Adults at risk of abuse and harm

Learning from serious case reviews and safeguarding adults reviews

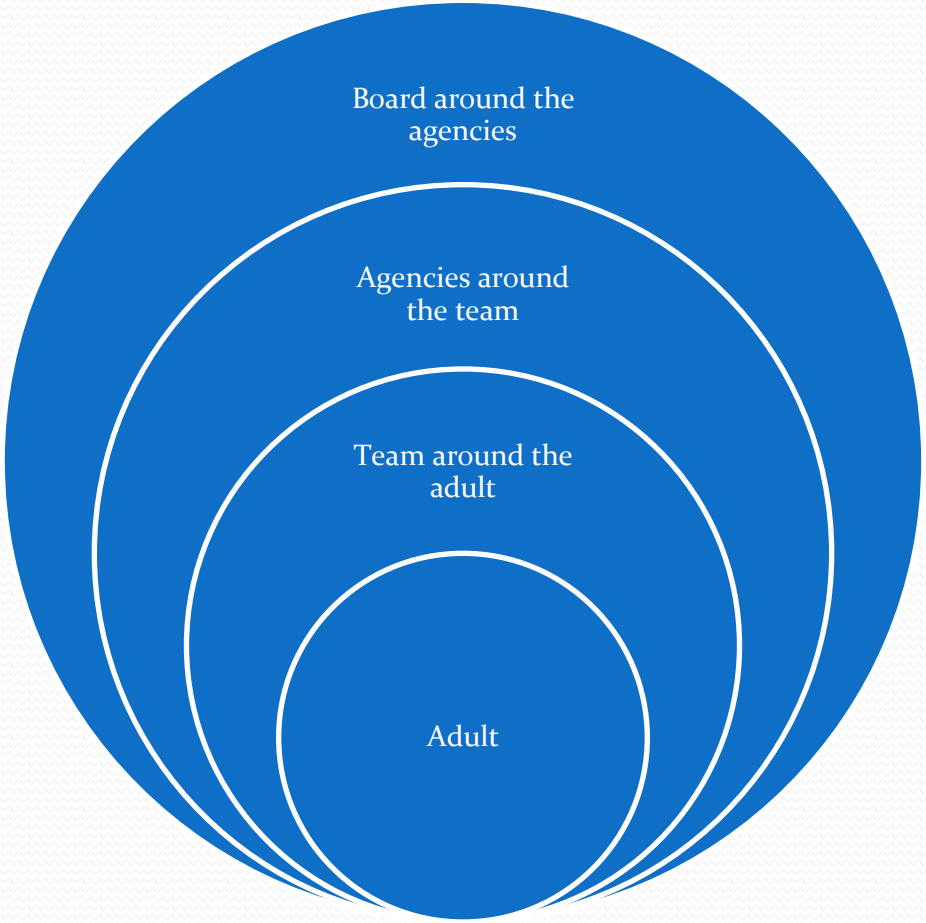
Question

- There is some excellent practice, locally, regionally and nationally in social care and in health care.
- However, how do we understand failures in social care and health care, such as have happened in some NHS Trusts and some establishments offering residential and nursing care?
- Do we see failures in individual and/or systems terms?
- Are our systems rather like computers, vulnerable to infection by a virus? Which viruses?
- Who or what might be the equivalent of Firefox?

Research Focus

- What themes emerge from SCRs/SARs and how do these add to understanding about professional intervention?
- Drawing on an analysis of 89 SCRs/SARs involving adults who self-neglect, plus experience of commissioning, writing and publishing reviews, and using reviews for staff and service development.
- Quite a process of discovery with implications for learning and service development, as no requirement that reviews or executive summaries are published.

Thematic Analysis of SCRs



Case and Review Characteristics

- Published reports do not always give exact details of how the individuals concerned died.
- Ethnicity is not routinely recorded in the reports.
- Some details withheld to protect the individual and wider family.
- Considerable variation in length.
- Similar variation in the number and detail of the recommendations.
- Different approaches towards naming SCR author & independent oversight of process.
- Mixture of methodologies – traditional (IMRs, collated chronology and overview report; significant incident learning process; systemic exploration of key episodes and learning points.
- Mixed attitudes towards publication.

Recommendations to Agencies

- (n=56) 82% contained recommendations for the SAB itself, with adult social care also targeted (64%).
- NHS commissioners (39%), Housing (29%), Mental health and acute care sectors (34%), Police (18%), GPs (23%)
- Some recommendations where it was not possible to identify the healthcare organisation (5 reports) or other agency (59%) charged with taking forward particular actions.
- Recommendations often directed simultaneously at a number of agencies and/or professionals, making audit of progress difficult. Occasional recommendations for national government, environmental health and ambulance services.
- Occasional recommendations for fire and rescue, ambulance services, environmental health.
- Only 20 SCRs (36%) contained action plans.

