Local Government Association

Analysis of Safeguarding Adult Reviews

April 2017 – March 2019

Findings for sector-led improvement

Final report

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1. Introduction

This report presents the findings of the first national thematic analysis of published and unpublished safeguarding adult reviews (SARs) in England since implementation of section 44, Care Act 2014. Hitherto, in place of a national overview, messages from SARs for sector-led improvement have been derived from regional analyses and from research studies that have focused on specific types of abuse and neglect.

Thus, thematic reviews have been commissioned by the London Safeguarding Adult Board (SAB)[1], by South West ADASS[2] and the East Midlands Safeguarding Adult Network[3], which enable analysis of SARs by type of abuse and neglect. More recently a review has been conducted of learning for the police from SARs[4]. Thematic reviews that focus on specific types of abuse and neglect have also been published, for example on self-neglect[5] [6], homelessness and rough sleeping[7], modern slavery[8], financial abuse[9] and alcohol-related deaths[10].

Since 2015-16, NHS Digital[11] has published data giving the number of reviews commissioned in each year, including the numbers of people involved, individuals who died and individuals who suffered harm. However, no breakdown is provided by type of abuse and neglect. The number of reviews commissioned has risen from 90 in year 1 (2015-16) to 135 in year 4 (2018-19). DHSC funded the establishment of a national library of SARs, hosted by SCIE, which contains reports and summaries provided voluntarily by SABs. However, in the absence of continuation funding, development of the library has stalled; it is incomplete and the search mechanisms are limited.

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[1] Braye, S. and Preston-Shoot, M. (2017) *Learning From SARs: A Report for the London Safeguarding Adults Board*. London: ADASS. http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf

[2] Preston-Shoot, M. (2017) *What Difference Does Legislation Make? Adult Safeguarding Through the Lens of Serious Case Reviews and Safeguarding Adult Reviews*. Bristol: South West ADASS. http://www.swcouncils.gov.uk/media/ADASS/Safeguarding_Review_2017.pdf

[3] Manson, S. (2017) *Report from a Thematic Review of Safeguarding Adults Reviews Within East Midlands*. East Midlands ADASS. http://www.nottinghamshire.gov.uk/media/132275/emsanthematicreviewsars.pdf

[4] National Police Chiefs Council – Violence and Public Protection (2020) *Learning for the Police from Safeguarding Adult Reviews: Quarter 4 Briefing*.

[5] Braye, S., Orr, D. and Preston-Shoot, M. (2015a) '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. (2015b) Serious Case Review Findings on the Challenge of Self-Neglect: Indicators for Good Practice. *Journal of Adult Protection,* 17, 2, 75-87.

[6] Preston-Shoot, M. (2016) 'Towards explanations for the findings of serious case reviews: understanding what happens in self-neglect work' 18(3) *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; Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20 (2), 78-92; Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234; Preston-Shoot, M. (2020) 'Safeguarding Adults Reviews: informing and enriching policy and practice on self-neglect.' *Journal of Adult Protection* (forthcoming).

[7] Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adults Reviews*. London: NIHR and Kings College London.

[8] Lincolnshire Safeguarding Adults Board (2019).

[9] Lincolnshire Safeguarding Adults Board (2017).

[10] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017.* London: Alcohol Change UK.

[11] NHS Digital (2019) *Safeguarding Adults Collection (SAC) England 2018-19 Experimental Statistics*. https://digital.nhs.uk/data-and-information/publications/statistical/safeguarding-adults/annual-report-2018-19-england

Improvement priority one
The future of the national library of SARs should be secured, with SABs committed to depositing completed reviews therein, and technology developed to enable reports to be searched more comprehensively.

The absence hitherto of a national review of SAR learning has deprived SABs and their partner agencies of an easily recognised pathway by which they can locate local learning themes within a national picture. For this reason, the commissioning and now reporting of a national analysis is a significant and timely development.

This national analysis covers all SARs completed between April 2017 and March 2019 inclusive. It was commissioned by the Care and Health Improvement Programme (CHIP), which provides support to councils in England for social care, integration and health and digital improvement, as well as supporting the Transforming Care programme for people with learning disabilities and/or autism. It is a sector-led improvement programme for care and health, co-produced and delivered by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS) in England and funded by the Department of Health and Social Care.

The analysis was commissioned so that the findings can inform sector led improvement in safeguarding adults in England, and the priorities of the adult safeguarding element of the Care and Health Improvement Programme. Accordingly, throughout the report, priorities for sector-led improvement are proposed. They are also collated in the final section of the report.

2. Methodology

2.1. Acquisition of materials

SAB websites were trawled for details and copies of SARs completed within the two-year time period. The SAR library hosted by SCIE was consulted to identify reports logged there that have been completed within the same two-year time period. A second repository[12] was also consulted for published reviews. A minority of SABs reported that their published SARs had only been made available through the national repository rather than, additionally, through their own websites. By contrast, some SABs either did not have websites or had not updated web pages for some considerable time, necessitating the use of other data collection methods.

SABs were also contacted directly using separate email address lists for Independent Chairs and Business Managers. The request was for copies of, or web links to, all published reviews completed within the two-year time span. This was designed to enable cross-referencing with published information gleaned from websites, and also to ensure the inclusion of SARs that had not been published on the websites but the details of which were nonetheless in the public domain.

SABs were also requested to provide copies of unpublished reviews, with the assurance that the confidentiality of this material would be respected. SABs were also asked to provide copies of, or web links to, their published annual reports for each of the two years in question. SAB annual reports are a viable route for including within the review the details and recommendations of SARs that are not published. Indeed, a minority of SABs reported that summaries of SARs are only published in their annual reports.

The definition of 'completed' used was that the SAR was accepted and signed off by the SAB within the dates in question. In addition, SABs were asked to identify any notable reviews falling outside of the two-year time period that they considered to have provided significant and enduring learning. These have been used in two ways: first, to inform commentary within this analytic report on seminal SARs and SCRs that should remain within the collective memory in order to continue to inform future practice; and second, to underscore the significance of particular themes that emerge from this analysis.

Finally, SABs were also asked to comment on any significant changes that have taken place as a result of the SARs they have undertaken during the period in question. One significant challenge for SABs is to turn learning and recommendations from SARs into change on the ground. It was considered important therefore to take this opportunity to seek information on impacts that have been achieved.

All SABs in England, a total of 132, were approached for this information. 129 SABs responded, representing a response rate of 98 per cent. 29 SABs (22 per cent) had not completed any SARs in the two-year time period for this national analysis. The data collection period ran from March to June 2020. Through this process 231 SARs were obtained. Where SABs had decided not to publish either a full report and/or executive summary, these SARs were shared on the strict understanding that no details would be disclosed in this report that could be attributed directly or indirectly to either the commissioning SAB or the individual and their family. After closure of the data collection period one SAB released for inclusion a SAR that had

[12] https://mhaandmca.co.uk

not been published. This SAR has been included in the qualitative commentary but not in the quantitative/statistical analysis since this had already been completed.

By cross-referencing the different sources for data collection, it became clear that the returns submitted by some SABs represented an incomplete picture of their review activity. This was sometimes explained as being the result of staffing changes (independent chairs and/or business managers) or new websites necessitated by changes to Board configurations. However, it highlights that SABs must retain an organisational memory and ensure accurate record keeping, not least to enable partners to track whether SAR findings and recommendations have resulted in ongoing improvements to policy, procedures and practice.

Improvement priority two
SABs should review their record-keeping to ensure that completed SARs remain in the collective memory and available as a baseline against which to measure subsequent policy and practice change.

2.2. The analytic framework

In order to ensure systematic analysis of the content of each SAR, a four-domain framework was used to map the learning. This has been employed successfully in the London (Braye and Preston-Shoot, 2017), South West (Preston-Shoot, 2017) and East Midlands (Manson, 2017) thematic reviews[13].

The analytic framework presents learning themes within four domains:

- direct practice with the individual
- inter-professional and interagency collaboration
- organisational features affecting how practitioners and teams worked
- SAB leadership, oversight and governance.

The analytic framework also enabled the collection of data on the characteristics of each case and review. This included:

- regional location
- details of the individual concerned, with the framework adapted to account for SARs concerned with more than one person

[13] The approach was first employed by Braye, Orr and Preston-Shoot (2015) in their analysis of SARs featuring self-neglect, with Preston-Shoot continuing to use that framework in his annual updates of SARs featuring self-neglect (for example, Preston-Shoot, 2019). That approach was itself modified from a framework used in thematic reviews commissioned by the Department for Education: Brandon, M., Sidebotham, P., Bailey, S. and Belderson, P. (2011) *A Study of Recommendations Arising from Serious Case Reviews 2009-2010*. London: Department for Education.

- details of the case, including type of abuse and neglect
- type of review and management of the review process, including impact of parallel processes
- number and type of recommendations.

The framework used in previous studies was reviewed and expanded to ensure that it was fit-for-purpose. Part of this development included a pilot to ensure that the framework was comprehensive and reliable. Use of the four-domain model ensures that a whole system approach is taken when identifying and analysing the learning from the SARs. It is designed to capture good practice as well as learning and recommendations for service and practice development from less positive outcomes.

Finally, to acknowledge the context within which adult safeguarding practice is situated, data was also collected on references in SARs to the national legal, policy and financial context. No one location can make sense of its own lived experience without reflecting on the impact of its surroundings.

Data was entered through a survey tool that enabled the collection and subsequent collation of both quantitative and qualitative data. This is a sustainable tool that can be used for subsequent local, regional and national analyses. It is reproduced as Appendix 1 to this report.

Improvement priority three
SABs locally and regionally should adopt the data collection tool as the basis for learning from SARs.

