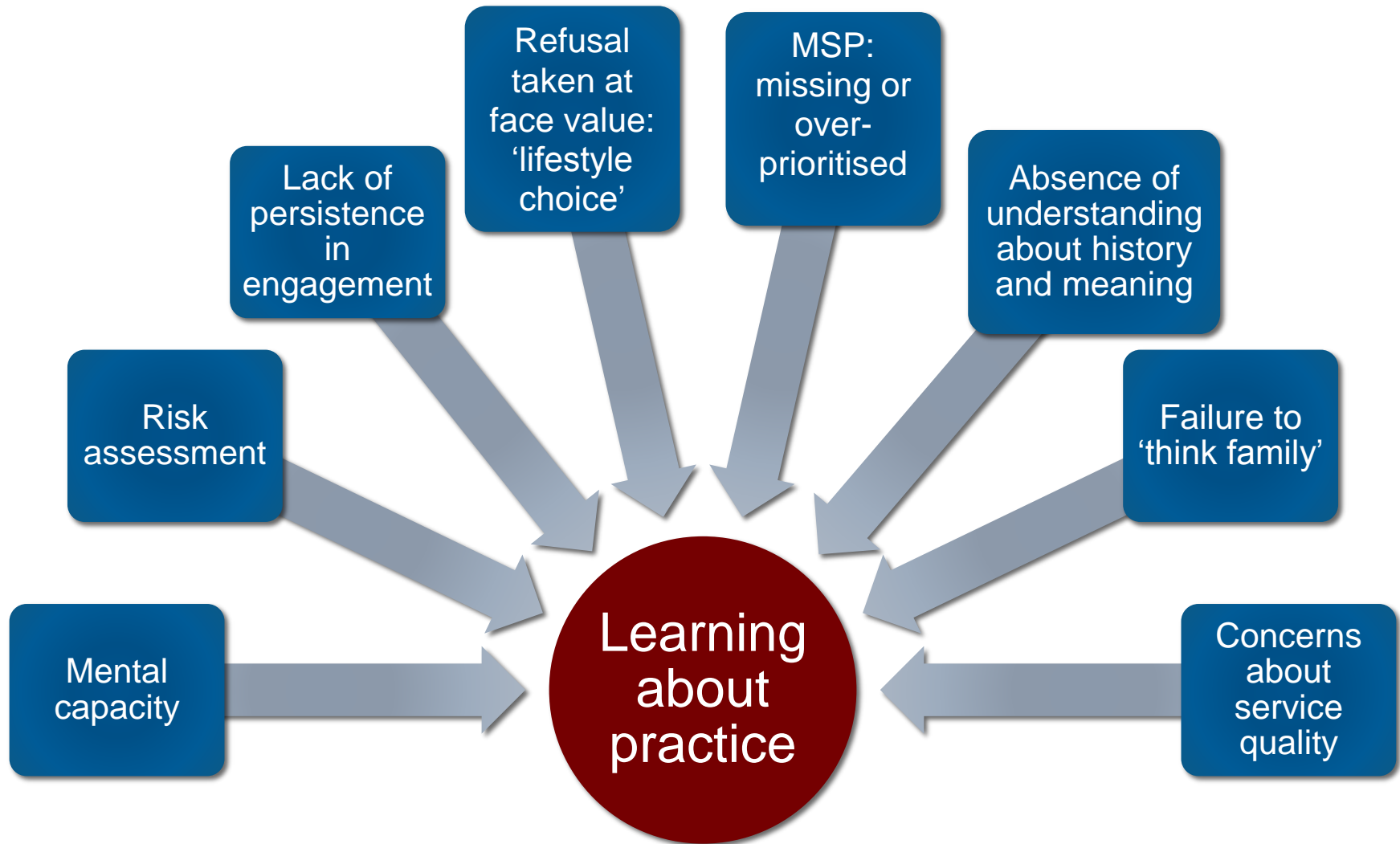


Review period	<ul style="list-style-type: none"> • 2 weeks – several years • Occasionally not stated
Independence	<ul style="list-style-type: none"> • Occasionally questionable
Family involvement	<ul style="list-style-type: none"> • Just over half of the reviews • Offered and declined in most other cases
Individual's involvement	<ul style="list-style-type: none"> • Where individual alive, unusual for reviews to indicate whether their involvement considered
Length of review process	<ul style="list-style-type: none"> • Not always clearly stated • Only 2 within 6 months • Delays: parallel processes, poor quality information, lack of engagement