Types of Recommendations

- Broad categories relating to procedures, best practice, SCR process, and staff training and support.
- Support – training, supervision
- Procedures – develop guidance, referral & assessment, case management, recording, working together , information sharing
- Best practice – relationship-centred, engaging hard to reach, mental capacity, carer involvement, legal knowledge, hospital discharge
- SCR process – action plan, managing process, using review for training
- How SMART are the recommendations?
- Why do we have repeated findings? What are the barriers to change?

Themes from SCRs/SARs

Thematic Analysis – Adult

- History – explore questions why; curiosity
- Person-centred approach – be proactive
- Hard to reach – try different approaches, use advocates and concerned others, raise concerns, discuss risks, maintain contact, avoid case closure
- Mental capacity – ongoing assessment & review, guidance for staff regarding people with capacity who refuse services and are at risk; applies to young people aged 16 and over
- Carers – offer assessments, concerned curiosity & challenge, explore family dynamics, engage neighbours, neglect and self-neglect may combine

Thematic Analysis – Team around the Adult

- Recording – clarity & thoroughness of work done, agreed plans, outcomes achieved, discussions held
- Legal literacy – know and consider available law
- Safeguarding literacy – awareness of guidance & procedures, of risks and vulnerabilities, of safeguarding systems; adequate exploration of apparent choices, access specialist expertise
- Working together – silo working, threshold bouncing, flexible procedures, shared assessments & plans, liaison & challenge, follow-through
- Information sharing
- Advocacy – consider use with hard to engage people
- Use of procedures – DNAs, safeguarding alerts, risk assessments
- Standards of good practice – thoroughness of assessments, challenge professional optimism, lack of assertiveness & curiosity, authoritative practice

Thematic Analysis – Organisations around the Team

- Support – cases are complex, high risk, stressful & demanding, so support systems essential; review scope and adequacy of policies
- Culture – encourage challenge & escalation of concerns; balance personalisation with duty of care; review case management approach; align procedures and structures to deliver best practice
- Supervision & managerial oversight – senior managers should take responsibility for overseeing complex cases; effective supervision; use risk panels; audit cases
- Staffing – practitioners must have appropriate experience & resilience; review allocation of work; mindful of health & safety

Thematic Analysis – LSAB around the Organisations

- Conducting SCRs/SARs – involve family & carers, avoid delay
- Monitoring & action planning – robust action plans and audits of impact needed
- Procedures & guidance – develop protocols on risk & capacity assessments, follow up of service refusal, cases where adults have capacity but at risk of harm
- Use of reviews – across LSABs, in training, with government departments, for procedural development
- Training – on mental capacity, law, procedures, writing IMRs, on person-centred approach & strategies to engage people; evidence outcomes

Themes from across Adult Safeguarding SCRs

- Lack of compliance with statutory requirements; poor legal literacy
- Uncertainty about interface between different legal mandates
- Concerns about practice standards, especially capacity assessments
- Lack of training & unrealistic expectations
- Lack of management oversight of complex cases
- Limited interagency cooperation
- Focus on areas of agreement
- Group think
- Power & status issues
- Roles unclear, overlapping functions
- Differing levels of knowledge – of case, of specific issues
- Variable definitions of professional ethics and need

Adult Safeguarding SCRs (2)

- Poor sharing of information
- Ignorance of case chronology
- Divergent thresholds
- Poor communication & recording
- Failure to speak to the adult at risk & significant others
- Failure to monitor communication & impact of context
- Acceptance of poor standards
- Failure to investigate; lack of rigour in inspection
- Failure to follow through on decisions
- Failure to escalate
- Rule of optimism – staff and relatives are caring
- Lack of curiosity and challenge

How? Why?

- Research pinpoints:
  - Client characteristics leading to neutralisation of moral concerns
  - Power and process in enclosed organisations
  - Complexity of work exacerbated by constraints
  - Conformity to organisational procedures and erosion of personal judgement
  - Policy overload, time and workload pressures
  - Complexity and misunderstanding of legal mandates
  - Multi-agency working grafted onto single agency structures

Final Observations

- Difficulty of obtaining SCRs limits learning.
- Emphasis on procedural development but guidance often ignored or not embedded.
- Emphasis on training but outcomes, if captured, variable.
- Does publication make a difference? Publication of executive summaries or full reports?
- No requirement to have local learning and service development strategies.
- Legal, ethical and organisational contexts important to explore in reviews. Law seen as difficult to use; ethics difficult to navigate
- Descriptive but why do things map out the way they did?
- To what degree is the Care Act helping – statutory LSABs, duty to cooperate, duty to review cases; but absence of power of entry & protection orders, and limited requirements to publish findings?

References

- Adams, G. and Balfour, D. (1998) *Unmasking Administrative Evil*. London: Sage.
- 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.
- 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.
- Northway, R., Davies, R., Mansell, I. and Jenkins, R. (2007) 'Policies don't protect people, it's how they are implemented: policy and practice in protecting people with learning disabilities from abuse.' *Social Policy and Administration*, 41, 1, 86-104.
- 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.
- Wardhaugh, J. and Wilding, P. (1993) 'Towards an explanation of the corruption of care'. *Critical Social Policy*, 37, 4-31.

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