2.3. SAR reading and analysis

Available materials relating to each SAR (full report, executive summary, SAB response, staff briefing and/or annual report summary) were read and the content used to populate the data collection survey, thus enabling each SAR to be mapped onto the analytic framework described above. All reviews were read by one person, with a small number initially read by two reviewers in order to check the comparability and reliability of the approach being taken.

Analysis was then carried out through:

- quantifying and summarising the core information (number of SARs by region, type of SAR, methodology employed, characteristics of the individuals involved, number and type of recommendations) to provide descriptive statistics on those features
- close examination and analysis of learning emerging from the process of commissioning, managing and disseminating the outcomes of SARs
- close examination and analysis of SAR learning relating to the four-domains (direct practice, interprofessional/interagency collaboration, organisational features and SAB governance) to identify the patterns and themes emerging and the implications for priorities for the future development and improvement of practice.

The themes emerging from the analysis of SAR learning across the four domains have been compared with those emerging from reviews identified by SABs as seminal. Previous reviews undertaken on a thematic or regional basis have also been used as comparative reference points. The purpose here has been to identify or reinforce key messages that should endure in the collective memory and to highlight where learning has (not) translated into policy or practice change.

A descriptive account has been given of SAB responses on the significant changes that they have achieved as a result of SARs they have undertaken, with examples where possible. These SAB responses have sometimes been included in their annual reports; sometimes they were included in SAB replies to the request for information for this national analysis. In the face of criticism that reviews result in little effective change[14], this part of the analysis explored the evidence of impact and how SABs have addressed the challenge of change[15].

The SAR quality markers[16] have been used as a reference point for evaluating the quality of the SARs reviewed and when commenting on any references to the challenges encountered from commissioning through to completion and dissemination of learning. The quality markers remain incomplete and have not been systematically reviewed since their publication.

Improvement priority four
The SAR quality markers should be reviewed and completed, informed by the findings of this national analysis. After dissemination of the revised quality markers, SABs should be asked to report on how they have been used to enhance the SAR process.

The statutory guidance[17] has also been used as a reference point in relation to decision making on what cases to review and how to manage the review process, disseminate the findings and implement the recommendations. This has enabled conclusions to be drawn regarding the degree of SAB compliance with the legal rules.

2.4. Quantitative Analysis

The data was collated using a survey tool that provided a mix of structured and unstructured data. This was managed using Smart Survey and a survey designed for the task of systematising data related to each SAR. Each entry using the data collection tool referred to a single SAR; however, each SAR could relate to several people, who could have been subject to multiple types of abuse in multiple locations. As such, throughout these analyses the numbers vary where multiple items have been recorded.

The data was further processed resulting in a two-table format:

[14] Wood, A. (2016) *Wood report: Review of the Role and Functions of Local Safeguarding Children Boards*. London: The Stationery office.
[15] Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20 (2), 78-92.
[16] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[17] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

- Table 1: Individuals: Containing details of the 263 individuals, some of whom feature in the same SAR.
- Table 2: Reviews: Containing details of the 231 SARs, including the type of review, methodology, case details, and themes emerging.

The analyses in this report are primarily grouped frequencies (ie counts) based on individual or multiple variables. In some instances, where appropriate, statistical analyses have been conducted. These are explained in the text.

Where comparisons are made to national data (for example, national and regional section 42 enquiries), data has been sourced from NHS Digital and refer to the 2017/18 data returns. Although this timeframe does not exactly match with the timeframe for SARs in the dataset, it is closer than other available national returns. Nonetheless, it should be treated as a comparison for context, and not a matched control group.

Tables have primarily been used to display data summaries and sorted for ease of interpretation. However, in some cases where there are multiple variables or more complex data summaries, figures are given and labelled accordingly. In most instances, data is split by geographic region of the SAB that commissioned / carried out the SAR. It should be noted that some regions have significantly fewer SARs than others, and that care should be taken in interpreting findings where sample sizes are low. For instance, a finding that the majority of cases in a region involve physical abuse is more likely to represent chance when a region only has a few SARs compared to when the sample size is larger. Conditional highlighting is used in several tables to assist with interpretation. Highlighting by columns is done in green (the highest value per column in the darkest shade) and by row in red. For example:

Column-wise formatting:		
	Column A	Column B
Row A	5	2
Row B	10	1

Row-wise formatting		
	Column A	Column B
Row A	5	2
Row B	10	1

Data processing, cleaning, and subsequent analysis and visualisation have been completed using the R programming language and Microsoft Excel. Full R scripts for the analyses are available.

2.5. Statistical terms used in this document

Simple definitions of the statistical terms and tests in this document are provided below[18].

- **Counts (n):** N values are used to denote the number of observations or frequencies in a given group (eg number of people in an age category).

[18] These are by no means full mathematical explanations and further reading on each definition can be found in statistical texts and online.

- **Mean:** The average of all numbers in a dataset, calculated by adding all numbers and dividing by the number of observations (the 'arithmetic mean').
- **Median:** The middle number in a dataset if all numbers were lined up in ascending order.
- **Standard deviation (Std Dev):** The dispersion of a dataset relative to its mean, calculated as the square root of the variance (measure of difference between each observation and the mean). If the data points are further from the mean, there is a higher deviation within the data set; thus, the more spread out the data, the higher the standard deviation.
- **Analysis of variance (ANOVA):** A statistical comparison of the mean values between two or more groups which considers the mean and variance of data on numeric outcomes. For instance, the difference in age between men and women.

2.6. Report

This report presents the findings of the analysis that has been undertaken. Specifically, it:

- sets out the descriptive statistics relating to core information about the SARs included within the analysis
- reports on the thematic analysis of key learning relating to the four domains, illustrating both good practice and practice that required improvement in the SARs analysed, where relevant including human stories drawn from the SARs to illustrate key messages
- comments on the extent to which equality and diversity emerged clearly within the learning themes generated by the analysis
- explores similarities and differences between the findings of the analysis and the findings of previous thematic reviews of SARs
- reports on the enduring learning from seminal SARs
- reports on significant changes that SABs have achieved as a result of SARs they have conducted
- provides commentary on the processes of commissioning and conducting SARs, with reference to the SAR quality markers, to identify any emergent model of good governance in this field
- considers how this learning can inform national priorities for development and improvement and makes recommendations for sector-led improvement and for how the Care and Health Improvement Programme can support local implementation of change.

So, the report focuses on learning from SARs with respect to the review process itself as well as what may be learned about working with different types of abuse and neglect. It looks forward and anticipates how development and improvement priorities can build on this consolidated body of evidence, and so inform sector-led improvement in adult safeguarding.

2.7. Review team contributions

This national analysis has been a team effort. The acquisition of SARs was mainly undertaken by Karen Allen (KA) and Michael Preston-Shoot (MPS) with support from Suzy Braye (SB) and Kate Spreadbury (KS). The original template into which data would be recorded was developed by SB and MPS but was developed and expanded for this project in consultation with Oli Preston (OP) and KA. It was further refined after SB, MPS and KS had discussed the experience of data input following a pilot. SB, MPS and KS read the SARs and completed data input. OP and KA analysed the quantitative data and wrote those sections of the report. SB and MPS analysed the qualitative data and wrote those sections of the report. The entire team discussed and agreed the final report.

3. SAB Governance of SAR Decision Making

3.1. Understanding the mandate

The overarching objective of a SAB is to assure itself that local safeguarding arrangements and partners are effective in helping and protecting adults at risk of abuse and neglect[19] [20]. SABs are under an absolute duty to conduct a SAR where an adult with care and support needs has died as a result of abuse and/or neglect, including self-neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person. There is a comparable absolute duty where the person has experienced serious abuse and/or neglect but survived. In these circumstances there is no discretion; a review is mandatory.

Serious abuse and/or neglect is defined as including where the person would have died but for intervention, or where they have experienced permanent harm or reduced capacity or quality of life[21]. In line with Making Safeguarding Personal, it is important to observe that the statutory definition of serious abuse and/or neglect is not tightly delineated and, therefore, due regard should be given to how a survivor views what they have experienced. The impact of abuse and neglect can include fear, shame, trauma, suicidal ideation, self-neglect, mental health and/or acute hospital admission, substance misuse, poverty and homelessness. The person does not need to have been in receipt of services as a result of their care and support needs[22].

SABs may also commission reviews in any other situations involving adults with care and support needs[23]. Such reviews are discretionary.

Not all SABs appear to have grasped the distinction between mandatory and discretionary reviews, or between the absolute duties in sections 44(1), (2) and (3) Care Act 2014 and the discretionary duty within section 44(4). There were references to a review being “non-statutory” or generic descriptions of referrals “not meeting the criteria” or “the threshold” for a SAR. The quantitative data below illustrates this observation. Greater precision is needed, which might be termed legal literacy, in order to ensure that decision making is defensible if ever challenged.

Type of abuse can be contrasted against the reason for initiating the SAR and whether there was a legal mandate. This highlights that the majority of SARs were the result of a section 44 legal mandate. It also raises the question as to what mandate a SAB was relying on to review a case if not section 44 Care Act 2014.