Length of report	<ul style="list-style-type: none"> • 2-98 pages • Median 33 (London) 24 (SW) • Executive summaries 2-18 pages
Recommendations	<ul style="list-style-type: none"> • 3-39 (London) 3-15 (SW) • Increasingly to the Board • Recommendations to national bodies rare
Publication	<ul style="list-style-type: none"> • 8 (London) 7 (SW) published • 4 (London) 3 (SW) summary/briefing published • Inconsistent mention in annual reports

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

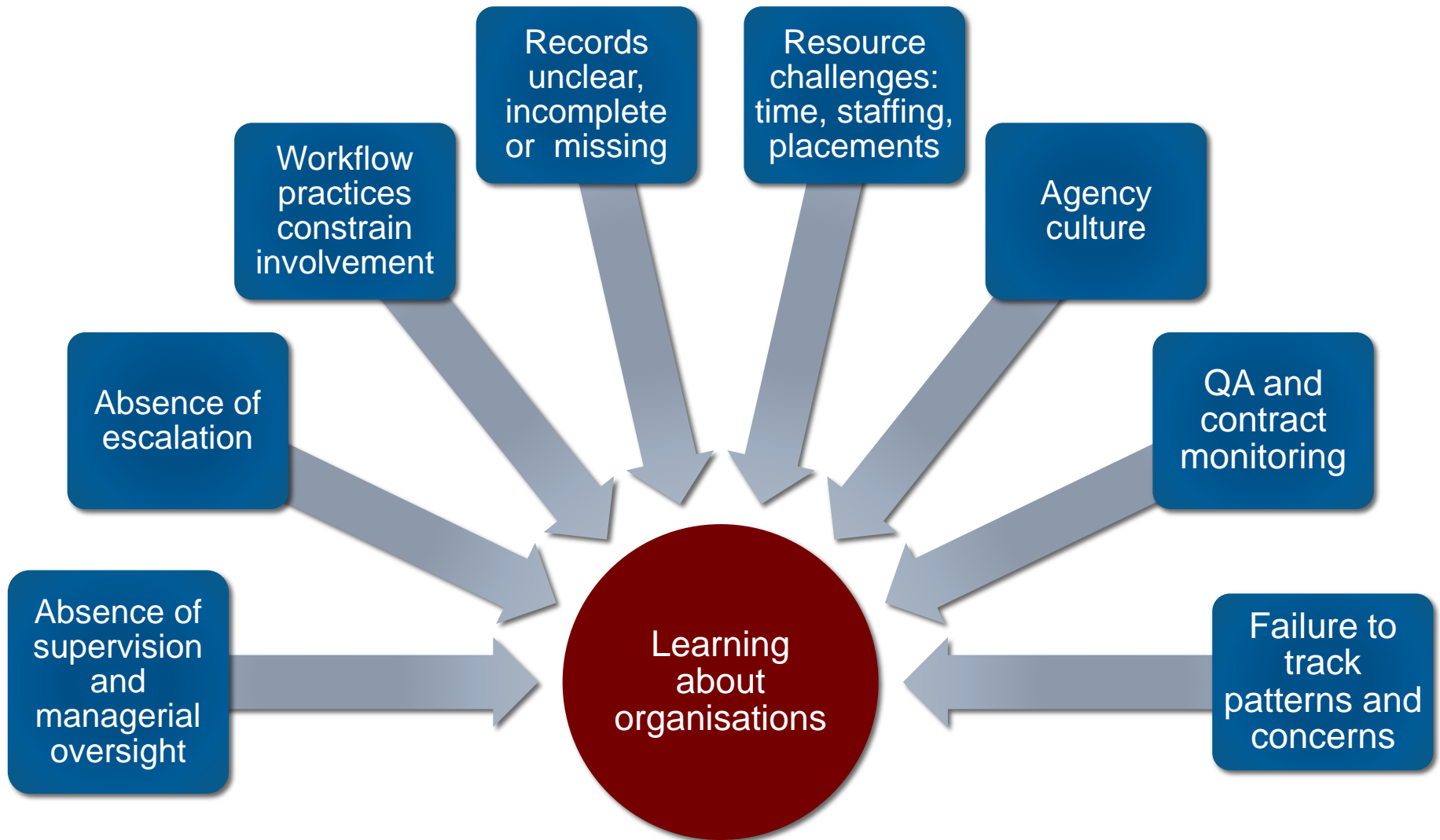
- Insufficient contact with the individual
- Unclear focus on individual's wishes, needs and desired outcomes
- Focus on autonomy excludes consideration of risks to others and duty of care

