LEARNING FROM SAFEGUARDING ADULTS REVIEWS IN LONDON 2015-2017

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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**

- What learning themes emerge from SARs conducted in London?
- 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 (29 individuals)
  - 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, emphasis on people 60+
  - Three-quarters involved individuals who had died
  - Almost half related to group living situations
  - More cases involved men (17/11/1)
  - Ethnicity unspecified in 21 cases

- Type of abuse
  - Organisational abuse (9)
  - Self-neglect (7)
  - Combined (5)

- Almost all were statutory reviews
  - Did not routinely indicate source of referral
SAR characteristics: methodology

- Documentary analysis: chronologies & IMRs (9)
- “Learning Together” (6)
- Hybrid/custom-built approaches (12)
| **Review period** | • 2 weeks – several years  
• In 6 cases not stated |
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<td><strong>Independence</strong></td>
<td>• Questionable in 4 cases</td>
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| **Family involvement** | • Half of the reviews  
• Offered and declined in most other cases |
| **Individual’s involvement** | • Where individual alive, no reviews indicated whether their involvement had been considered |
| **Length of review process** | • Not stated in almost half  
• Only 2 within 6 months  
• Delays: parallel processes, poor quality information, lack of engagement |
| **Length of report** | • 2-98 pages  
• Median 33  
• Executive summaries 2-18 pages |
| **Recommendations** | • 3-39  
• Board, all agencies, single agencies (ASC)  
• National body (1) |
| **Publication** | • 8 published  
• 4 executive summaries published  
• 4 instances of missing mention in annual report |
SAR content: whole system understanding
Direct practice with the adult

Learning about practice

- Risk assessment
- Mental capacity
- Refusal taken at face value: ‘lifestyle choice’
- Absence of understanding about history and meaning
- Failure to ‘think family’
- Concerns about service quality
- Lack of persistence in engagement
- MSP: missing or over-prioritised
Organisational factors

- Absence of supervision and managerial oversight
- Workflow practices constrain involvement
- Records unclear, incomplete or missing
- Resource challenges: time, staffing, placements
- Absence of escalation
- Agency culture
- QA and contract monitoring
- Failure to track patterns and concerns

Learning about organisations
Interagency cooperation

Learning about working together

- Lack of leadership and coordination
- Absence of challenge to poor service standards
- Absence of safeguarding literacy
- Absence of legal literacy
- Failures of communication and information-sharing
- Silo working: uncoordinated parallel lines
- Collective omission of ‘the mundane and the obvious’
SAB governance

Debated panel membership

Value of using research to underpin analysis and learning

Protocols on parallel processes

Action planning for implementation of learning

Action planning for implementation of learning

Family involvement

Poor agency participation; failure to provide information

Learning about SAB role
Recommendations

- Legal and policy context
- SAB governance
- Interagency collaboration
- Organisations
- Direct practice
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

### Safeguarding practice

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

### SARs

- Expand quality markers in LSAB SAR policy
- 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

Report


Articles

Key contacts

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