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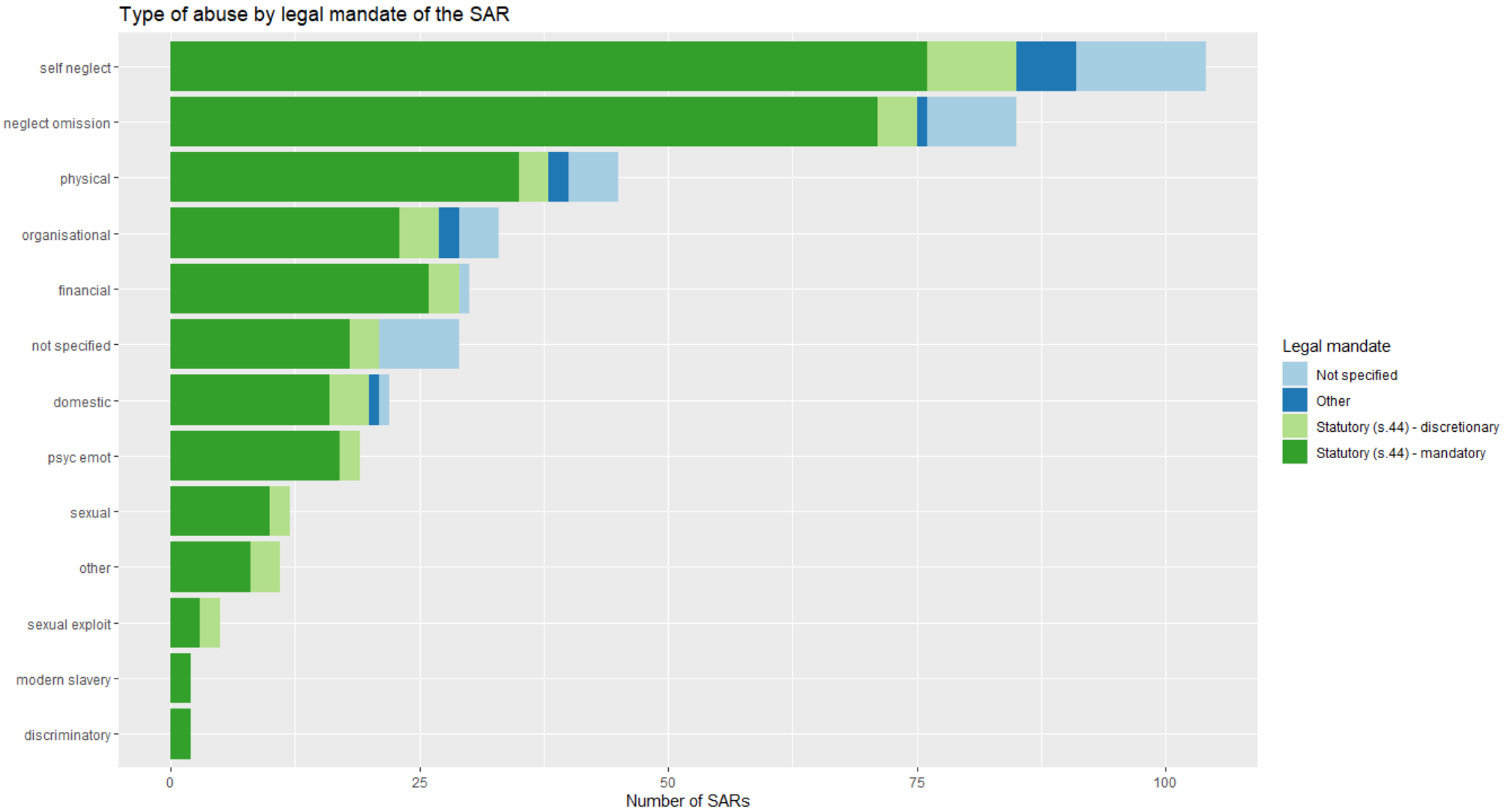
[19] The adults in question are those described in section 42(1), Care Act 2014.
[20] The SAB’s assurance role is set out in statutory guidance: Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (sections 14.133 and 14.139).
[21] Section 44(1), section 44 (2) and section 44(3), Care Act 2014; Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (sections 14.162 and 14.163).
[22] Section 44(1), Care Act 2014; Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.165).
[23] Section 44(4), Care Act 2014. Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.163).


Type of abuse by legal mandate of the SAR
self neglect
neglect omission
physical
organisational
financial
not specified
domestic
psyc emot
sexual
other
sexual exploit
modern slavery
discriminatory
0
25
50
75
100
Number of SARs
Legal mandate
Not specified
Other
Statutory (s.44) - discretionary
Statutory (s.44) - mandatory

Improvement priority five
SABs and their partner agencies should review their shared understanding of the relevant legislation regarding referral and commissioning of SARs to ensure this accurately reflects the absolute and discretionary duties within section 44, Care Act 2014.

The quality markers[24] do remind SABs to ensure that referrals state which of the statutory criteria are met and that the rationale for decision making is clear and defensible by reference to the Care Act 2014. There were examples of SARs where the review was explicitly described as discretionary because the cause of death was not related to abuse and/or neglect, or it was uncertain whether the individual had care and support needs, but where learning could be derived from how services worked together. Such reviews were termed variously as learning lessons reviews, management case reviews, multiagency reviews or partnership reviews.

The Local Government and Social Care Ombudsman's (LGSCO) remit extends to investigating complaints about how SABs and partner agencies have managed the SAR process. The LGSCO may investigate terms of reference, outcomes of a SAR, the administrative support given to a review, family involvement, and conflicts of interest. Sometimes no fault has been found in decision making regarding whether to carry out a safeguarding review[25]. In another case, no fault was attributed to either the local authority or the SAB[26]. On occasion the LGSCO has judged that a SAB was better placed to investigate the handling of a case, with a SAR being the preferred route[27].

However, SABs have been reminded of the importance of sound governance. In one case, no fault was found in the decision not to commission a SAR but the SAB was criticised because of the confusion that had been created whilst decisions were being made[28]. One SAB has been reminded that decision making on whether or not to undertake a SAR must follow the requirements of statutory guidance[29].

There are administrative law standards for decision making[30]. Amongst these standards, decision making must be lawful and reasonable, taking account of all relevant considerations. Discretion must not be fettered through the application of blanket policies and reasons must be given for the decisions reached. In their contributions to this national analysis, one SAB commented that "many SABs might not have commissioned a review of such a case". Another SAB referred to its "thresholds for a SAR" and expressed the view that some of their reflective reviews may have been SARs in other areas. Yet another SAB referred to tabletop reviews "where SAR criteria have not been met." Put another way, some SABs described adopting a tight focus on what cases were reviewed, whilst others clearly took a wider view on safeguarding. These comments reinforce the importance of legal literacy, understanding that all reviews are statutory where the only distinction is whether they are mandatory or discretionary. Moreover, with

[24] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[25] LGSCO and Buckinghamshire County Council (19 005 339) (2020)
[26] LGSCO and Leeds City Council (18 000 768) (2018)
[27] LGSCO and Hampshire County Council (19 013 243) (2020)
[28] LGSCO and Sefton Metropolitan Borough Council (18 008 491) (2019)
[29] LGSCO and Wiltshire County Council (15 005 127) (2015)
[30] Preston-Shoot, M. (2019) *Making Good Decisions: Law for Social Work Practice* (2nd ed). London; Macmillan/Red Globe Press.

reference to administrative law standards, a blanket approach to referrals would be unlawful; decisions must be based on the unique circumstances of each case and reasons clearly recorded.

SARs may also be commissioned to explore examples of good practice in order to identify lessons for future cases[31]. There was one case in the sample where this was the reason for commissioning a SAR. This would appear to be an under-utilised or missed opportunity to disseminate learning from positive practice.

Improvement priority six
Regional and national SAB networks to be used to review approaches to the interpretation and application of section 44 Care Act 2014 in decision making about SAR referrals.

3.2. Referrals

The source of referral for the review, where included in the report, was recorded for this analysis. However, in the majority of cases (68 per cent) no source was given, an omission and imprecision that makes it difficult to demonstrate the line of accountability.

Source of SAR referral										
Source of referral	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**Total**
Local authority	3	0	12	2	3	3	5	1	0	**29**
Police	3	1	1	0	3	0	2	0	1	**11**
Hospital trust	1	0	3	0	0	0	0	1	0	**5**
Fire & Rescue service	0	0	0	0	1	0	0	1	1	**3**
Mental health trust	1	1	1	0	0	0	0	0	0	**3**
CCG	0	0	1	0	0	0	1	0	0	**2**
Coroner	0	0	0	0	2	0	0	0	0	**2**
Family member	0	0	0	0	0	2	1	0	0	**3**
Not specified	7	5	44	15	27	21	13	13	13	**158**
Other	2	0	3	0	2	1	2	2	1	**13**

[31] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.164).

The aforementioned administrative law standards include that decision making should be timely, avoiding unnecessary delay. The aforementioned quality markers advise that referrals should be timely and explanations given for any delays in submitting referrals. Subsequently, SAB decision making should evidence multiagency discussion and appropriate challenge, with explanations given for any subsequent delays.

Within the sample were examples where referrals had been submitted shortly after the death or significant incident about which there was expressed concern. In other instances there had been a significant passage of time before a case was referred, the reasons for which were not consistently noted in reviews. There were examples of referral delays of six months, eleven months and sixteen months for example.

The LGSCO may investigate decision making regarding referrals. In one instance no fault was found regarding whether the local authority should have requested a SAR[32].

There were also delays in SAB decision making once referrals had been received. Once again, sometimes explanations were given, such as awaiting completion of other investigations, for instance a section 42 Care Act 2014 enquiry or NHS Trust serious incident report and root cause analysis, or a statement from the Coroner on cause of death. Other parallel processes might also be offered as explanations for positive delay in decision making, such as criminal investigations, court proceedings or referrals to regulatory and/or professional bodies, such as the Independent Office of Police Conduct (IOPC).

