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?

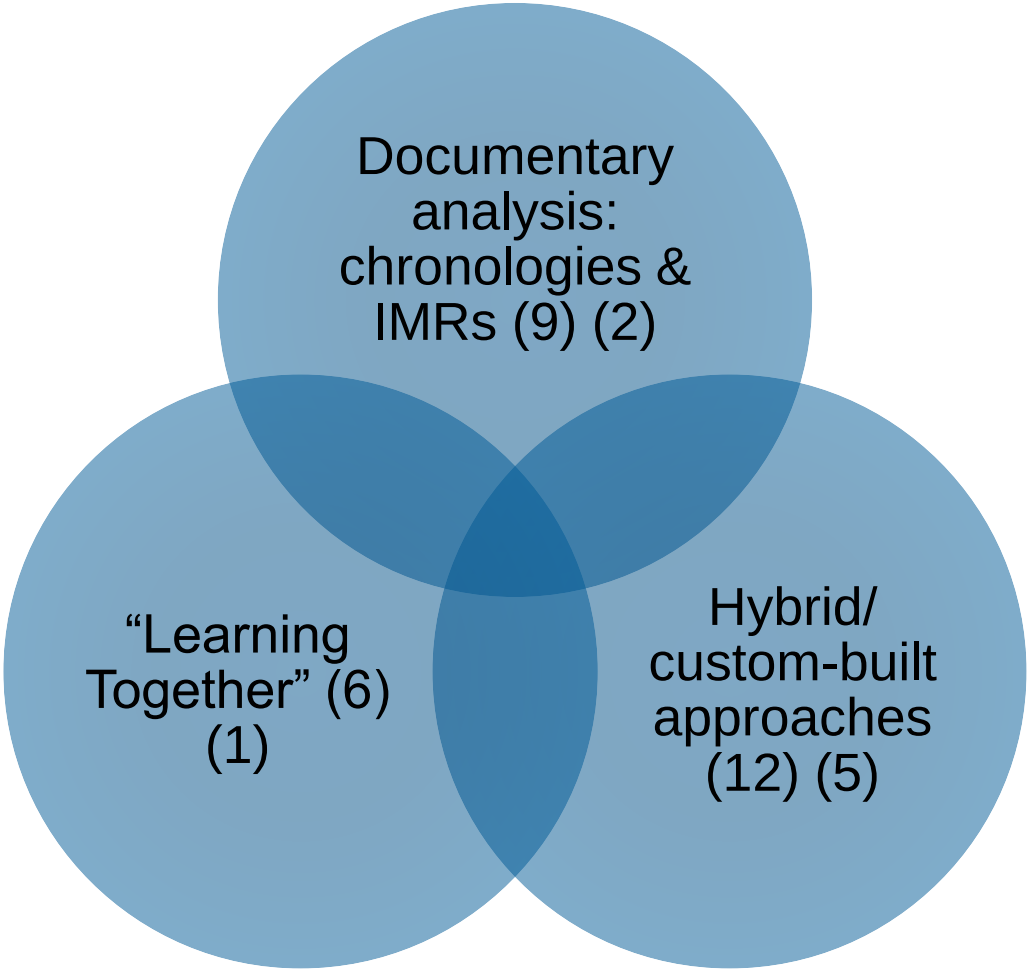
The approach

- 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

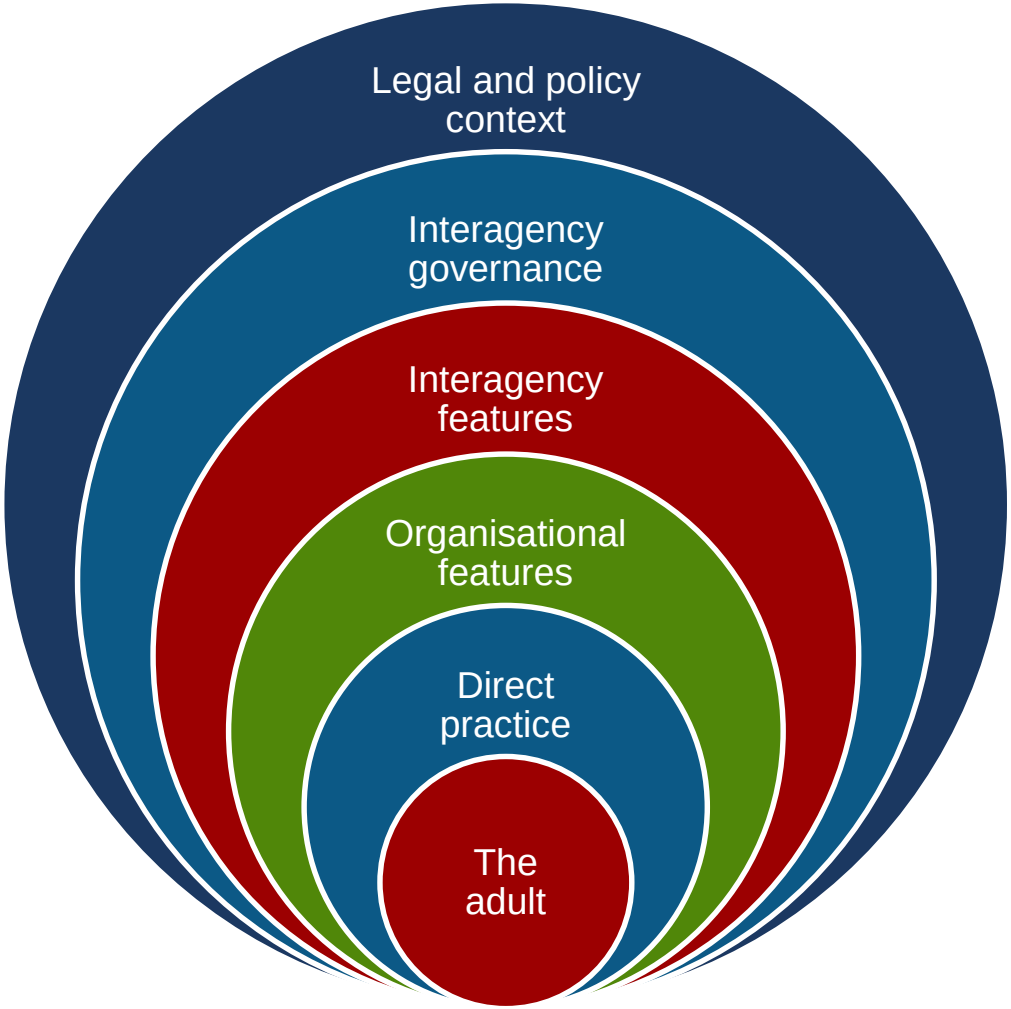
- Demographics
  - All age groups represented, London emphasis on people 60+
  - Three-quarters involved individuals who had died
  - Almost half London sample related to group living situations
  - More cases involved men
  - Ethnicity usually unspecified
- Type of abuse
  - Organisational abuse (9 – 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