Absence of attention to complex family dynamics; failure to involve carers

Lack of curiosity about meaning of behaviour & key features in a biography

Lack of time & agency encouragement of relationship & trust building; absence of continuity

Organisational factors



Missing or unclear policies; lack of attention to roll-out

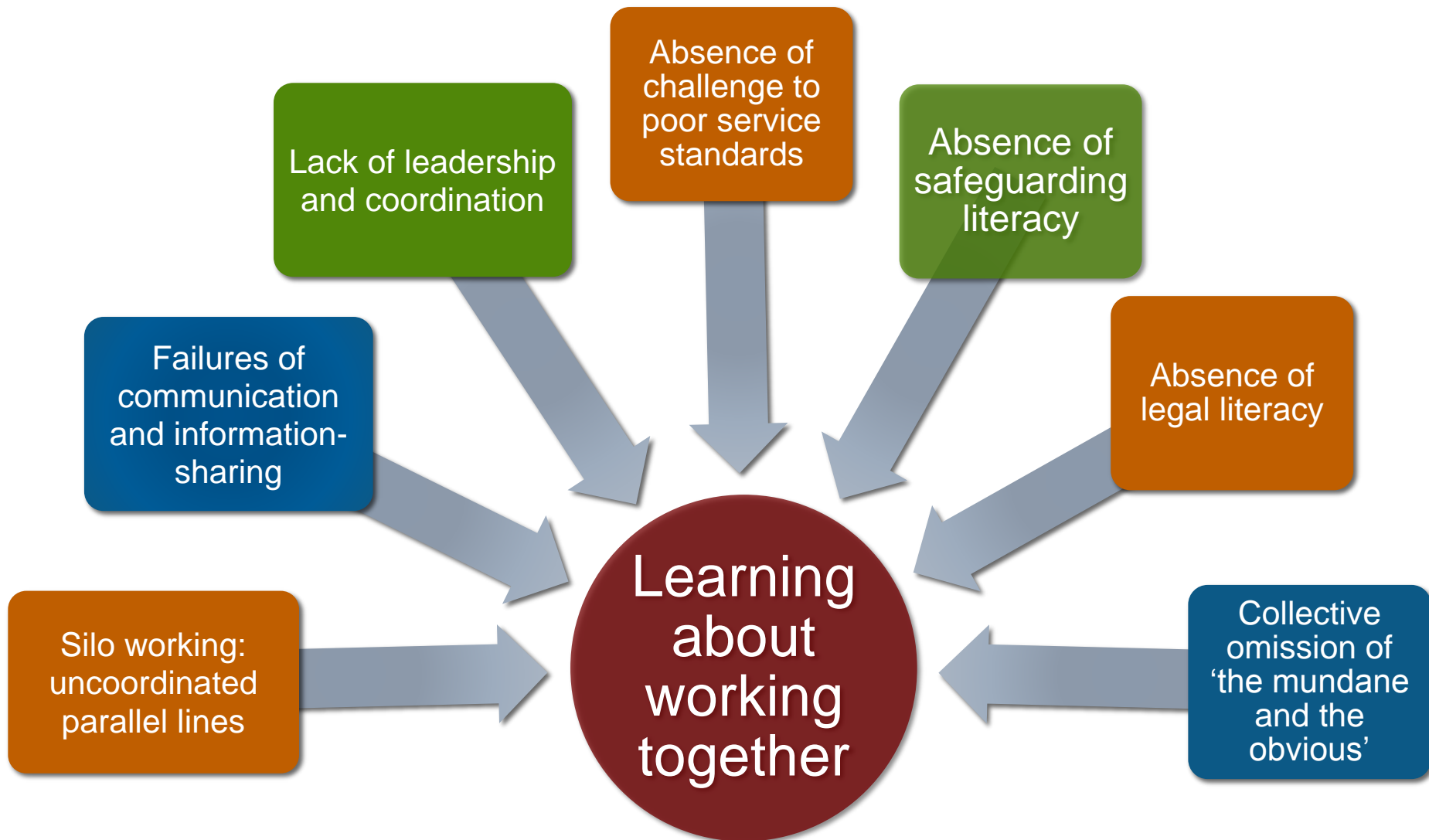
Insufficient attention to legal powers and duties