Occasionally, SARs were candid that there had been mixed views on whether the criteria outlined in section 44 Care Act 2014 had been met. Perhaps of greater concern were occasional strident criticisms in SARs of a lack of understanding of the criteria and process for initiating reviews, and of poor decision making, including where initial decisions not to commission a review had been overturned by the independent chair following challenge from family members. This was mirrored in commentary from a minority of SABs when submitting material for this national analysis, namely that their procedures for managing the entire SAR process were unclear. One SAB, in its contribution to this national analysis, commented as follows:

> "In addition, the process for receiving and considering requests was not believed to be robust since it is based on single agency information provided within the SAR request. In order to address this the Review and Learning sub-group (SAR Panel) has revised its arrangements. Partners are asked to submit information that will be reviewed at the subgroup meeting where a decision is made. The subgroup will meet on a monthly basis based on the number of SAR requests received and those on-going."

Another SAB commented on learning from experience about managing the SAR process. Despite full commitment from partners, improvements were needed to enhance the timeliness, quality, effectiveness and coordination of the SAR process. Given that SAB decisions can be challenged by way of judicial review or LGSCO investigation, it is essential that governance here is sound, not least because, as several SABs observed, workloads arising from SAR referrals have increased quite dramatically.

[32] LGSCO and Bromley LBC (18 009 386) (2018)

Equally of concern in terms of the quality of reviews is where dates are given for receipt of referrals and commissioning decisions but without explanation for apparent delays. Similarly, as the quantitative data illustrates, in almost 70 per cent of cases the identity of the referring agency is omitted from the review.

Improvement priority seven
SABs should review their governance procedures for SARs and ensure that referrals and decision making are timely, with meeting minutes and reviews clearly noting the reasons for positive or negative delay.

3.3. Type of abuse and neglect

The following tables provide the quantitative data regarding the types of abuse and neglect investigated by SARs, together with a regional breakdown, cross-referencing to age-related data, and comparative analysis with available section 42, Care Act 2014, data. The most common type of abuse in SARs was self-neglect, followed by neglect / omission; however, this is not consistently the case across all regions.

Types of abuse and neglect										
Type of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Discriminatory abuse	0	0	1	0	0	0	1	0	0	**2**
Domestic abuse	3	3	2	0	5	2	3	3	1	**22**
Financial/material abuse	2	2	5	2	4	4	8	3	0	**30**
Modern slavery	0	0	1	0	0	0	0	1	0	**2**
Neglect/omission	7	2	20	7	19	12	6	5	7	**85**
Organisational abuse	2	0	9	1	7	4	5	2	3	**33**
Physical abuse	2	4	6	2	11	5	7	6	2	**45**
Psychological/emotional abuse	2	2	2	1	3	2	4	3	0	**19**
Self-neglect	9	3	29	7	16	16	14	4	6	**104**
Sexual abuse	0	1	2	2	1	0	1	5	0	**12**
Sexual exploitation	0	1	0	2	0	1	0	1	0	**5**
Not specified	1	2	8	2	7	3	1	3	2	**29**
Other	0	0	4	1	2	2	1	1	0	**11**
Total	**28**	**20**	**89**	**27**	**75**	**51**	**51**	**37**	**21**	**399**

In the table below, type of abuse is presented as a percentage of total number of SARs per region (for example, domestic abuse was a factor in 18 per cent of SARs in the East region). This presents a view of abuse that is weighted by the number of reviews carried out. Of particular interest are cases where over 50 per cent of SARs involved a particular form of abuse in regional breakdowns. These have been highlighted blue.

Type of abuse as a percentage of the total number of SARs per region										
Type of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Discriminatory abuse	0%	0%	2%	0%	0%	0%	4%	0%	0%	1%
Domestic abuse	18%	43%	3%	0%	13%	7%	13%	17%	6%	10%
Financial/material abuse	12%	29%	8%	12%	11%	14%	33%	17%	0%	13%
Modern slavery	0%	0%	2%	0%	0%	0%	0%	6%	0%	1%
Neglect/omission	41%	29%	30%	41%	50%	43%	25%	28%	44%	37%
Organisational abuse	12%	0%	14%	6%	18%	14%	21%	11%	19%	14%
Physical abuse	12%	57%	9%	12%	29%	18%	29%	33%	13%	19%
Psychological/emotional abuse	12%	29%	3%	6%	8%	7%	17%	17%	0%	8%
Self-neglect	53%	43%	44%	41%	42%	57%	58%	22%	38%	45%
Sexual abuse	0%	14%	3%	12%	3%	0%	4%	28%	0%	5%
Sexual abuse exploit	0%	14%	0%	12%	0%	4%	0%	6%	0%	2%
Not specified	6%	29%	12%	12%	18%	11%	4%	17%	13%	13%
Other	0%	0%	6%	6%	5%	7%	4%	6%	0%	5%

Multiple abuse types can be logged per case. The data below shows the number of SARs recording any type of abuse and the total is higher than the number of SARs recorded. Across all regions, an average of 1.73 abuse factors were recorded per case. Regionally, this ranges from 1.31 (Yorkshire and Humberside) to 2.86 (East Midlands).

Multiple abuse types per case										
n types of abuse recorded	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humberside**	**All regions**
Mean	1.65	2.86	1.35	1.59	1.97	1.82	2.13	2.06	1.31	**1.73**
Median	1	2	1	1	2	2	2	1	1	**1**
Std Dev	1.06	2.27	0.75	0.94	1.15	0.86	1.08	1.70	0.60	**1.10**

In total, there are 231 reviews in the dataset, which are further categorised across the nine regions of England. This can be contrasted to the number of section 42 enquiries across the same regional areas. Regional population data allows for a normalised comparison of section 42 enquiries and SARs completed per 100,000 people in the population, highlighting areas such as Greater London, the North East and North West, where there are a higher number of SARs per person than elsewhere in the country. A Spearman's Rho[33] analysis of the ranked data shows that there is no correlation between the two groups ($p = 0.827$), highlighting that **the population normalised, regional prevalence of SARs does not correlate to the prevalence of section 42 enquiries**.

While this may be unsurprising, it is nonetheless of interest in that it demonstrates regional variations in both the statutory investigation of abuse and neglect and the conduct of SARs. So, to take one example, Greater London per 100,000 population has the lowest prevalence of section 42 enquiries but the highest prevalence of SARs.

Regional variation in section 42 enquiries and SARs per 100,000 population					
Region	**Number of Section 42 enquiries**	**Number of SARs**	**Regional population[34]**	**Section 42 per 100,000**	**SARs per 100,000**
East	14,790	17	6,236,072	237.17	0.27
East Midlands	11,345	7	4,835,928	234.60	0.14
Greater London	14,725	66	8,961,989	164.31	0.74
North East	12,310	17	2,669,941	461.06	0.64
North West	20,225	38	7,341,196	275.50	0.52
South East	19,145	28	9,180,135	208.55	0.31
South West	11,910	24	5,624,696	211.74	0.43
West Midlands	9,740	18	5,934,037	164.14	0.30
Yorkshire & Humberside	17,675	16	5,502,967	321.19	0.29
Total	**131,865**	**231**	**56,286,961**	**234.27**	**0.41**

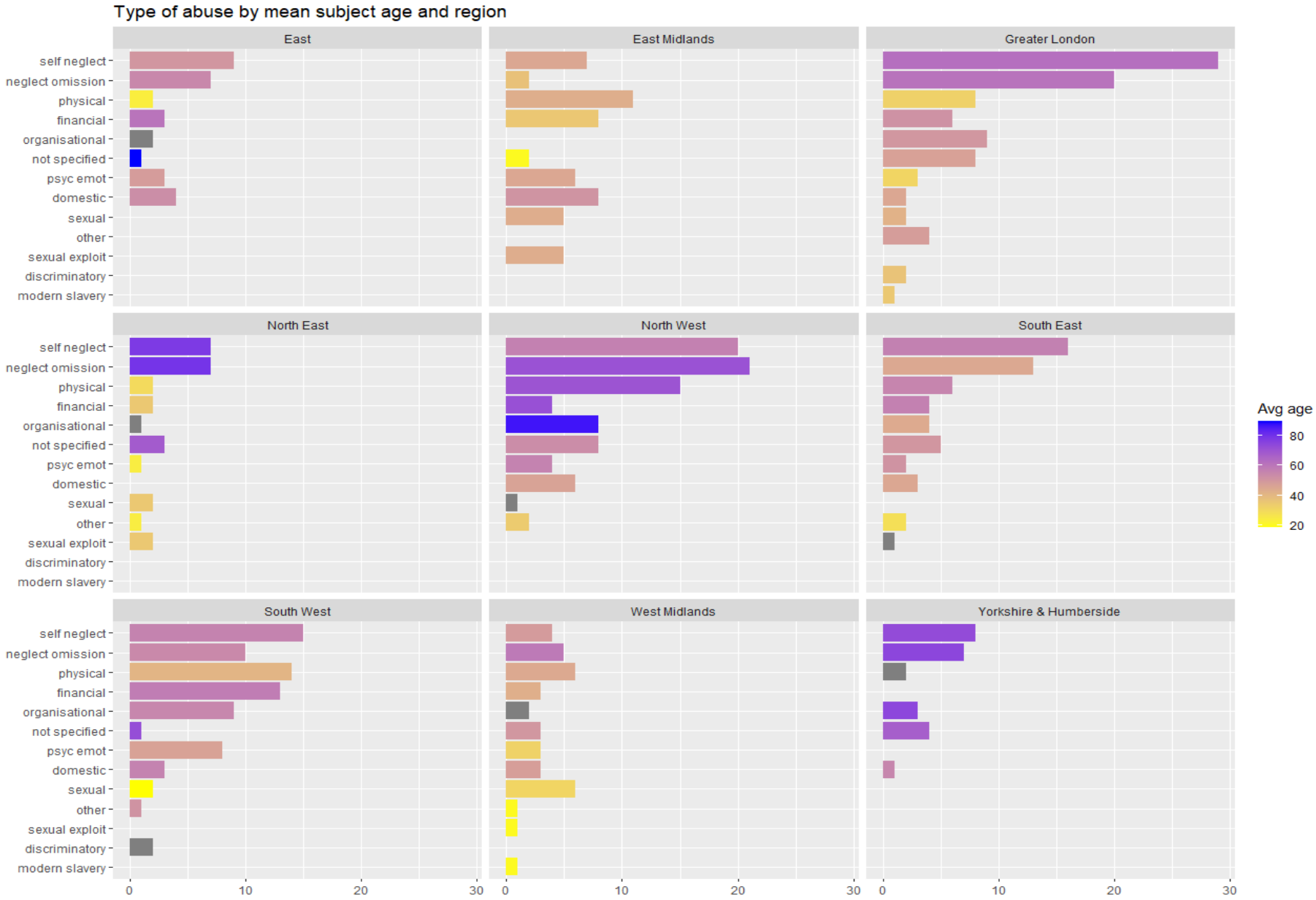
[33] Spearman's Rho (or Spearman's rank): A non-parametric measure of correlation between two ranked lists of data. If the two lists are ranked exactly the same, there is a perfect correlation. The correlation strength is denoted by the r value ($r = 1$ is a perfect positive correlation), and the statistical significance by the p-value (if $p < 0.05$, the r value is significant). No correlation ($p > 0.05$) indicates that the two lists are independent of each other.