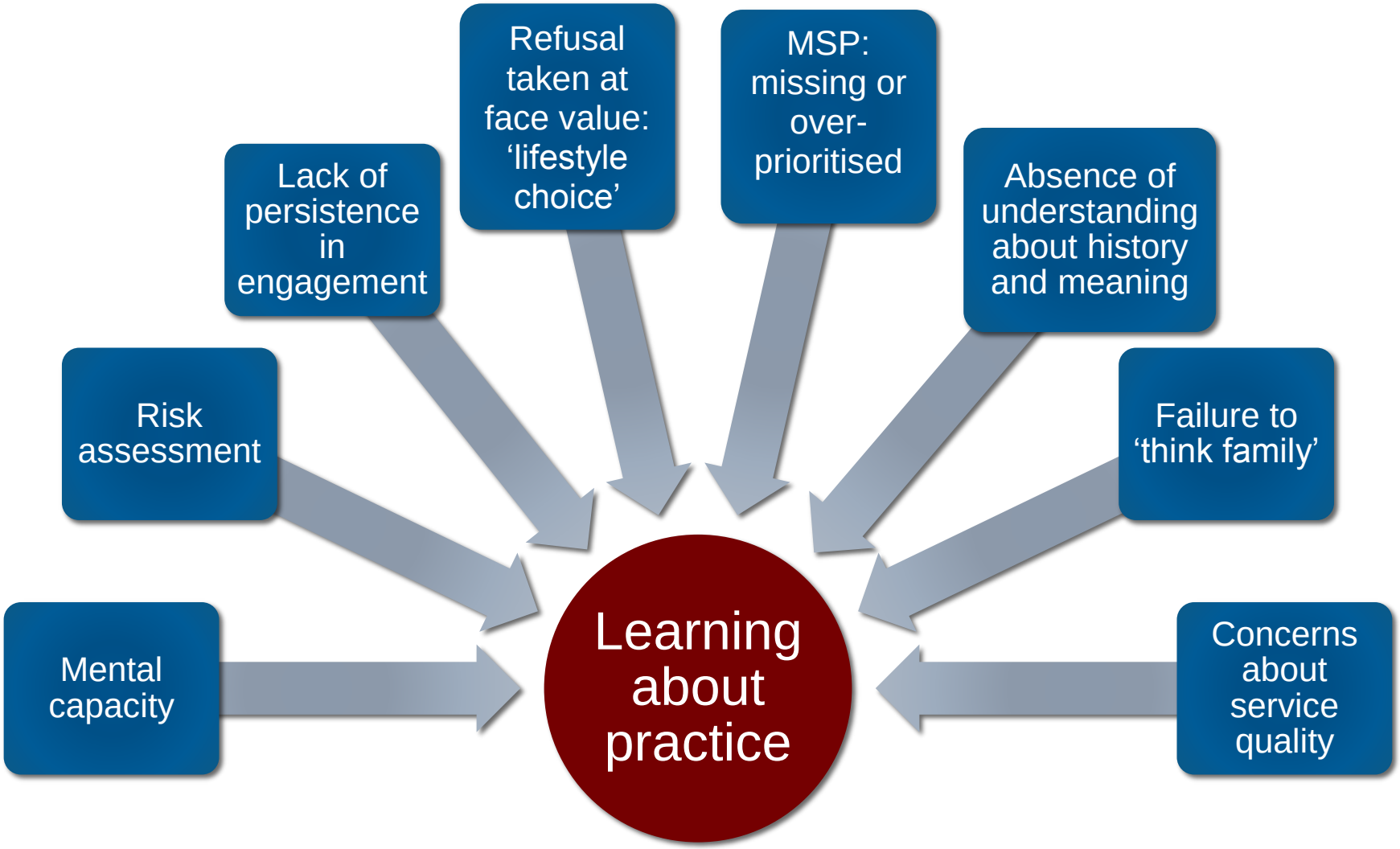


Review period	• 2 weeks – several years • Occasionally not stated
Independence	• Occasionally questionable
Family involvement	• Just over half of the reviews • Offered and declined in most other cases
Individual's involvement	• Where individual alive, unusual for reviews to indicate whether their involvement considered
Length of review process	• Not always clearly stated • Only 2 within 6 months • Delays: parallel processes, poor quality information, lack of engagement
Length of report	• 2-98 pages • Median 33 (London) 24 (SW) • Executive summaries 2-18 pages
Recommendations	• 3-39 (London) 3-15 (SW) • Increasingly to the Board • Recommendations to national bodies rare
Publication	• 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