Safeguarding knowledge and confidence

Focus on case management and not reflective practice

Failure to ensure staff competence for work required

Interagency cooperation



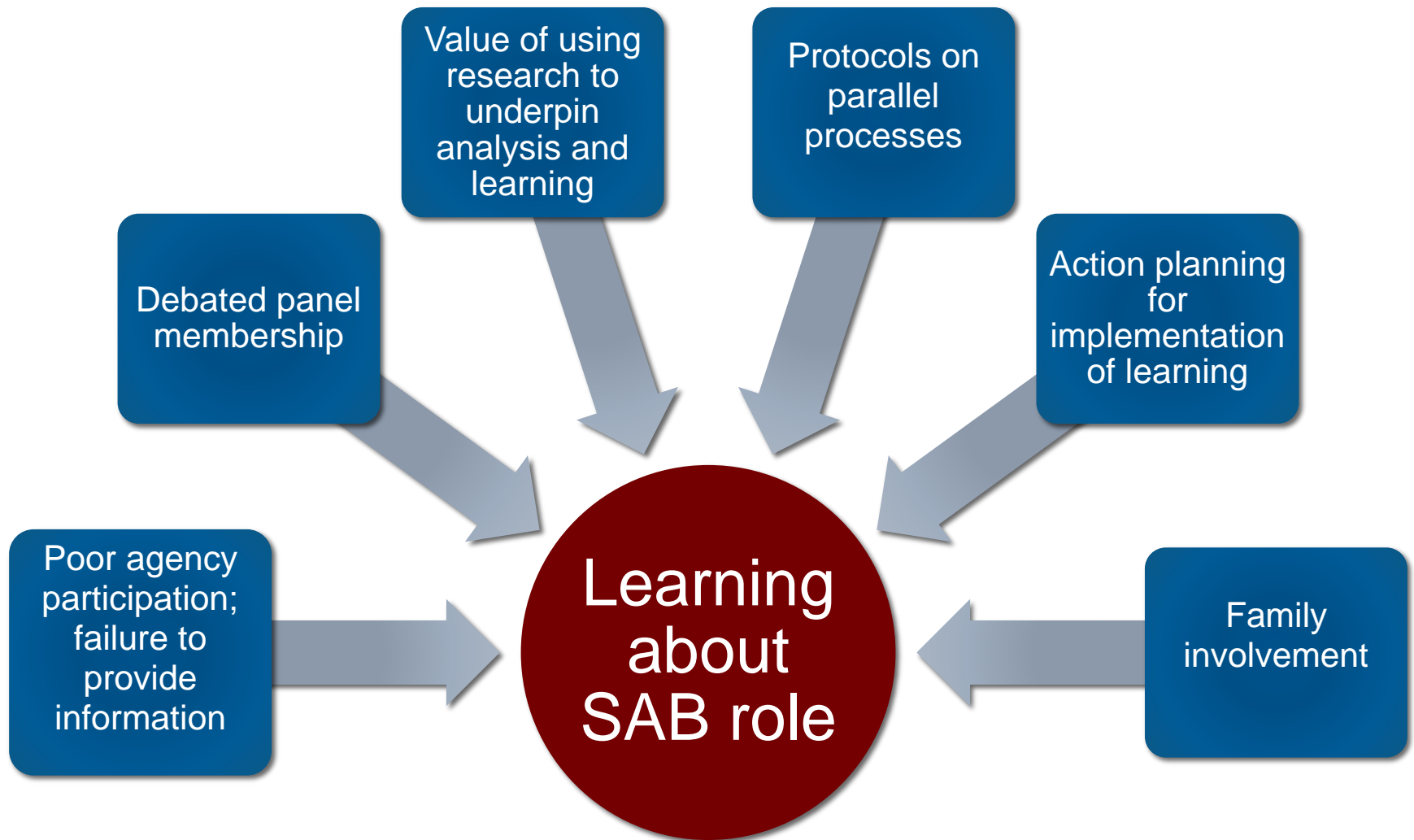
Absence or non-use of multiagency forum

Use of thresholds and eligibility criteria to gate-keep

Inadequate recognition, referral and response to safeguarding

Absence of escalation

SAB governance



Recommendations



Direct practice

Person-centred,
relationship-
based practice

Assessment &
review of risk
and capacity

Family
involvement

Availability of
specialist
advice

Legal literacy

Balancing
autonomy with
a duty of care

Organisational environment

Development,
dissemination &
review of
guidance

Clarifying
management
responsibilities

Staffing,
supervision,
support &
training

Recording

Commissioning
& contract
monitoring

Inter-organisational environment

Guidance on
balancing
autonomy with a
duty of care

Information-
sharing &
communication

Management of
complex cases

Hospital
admission and
discharge
procedures

Clarifying roles
and
responsibilities

Senior
management
oversight

SAB governance

Audit & quality
assurance of what
good looks like