[34] Mid-year estimates 2019, Office for National Statistics

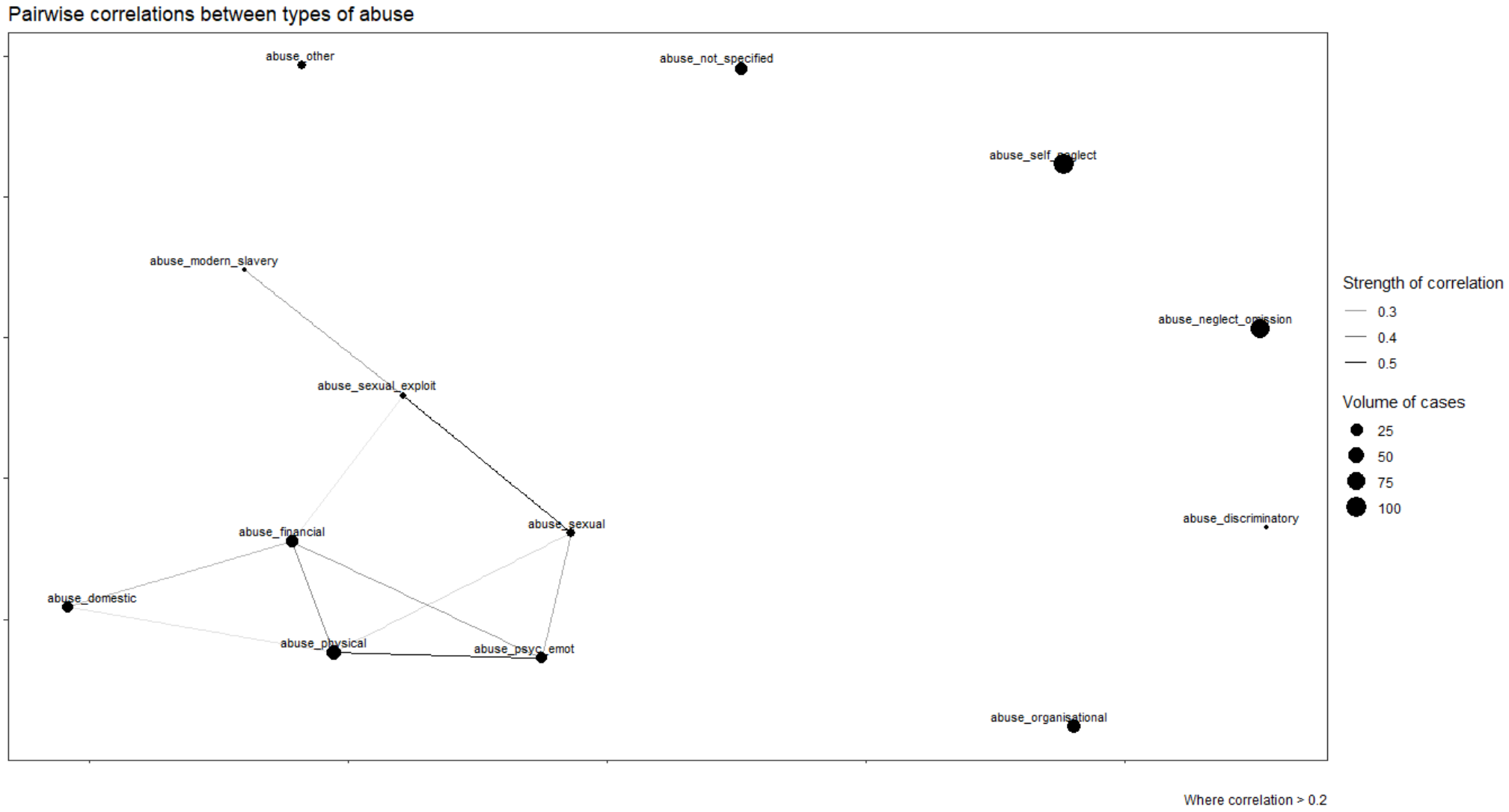
Where age data was available, this has been joined to the type of abuse data (though note the previous cautions around data accuracy, and that multiple abuse types and individuals could be recorded per SAR). Furthermore, age data was not available for all individuals. Therefore the table below shows the total number of SARs where a person or people in a particular age category and abuse category were recorded; for example, there was one person aged 18-29 recorded in a SAR where discriminatory abuse was present. The table has been highlighted row-wise (red: see introduction), showing how age differs by type of abuse. For instance, modern slavery, sexual abuse, and sexual exploitation occurred more prevalently in younger people, whereas neglect and abuse by omission occurred more in older people.

Number of SARs recording type of abuse within each age group								
Type of abuse	**0-17**	**18-29**	**30-49**	**50-69**	**70-89**	**90+**	**No age given**	**All ages**
Discriminatory abuse	0	1	0	1	0	0	2	**4**
Domestic abuse	0	3	7	10	2	1	7	**30**
Financial/material abuse	0	6	9	14	7	1	6	**43**
Modern slavery	0	1	1	0	0	0	0	**2**
Neglect/omission	0	8	15	24	19	9	17	**92**
Organisational abuse	0	2	5	4	6	4	17	**38**
Physical abuse	0	14	10	16	8	1	17	**66**
Psychological/emotional abuse	0	8	8	8	3	0	3	**30**
Self-neglect	1	7	21	28	23	5	30	**115**
Sexual abuse	0	6	6	4	0	0	2	**18**
Sexual exploitation	0	1	4	2	0	0	2	**9**
Not specified	0	4	13	28	6	2	8	**61**
Other	0	5	3	2	0	1	0	**11**
Total	**1**	**66**	**102**	**141**	**74**	**24**	**111**	**519**

The figure below combines age, type of abuse, and region (the two tables above), to show how this varies geographically. The colour indicates the average ages of individuals for a particular type of abuse in a given region. For instance, the average age of people in self-neglect cases in the East is lower than those in the North East, as shown by the bluer coloured bar in the North East tab. Where age data was not available for a particular type of abuse, the bar is coloured grey. The chart highlights the younger age in general of those in the Midlands, and more elderly population in the North West.


Type of abuse by mean subject age and region
East
East Midlands
Greater London
North East
North West
South East
South West
West Midlands
Yorkshire & Humberside
self neglect
neglect omission
physical
financial
organisational
not specified
psyc emot
domestic
sexual
other
sexual exploit
discriminatory
modern slavery
0
10
20
30
Avg age
80
60
40
20
Where SARs record multiple subjects and/or types of abuse, it is assumed that all types of abuse happen to all subjects for this analysis, though that may not be the case in all SARs

The following figure visualises the correlations between individual types of abuse recorded in SARs. For instance, if sexual exploitation and sexual abuse were consistently recorded on SARs, this would be a strong positive correlation. This chart shows correlations between types of abuse as a line between two points. The stronger lines show stronger correlations, and the size of the points indicate how prevalent a particular type of abuse is in the dataset.



The correlations shown in the figure above highlight a grouping of factors that are positively associated with one another. For instance, sexual exploitation and sexual abuse are strongly correlated, as are physical and emotional abuse. There is a clear cluster of domestic, financial, physical, and emotional abuse as well, which may point towards a particular case type for further qualitative exploration. Conversely, some types of abuse appear unrelated to all other types, such as neglect and omission. That is not to say they are the only types of abuse recorded on cases, but that they do not consistently occur alongside other types of abuse.

Type of abuse can also be contrasted with national data for section 42 enquiries. National data (Safeguarding Adults, England 2017/18 Experimental Statistics, Annex B: Initiated and Concluded Enquiries) also allows for the recording of multiple categories of risk / abuse. However, it should be noted that data arises from different sources. A ranked comparison indicates that there is a no correlation between the types of abuse recorded in section 42 enquiries and the SAR dataset (Spearman's Rho[35]; $p = 0.092$), **highlighting that the types of abuse and neglect reviewed in SARs do not correspond to the types of abuse and neglect seen across section 42 enquiries**.