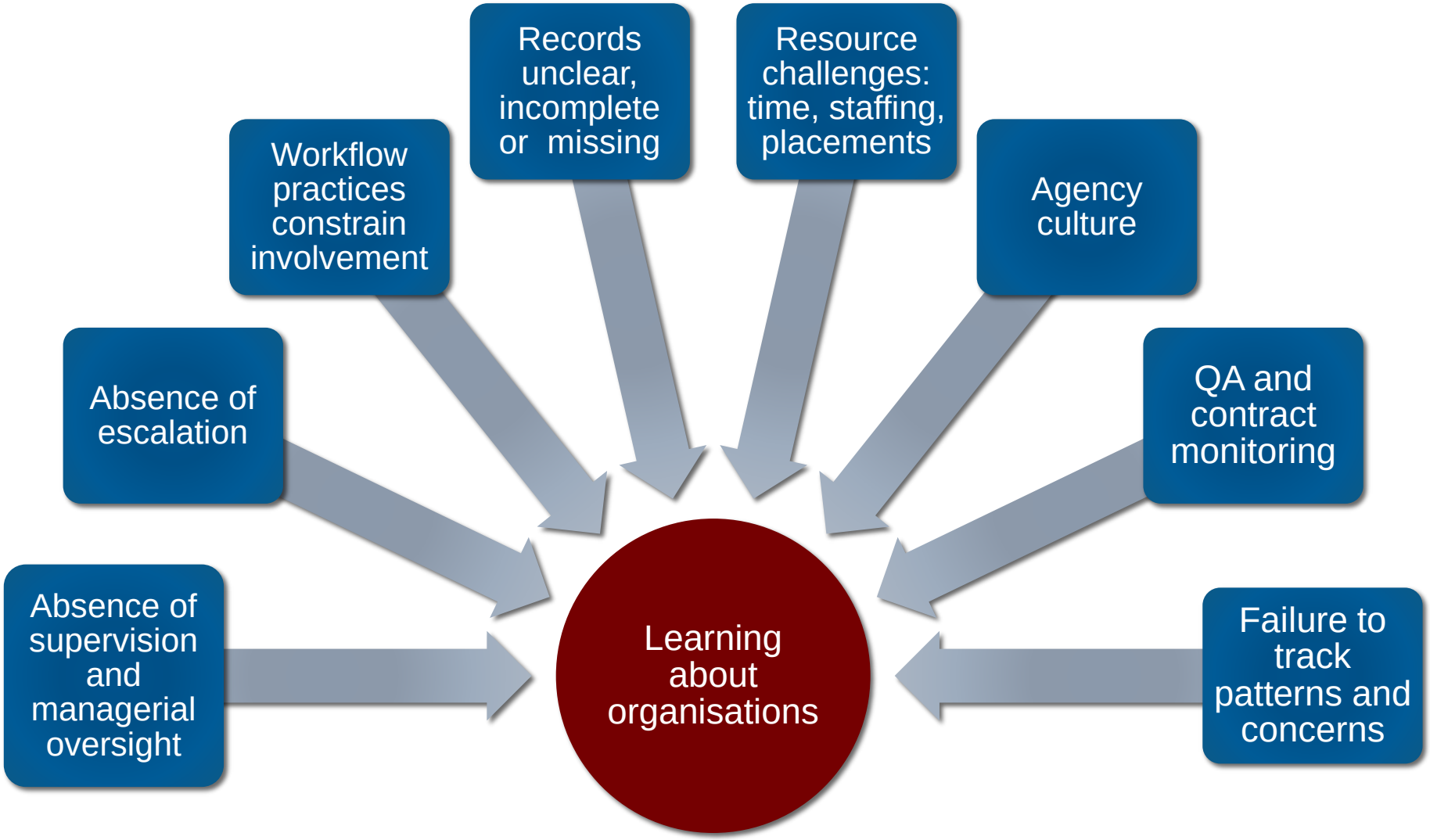
- Assessments missing, poorly performed or not reviewed
- Absence of detail about best interest decision-making