Training for IMR
writers & case
review group
members

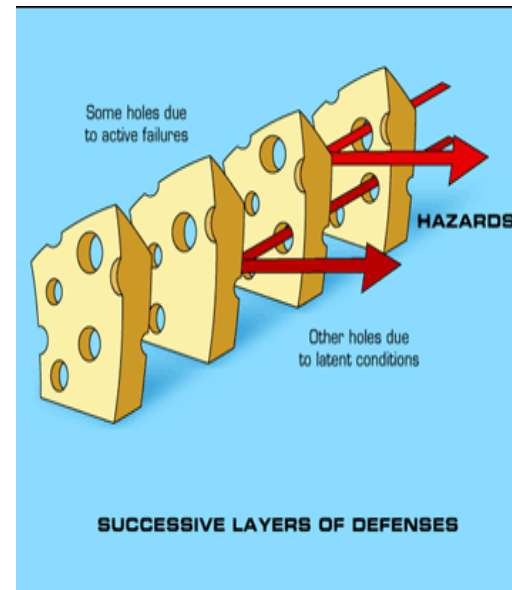
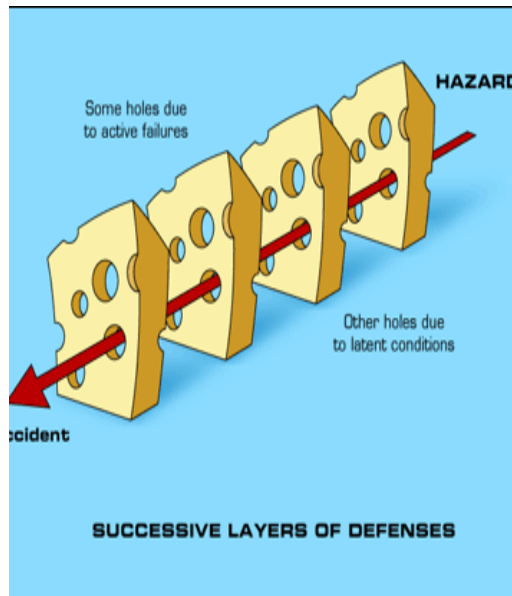
Review of
management of
SARs

Workplace as well
as workforce
development

Continual review
of outcome of
recommendations

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'



Recommendations to London SAB and SW SABs

Safeguarding practice

- Support SABs to implement SAR findings
- SABs to review safeguarding policies and procedures in the light of these findings
- SABs to consider further work to track impact and outcomes of SARs conducted

SARs

- Expand quality markers and assurance in LSAB SAR policies
- 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
- Consider further work on
 - Thresholds for SAR commissioning
 - Advantages/disadvantages of methodologies

Dissemination to DH and national bodies representing SAB partners

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 Differences does Legislation Make? Adult safeguarding through the Lens of Serious Case Reviews and Safeguarding Adult Reviews*. Bristol: SW ADASS.

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 contacts

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