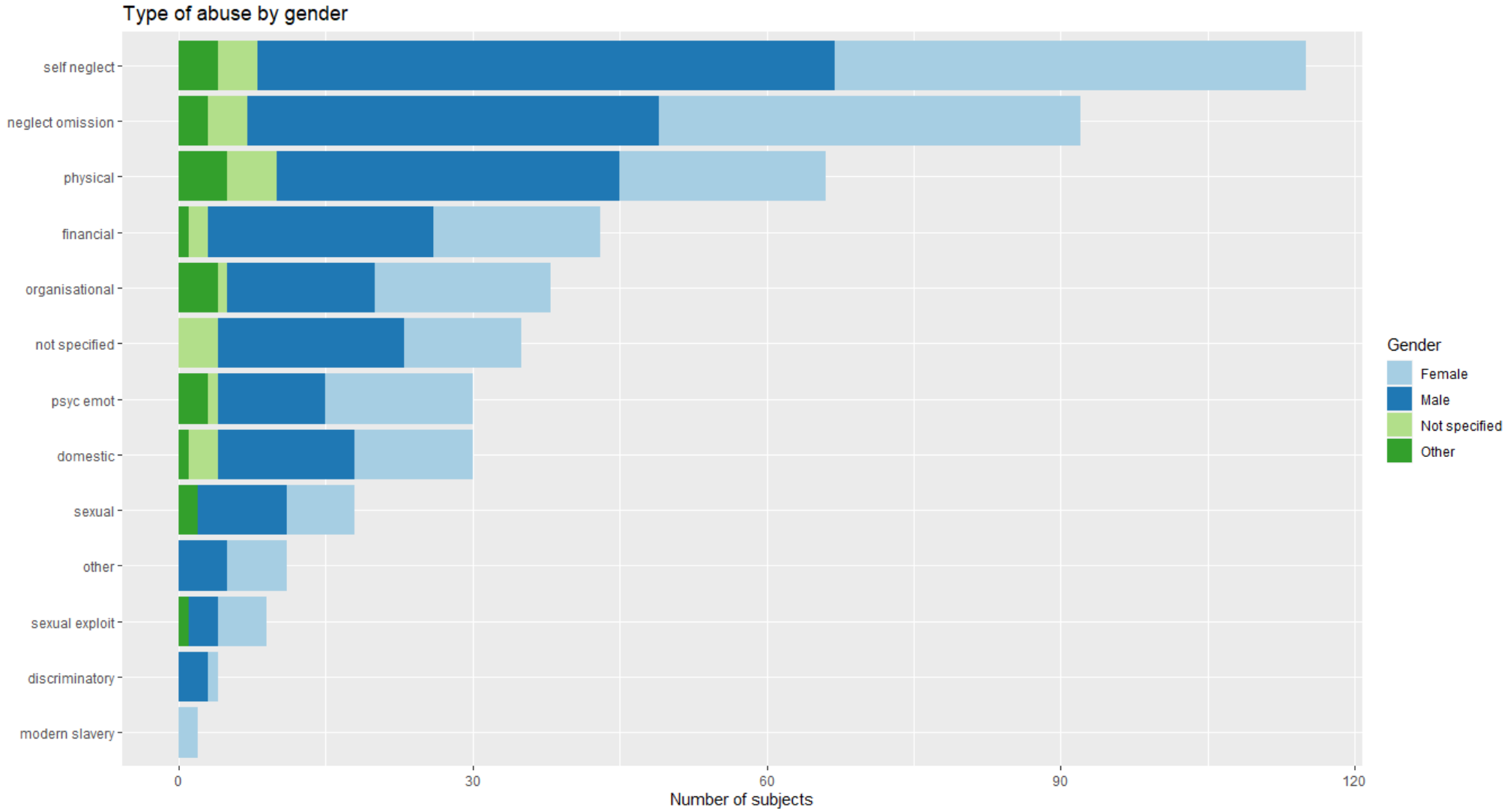
The chart below contrasts the profile of type of abuse for section 42 to the SAR dataset by region, allowing for an exploration of where the type of abuse in enquiries is different to reviews. These are presented as percentages to normalise the data due to the high volume of enquiries. In other words, a bar that is 60 per cent long, and of equal red and blue indicates that, in that region, 30 per cent of section 42 enquiries and 30 per cent of SARs featured this type of abuse / risk. Therefore, bars that are not of equal length shows a difference within a region of the risk / abuse in the population, and that which features in SARs. Across all areas, the figure highlights the imbalance between section 42 enquiries and SARs for certain types of abuse. For instance, across all regions, self-neglect is a highly prevalent factor (a long bar), which is skewed towards SARs (longer blue segment). This can be contrasted to the bars for abuse through neglect and omission, and physical abuse, which are also highly prevalent, but much more balanced between section 42s and SARs.

[35] Spearman's Rho (or Spearman's rank): A non-parametric measure of correlation between two ranked lists of data. If the two lists are ranked exactly the same, there is a perfect correlation. The correlation strength is denoted by the r value ($r = 1$ is a perfect positive correlation), and the statistical significance by the p-value (if $p < 0.05$, the r value is significant). No correlation ($p > 0.05$) indicates that the two lists are independent of each other.

Comparison between national Section 42 and SAR data

Type of abuse, by region, as % of all abuse types recorded

A gender breakdown of type of abuse shows those types which are more prevalent for certain genders. For instance, psychological / emotional abuse and modern slavery is more prevalent for females, whereas financial, physical abuse and self-neglect are slightly more prevalent for males.



Clearly in some cases decision making was contested because of the phrase in section 44(2) Care Act 2014 that the death "resulted from" abuse and neglect. There were examples where SABs had used their discretion in section 44(4) to commission reviews where financial abuse was known or suspected but was not the cause of death, or where there was evidence of self-neglect or neglect but where health complications had been the cause of death. The same discretion had been employed to review cases involving suicide, homelessness, immigration issues and no recourse to public funds.

There was one case in the sample where the SAR found no evidence of abuse or neglect.

There were examples where reports engaged in detailed discussion of the type of abuse and/or neglect involved, in one instance concluding that physical abuse and neglect/omission were centrally involved, possibly associated with emotional abuse, including coercive and controlling behaviour, and sexual abuse. More common were cases involving multiple types of abuse, for example self-neglect, financial abuse and physical abuse whilst homeless, or self-neglect alongside sexual exploitation and financial and physical abuse, or physical and psychological abuse alongside discriminatory (racial) abuse and financial abuse.

However, not all reports clearly name the types of abuse and neglect that have prompted SARs to be commissioned. Similarly, not all accounts given in annual reports specify the type of abuse or neglect involved. Reports should be explicit. Indeed, the aforementioned quality markers include a question about whether discussions of referrals have included a focus on the type of abuse and neglect suffered by the person, including self-neglect. This was not demonstrated in every case reviewed in the sample.

Improvement priority eight
SABs must ensure that SARs identify the types of abuse and neglect within cases being reviewed.

When Coroners record cause of death, they identify immediate, underlying and contributory causes. Particularly where SARs involve multiple types of abuse and neglect, it might be helpful to consider a similar demarcation.

There are, however, some definitional issues that have complicated the description of the type of abuse and neglect involved. Amongst the eleven cases described as "other" were suicides, mate crime (which could be classified as discriminatory abuse), animal hoarding (which could be included under self-neglect), self-harm, and exploitation and trafficking (which might fall into the category of modern slavery). Occasionally SARs were critical of attitudes exhibited by practitioners and/or acquaintances of an individual. In respect of practitioners involved, such attitudes were sometimes linked to cultural or systems issues. However, they were not usually framed as discriminatory abuse.

A particularly challenging definitional issue to resolve is the difference between neglect/omission and organisational abuse/neglect. It was not always clear whether reviewers were asking the question whether shortcomings in practice were unique to this one case or emblematic of system-wide issues. Phrases such as "avoidable lapses", "systems issues" and "cultural and systems issues" do not clearly convey the nature of the concern. How,

for example, are delays in conveying a person to hospital, or conducting mental health assessments in Accident and Emergency Departments to be understood? When the focus is on practice in care settings, and indeed also on concerns regarding how services and agencies have worked together, reviewers should be very clear whether neglect or poor practice is the result of structures, policies, processes and practices in the organisation[36]. The aforementioned quality markers also emphasise consideration of whether a case indicates that there are system conditions that result in poor practice, and whether systemic causes are new, complex and/or repetitive.

Improvement priority nine
In light of the findings from this national analysis, the statutory definitions of types of abuse and neglect should be revisited and, if necessary, revised to ensure that they fully capture the developing understanding of the contexts in which adult safeguarding concerns and risks emerge.

One notable finding, foregrounded above, is that cases of self-neglect feature so strongly amongst SARs but much less so in the national data for section 42 Care Act 2014 enquiries, where neglect/omission, physical abuse, financial abuse and psychological abuse are the first four types of abuse and neglect amongst referrals. Equally, the same data raises the question as to decision making when some types of abuse and neglect are more evenly spread across section 42 enquiries and section 44 reviews. While it would be possible to hypothesise about the reasons for this, the data in the present analysis cannot provide answers about why it should be the case. Improvement priority seventeen, later in the report, picks up this research question.

3.4. Types of reviews

Statutory guidance[37] gives SABs discretion as to what type of review process is most likely to promote effective learning and improvement action. The same guidance advises that reviews should be proportionate to the scale and level of complexity of the case[38]. Similarly, the quality markers[39] advise that consideration should be given to the appropriate size and scope, form and focus of the review given the case and its context.

There were occasional acknowledgements of the principle of proportionality. One review, for instance, noted that a local learning review was judged to be a proportionate response. In another instance, a thematic review was commissioned because of the similarities across referrals. There were also examples where Domestic Homicide Reviews or Serious Case Reviews had been combined with SARs, again in line with proportionality.

The majority of SARs (75 per cent) used a standard SAR approach, with only a few categorised as learning or thematic reviews across all regions.

[36] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.17).
[37] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.164).
[38] Section 14.167.
[39] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.