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

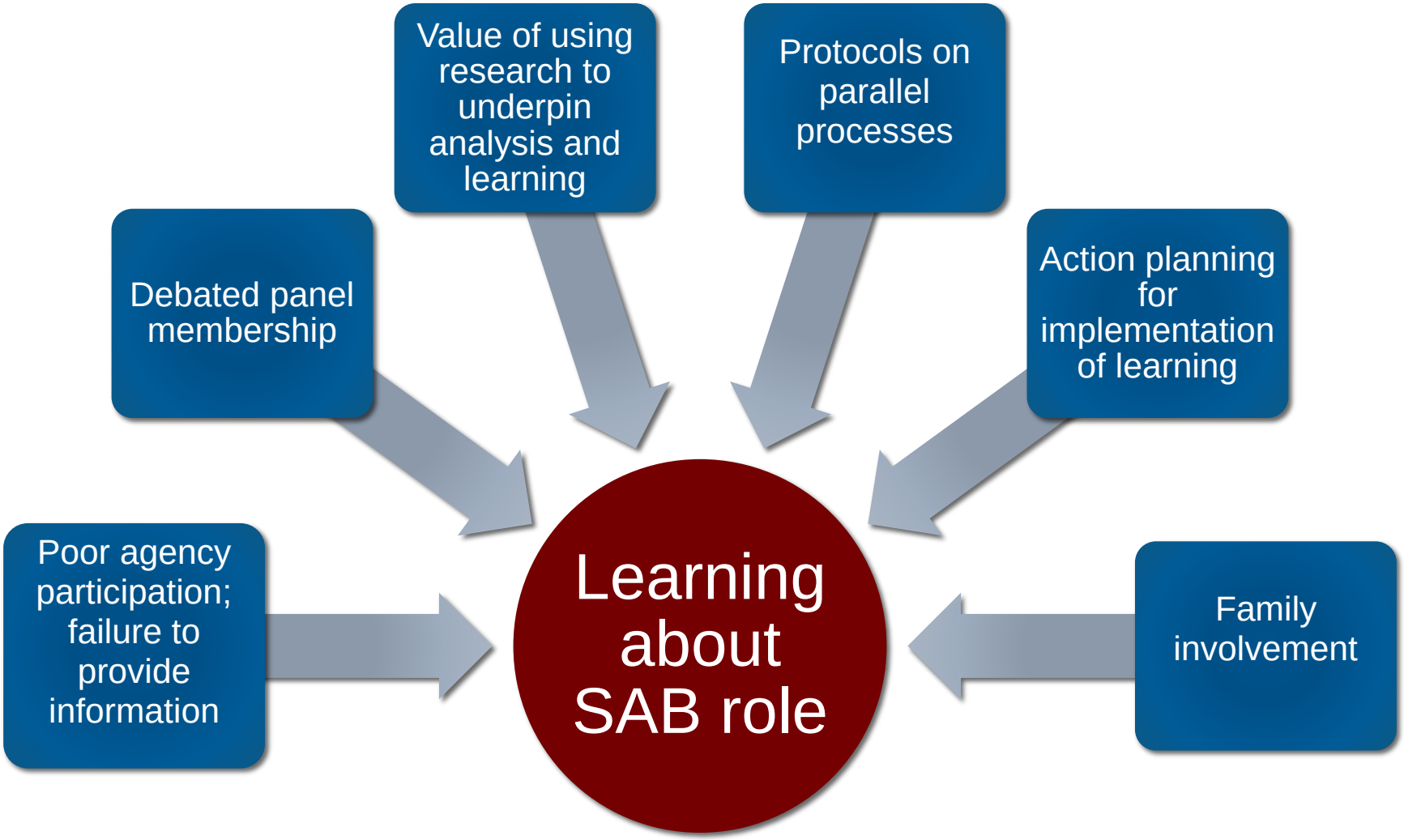


- Missing or unclear policies; lack of attention to roll-out
- Insufficient attention to legal powers and duties
- Safeguarding knowledge and confidence
- Focus on case management and not reflective practice
- Failure to ensure staff competence for work required

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

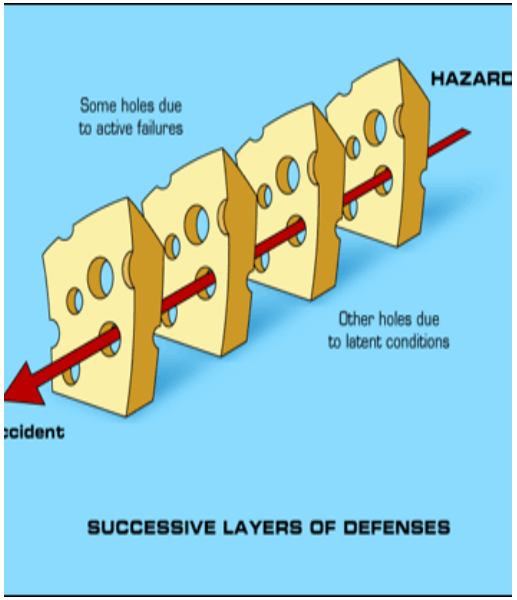
Review of management of SARs

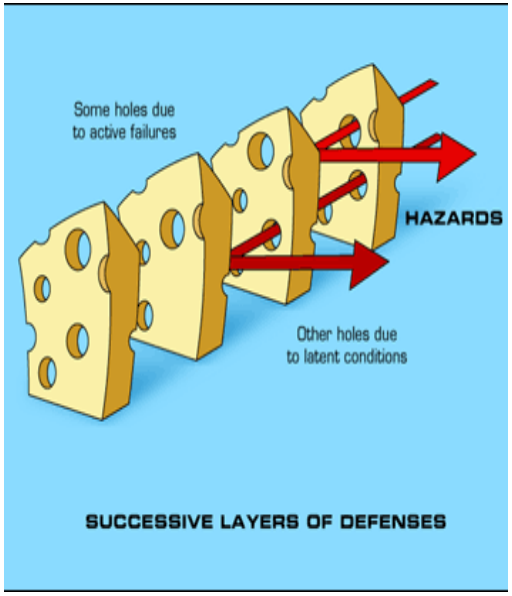
Workplace as well as workforce development

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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