Types of review used in the SARs										
Type of Review	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Learning review	6%	14%	2%	29%	13%	11%	8%	11%	19%	10%
Standard SAR	76%	43%	92%	53%	79%	75%	79%	78%	63%	78%
Thematic review	0%	14%	3%	6%	0%	4%	4%	0%	6%	3%
Other	18%	29%	3%	12%	8%	11%	8%	11%	13%	9%

However, the majority of reviews gave no indication on why a particular approach had been taken. Moreover, some of the terminology used for types of review obscured rather than clarified the approach being adopted, for example “concise review” or “internal focused review.”

Some SABs have been in the position of commissioning a SAR involving a type of abuse and/or neglect that has been the focus of one or more earlier reviews. The response generally has been to commission a further individual SAR rather than to consider a proportionate response that begins with the learning and recommendations from earlier reviews and then questions what has (not) changed, what has facilitated or obstructed change, and what further work is required.

Within the above broad categories, various review models were employed. As found in other thematic analyses[40], a hybrid approach combining elements of other models was the methodology most often adopted. Various descriptive terms were used for other approaches, the meaning of which was assumed rather than explained.

Methodology		
Description	**n**	**Per cent**
Hybrid (combining approaches)	108	46.76%
Traditional (document analysis only)	39	16.88%
SCIE Learning Together	18	7.79%
SILP	9	3.89%
Welsh Model	5	2.17%
Root Cause Analysis	2	0.86%
Not stated	40	17.32%
Other	10	4.33%

[40] For example, Braye, S. and Preston-Shoot, M. (2017) *Learning From SARs: A Report for the London Safeguarding Adults Board*. London: ADASS. Preston-Shoot, M. (2019) ‘Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.’ *Journal of Adult Protection*, 21 (4), 219-234.

Single examples were found of models variously described as root cause analysis, appreciative systemic enquiry, significant event analysis, LeDeR methodology, organisational accident causation model, local procedures model, a systems model used in children's SCRs, and a DHR model.

The regional breakdown relating to the main models used shows that some were more routinely employed in certain locations, with all the Welsh model SARs in the North West, for example, and over 50 per cent of the SCIE learning together reviews in Greater London. Hybrid approaches were common across all regions.

Regional breakdown of approaches used										
Methodology	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	Total
Hybrid (combining approaches)	9	3	24	5	20	17	13	9	8	108
Traditional (document analysis only)	5	3	12	0	3	7	3	5	1	39
SCIE Learning Together	0	0	10	0	3	0	4	1	0	18
SILP	0	0	2	1	1	0	4	0	1	9
Welsh model	0	0	0	0	5	0	0	0	0	5
Appreciative Enquiry	0	0	0	2	0	0	0	0	0	2

Regardless of the overall model employed, multiple methods of gathering information could be selected for each SAR. The table below presents methods as a percentage of total SARs by region. For example, 71 per cent of SARs in the East of England used chronologies. Across all SARs, chronologies, internal (agency) management reviews and manager learning events were most commonly used. The colour scale highlights the most commonly used (darker green) method for each region. The North East stands out as not using chronologies as much as other areas.

Regional breakdown of methods used for gathering information										
Information gathering method	East	East Midlands	Greater London	North East	North West	South East	South West	West Midlands	Yorkshire & Humber	Total
Chronology	71%	57%	48%	29%	68%	75%	50%	42%	63%	57%
IMR	71%	71%	36%	41%	47%	64%	67%	50%	31%	51%
Interviews	6%	14%	29%	12%	29%	39%	46%	17%	13%	27%
Learning event	53%	57%	39%	35%	61%	57%	63%	33%	50%	50%
Not specified	6%	0%	26%	41%	13%	7%	4%	17%	19%	17%
Other	18%	14%	35%	18%	42%	46%	38%	8%	44%	33%

The category "other" most often included reading agency records, including submissions to the Coroner and other investigations, sometimes alongside evidence from previous SARs and/or agency responses to specific questions raised by a reviewer or panel. Of greater concern is the

number of reports where how evidence was collected is not specified. As with detail about the overall approach being adopted, readers must have confidence in the methodology being used if they are to have similar confidence in the findings, conclusions and recommendations. This should be a key quality standard.

Improvement priority ten
SARs should give a full account and offer a reflective analysis of the methodology used. The quality markers should be revised to emphasise the importance of methodological rigour.

Improvement priority eleven
Regional and national networks provide a space where SABs can discuss learning regarding a proportional and change-oriented approach to cases involving types of abuse and neglect that have previously been the subject of local reviews.

While different methodological approaches have been developed, comparative research has been limited[41]. Whilst it remains appropriate that SABs exercise discretion regarding the approach they believe is most likely to elucidate learning from the case, the paucity of research on the strengths of different approaches means that choice of methodology may come down to personal preferences.

Improvement priority twelve
Comparative research should be commissioned to highlight the effectiveness of different review methodologies.

3.5. Involvement of the individual and their family

The statutory guidance requires early discussions with the individual, family and friends to agree how they wish to be involved[42]. It further requires[43] that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively. These requirements are reinforced by the quality markers[44], where particular emphasis is given to explaining the purpose, process and parameters of SARs, documenting

[41] For one example, see Kingston, P., Eost-Telling, C and Taylor, L. (2018) *Comparing Safeguarding Review Methodologies*. Lancashire Safeguarding Boards.
[42] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.165).
[43] Section 14.167.
[44] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.

any reasons for non-involvement, providing statutory advocacy and other forms of support where necessary, and facilitating their contribution in as many stages of the process as possible.

That this can prove challenging is demonstrated by LGSCO reports. In one case[45], involving a SAB and its partners, the SAR process itself had caused the complainant both uncertainty and distress. In another case, judgement found significant fault in how the SAB had handled the SAR process, especially involvement of relatives[46].

The quantitative data indicates the degree of involvement of the individual and their family achieved across the SARs in the sample. For the majority of SARs, the adult was not involved due to having died as a result of the abuse. In the few cases where the adult were involved, this was typically through a conversation with the reviewer.

Involvement of the Individual and their family in SARs										
Adult involvement	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Contributed to report	0	0	1	1	1	0	1	1	0	**5**
Conversation	0	2	1	1	1	4	2	3	0	**14**
Input to ToR / focus	0	0	1	1	0	0	0	0	0	**2**
Invited: did not participate	1	1	1	0	2	0	2	0	0	**7**
Member panel	1	0	1	0	0	0	0	0	0	**2**
Not invited	0	0	2	0	3	0	1	1	1	**8**
Reviewed report	0	0	1	1	0	1	0	2	0	**5**
Supported by advocate	0	0	2	1	0	1	1	1	0	**6**
NA deceased	15	5	51	13	33	22	20	13	10	**182**
Not specified	1	0	8	2	1	1	1	1	5	**20**
Other	0	0	2	1	0	1	0	0	0	**4**
Total	**18**	**8**	**71**	**21**	**41**	**30**	**28**	**22**	**16**	**255**

Within the sample was one review where the individual helped to co-produce the report and another where the person concerned had been assisted to produce a contribution for the practitioner learning event that was held. There were also examples where either keyworkers and/or advocates had provided support to enable the person to contribute, with clear sensitivity shown regarding how much information they were willing and able to provide. Less positively, it was not always clearly stated why the individual was not invited to participate, although occasionally there were references

[45] LGSCO and Summerhill Surgery (18 009 105) (2020)
[46] LGSCO and West Sussex County Council (16 017 502) (2019)

to the outcome of mental capacity assessments or to advice from practitioners that involvement would be emotionally unhelpful. Once again, standards of decision making require that clear reasons are available for how statutory authority has been exercised[47].

Across all SARs, families were involved to some extent with the review approximately two thirds of the time (65 per cent). There appear to be some areas which have a stronger record of family contribution than others, such as the East, North West, and the South West.

Family involvement by region										
Any family involvement	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
n cases where family were involved or invited	13	4	36	10	30	17	20	12	9	**151**
Percentage of total cases by region	76%	57%	55%	59%	79%	61%	83%	67%	56%	**65%**

Family involvement is split by the specific type of involvement below. It should be noted that for each review, multiple types of involvement can be recorded. Where the family were involved in the SAR this was typically through a conversation with the reviewer.

Type of family involvement by region										
Family involvement	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Contributed to report	3	1	7	1	14	5	6	3	0	**40**
Conversation with reviewer	9	2	19	7	24	11	15	7	6	**100**
Input to ToR / focus	0	0	3	3	1	2	5	2	0	**16**
Invited didn't participate	4	1	11	2	8	4	5	6	2	**43**
Not invited	1	2	3	0	2	5	3	1	1	**18**
Not specified	3	2	21	7	10	5	1	4	6	**59**
Other	2	2	6	2	2	4	1	3	0	**22**
Reviewed report	3	1	4	2	14	5	10	6	2	**47**
Total	**25**	**11**	**74**	**24**	**75**	**41**	**46**	**32**	**17**	**345**

Below, family involvement is presented as a percentage of total SARs per area. For instance, in the North West the family had a conversation with the reviewer in 63 per cent of cases, whereas this only happened for 29 per cent of reviews in Greater London.

[47] Preston-Shoot, M. (2019) *Making Good Decisions: Law for Social Work Practice* (2nd ed). London; Macmillan/Red Globe Press.

Type of family involvement by region as percentage of SARs conducted										
Family involvement	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**Total**
Contributed to report	18%	14%	11%	6%	37%	18%	25%	17%	0%	17%
Conversation with reviewer	53%	29%	29%	41%	63%	39%	63%	39%	38%	43%
Input to ToR / focus	0%	0%	5%	18%	3%	7%	21%	11%	0%	7%
Invited didn't participate	24%	14%	17%	12%	21%	14%	21%	33%	13%	19%
Not invited	6%	29%	5%	0%	5%	18%	13%	6%	6%	8%
Not specified	18%	29%	32%	41%	26%	18%	4%	22%	38%	26%
Other	12%	29%	9%	12%	5%	14%	4%	17%	0%	10%
Reviewed report	18%	14%	6%	12%	37%	18%	42%	33%	13%	20%

The involvement of family members especially, but also in some instances friends and acquaintances, appears most often in terms of contributing information, recounting experiences of how services worked together and practitioners engaged with them and with the individual concerned. There are examples, albeit less frequent, where they were also involved in the construction of terms of reference for the SAR and in reading through and commenting on drafts of the final report. There are occasions when reviewers have noted that family members had contested the original decision not to commission a SAR or had argued for inclusion of additional terms of reference that were ultimately judged to be out of scope, and/or had disagreed with aspects of report content and analysis.

Occasionally there is acknowledgement of their positive contribution, especially in providing background information about the individual, indirectly recognising how little practitioners and services knew about the people they are working with. One review, for instance, recognised the family's "wholehearted cooperation" including "candour" about the difficulties the family had faced in trying to support the individual. There are examples of family members providing a pen picture of the person and/or a separate submission, either published alongside the SAR or included within it, about their experiences of the SAR process and of how services sought to safeguard their family member. There are two instances when family members appear to have attended the SAB itself when the report was presented.

In terms of review and report quality, what had influenced decisions about the level of involvement offered was not consistently stated. There were examples where reports were silent on whether or not involvement had been offered. There were no instances where family members attended part or all of a learning event but there were a few examples where they provided photographs and/or reflections and questions as contributions. Similarly, family involvement might prove less than straightforward for several reasons. Examples here included conflict between different family members, the absence of next of kin details held by the agencies involved, or their inclusion in criminal investigations and proceedings. There were also examples that illustrated the importance about sensitivity regarding the timing of offering involvement, with family members finding an initial approach to be "too soon" but able to respond later in the process.

Occasionally reports indicate that family members found involvement helpful as part of their "healing process." More often, where their involvement is especially detailed, it is clear either that they subscribed to and endorsed the purpose of reviews, namely to learn lessons, or that they were disappointed, seeking a different kind of accountability and/or were sceptical that SARs would have any significant impact. For everyone involved in SARs it is imperative that SABs and their partners can evidence the difference that reviews have made to practice, organisational culture, policies and procedures[48].

A number of reviews explicitly referenced a journal article on family participation in case reviews[49]. Learning lessons about how to involve individuals and their families and friends in SARs is a work in progress, with parallels to earlier learning journeys about the involvement of service users and carers in social work education, for example, of families in child protection case conferences and of patients in health decision making. Partnership and empowerment are strongly foregrounded in statutory guidance. A question that arises from how reviews have approached the involvement of the individual and/or their family is whether what has really been offered is participation in an agenda controlled by agencies or partnership that involves open discussion of how power within a process is distributed and used. Partnership requires that all involved, especially those who have not participated in such a process before, have sufficient information to understand and contribute, and the power to influence outcomes[50].

The statutory guidance[51] comments that in some cases it may be helpful to communicate with the person who caused the abuse and neglect. This was achieved in a very few cases involving domestic violence, physical and financial abuse. Where it did not prove possible, this was sometimes on the advice of lawyers or mental health practitioners, and sometimes because individuals declined to participate, for example in relation to a review of sexual exploitation.

Improvement priority thirteen
Regional and national networks should provide a space where SABs can discuss and disseminate learning from experiences of involving the individual and/or their family in SARs.

3.6. Terms of reference

The statutory guidance[52] advises that terms of reference should be published and openly available, and that SARs should reflect the six adult safeguarding principles. Some SARs do indeed include the terms of reference, either within the report itself or as an appendix, occasionally acknowledging that they were revised as new information emerged, for example from family members or at a learning event. Others, however, do not,

[48] Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20(2), 78-92. Preston-Shoot, M. (2020) 'Making any difference? Conceptualising the impact of safeguarding adults boards.' *Journal of Adult Protection*, 22 (1) 21-34.
[49] Morris, K., Brandon, M. and Tudor, P. (2015) 'Rights, responsibilities and pragmatic practice: family participation in case reviews.' *Child Abuse Review*, 24, 198-209.
[50] Braye, S. and Preston-Shoot, M. (1995) *Empowering Practice in Social Care*. Buckingham: Open University Press.
[51] Section 14.171.
[52] Section 14.166.

especially if what is in the public domain is only an executive summary or seven-minute briefing. Thus, practice appears variable. The same is true of explicit reference to how the six principles have been applied.

One particular element within terms of reference is the period of time on which a learning lens focuses. Here, as the quantitative data reveals, the range was between one month and 312 months. Variable too is whether a commentary is included on why a particular time span was chosen and whether, in order to provide background and context, information judged to be significant before the time formally in scope was accessed. Indeed, there are reviews in the sample where the time span was not specified.

It was not unusual, where the time span being reviewed was specified, for the focus to conclude at the point of a person's death. However, as a minority of reports make clear, what follows may include significant learning, for example in relation to risks to other residents in care homes.

Occasionally report authors comment on the particular challenges involved when the time period under review is either extremely condensed or much extended. The latter especially is associated with changes in legislation and policy, staff departures, and difficulties of recall and therefore of achieving an understanding of decision making after a significant passage of time

3.7. Length of SAR process

The statutory guidance recommends that the aim should be to complete SARs within a reasonable time period and, in any event, within six months of initiating it unless there are good reasons otherwise, such as avoidance of prejudicing court proceedings[53]. What is not clear within the guidance, however, is what is considered to be the point of initiation. Is it when a decision to commission is taken, or when a reviewer is appointed, or when the panel or sub-group overseeing the process first meets? The aforementioned quality markers also advise that the process should run smoothly and conclude in a timely manner.

Improvement priority fourteen
The statutory guidance should be revised to indicate the date from which the time period for a SAR commences.

As the quantitative data reveals, only 10 per cent of SARs were completed within six months, as far as could be judged from the information available. It was frequently difficult if not impossible to deduce the length of time that a review had taken as key dates were not specified. Reviews typically took 6 months or longer. Most areas had a similar proportion taking 6-12 months and 12+ months. Very few reviews were completed in less than 6 months, and many did not specify.

[53] Section 14.173.

Length of SAR process by region										
Length of review	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
0-6 months	0	0	9	3	3	3	3	0	1	**22**
6-12 months	4	0	14	6	12	13	11	6	4	**70**
12+ months	9	3	18	2	12	7	6	5	2	**64**
Not specified	4	4	25	6	11	5	4	7	9	**75**

Some reports indicated that there had been what may be termed positive delay. New lines of enquiry may have emerged that required the terms of reference to be revised. To ensure comprehensive analysis, the inclusion of additional services or agencies may have been deemed necessary. Of the six adult safeguarding principles, accountability is particularly relevant here, ensuring that the process is characterised by timeliness and candour, and that lessons are learned.

However, in addition to delays in referrals being submitted, noted earlier, there were other issues that impacted on timely completion. SABs themselves could be directly implicated here. One SAB had no budget with which to resource SARs, whilst it was also clear that the administrative resources available were stretched by the volume of SARs and other business to manage. Others were in the process of developing new procedures for commissioning and managing reviews or recognised as a result of events surrounding particular reviews that it was necessary to revisit policies and procedures with its partners. This included the procedures to be followed in the event of disagreement about whether a SAR should be commissioned or, subsequently, differences of opinion regarding the analysis of particular episodes or events. As one SAB commented, it had proved necessary for the SAB itself to learn lessons and to review the effectiveness and coordination of the SAR process, with particular reference to timeliness and the quality of reports.

Other barriers to timeliness included difficulties in finding appropriate independent reviewers and/or panel chairs, delays in agencies submitting individual management reports (IMRs) and/or the necessity of requesting IMR revision owing to the poor quality of candour, reflection and analysis. Parallel processes, such as criminal investigations, inquiries by regulatory or professional bodies, and Coroner inquests, also had an impact on timely decision making about whether to commission a SAR and/or completion. SABs have to balance the desirability of disseminating learning as quickly as possible with the avoidance of compromising other proceedings and with the importance of learning directly from those most involved at the time.

There were occasional comments that the process had been delayed because of people's workloads, staff movement and/or changes in the configuration of services. In a very few instances it was clear that a reviewer had withdrawn or refused to amend a report judged to be lacking in quality.

It was not always clear, through reading SARs themselves or how they had been summarised in a SAB's annual reports, when reports had been accepted by the SAB and when published. Sometimes there was a significant delay between completion and publication, not usually explained although occasionally because of ongoing regulatory investigations or other (disciplinary) procedures. The impact of delays on family members who had chosen to participate was rarely acknowledged but in terms of reaching some form of closure could be imagined to be significant. Quantitative data on the time difference between acceptance and publication of the report follows here.

Other time variables recorded were the date of acceptance of the report by the SAB and the date of publication, allowing for calculation of time between these two points. Across all regions it took an average of 86 days (3 months) to publish after sign-off. However, there was a large regional variance with an average of 8 days in the East of England, and 126 days in the South West.

Number of days between SAB acceptance of the SAR report and publication										
Days between sign-off and publication	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
n reviews with both dates available	5	1	23	3	8	12	13	3	8	**76**
Mean	8.40	92.00	106.26	29.67	86.75	108.67	126.31	20.33	19.63	**85.86**
Median	6	92	5	0	62.5	25.5	0	0	0	**2.5**
Std Dev	9.21	NA	155.19	51.38	98.89	213.10	241.81	35.22	44.33	**161.08**

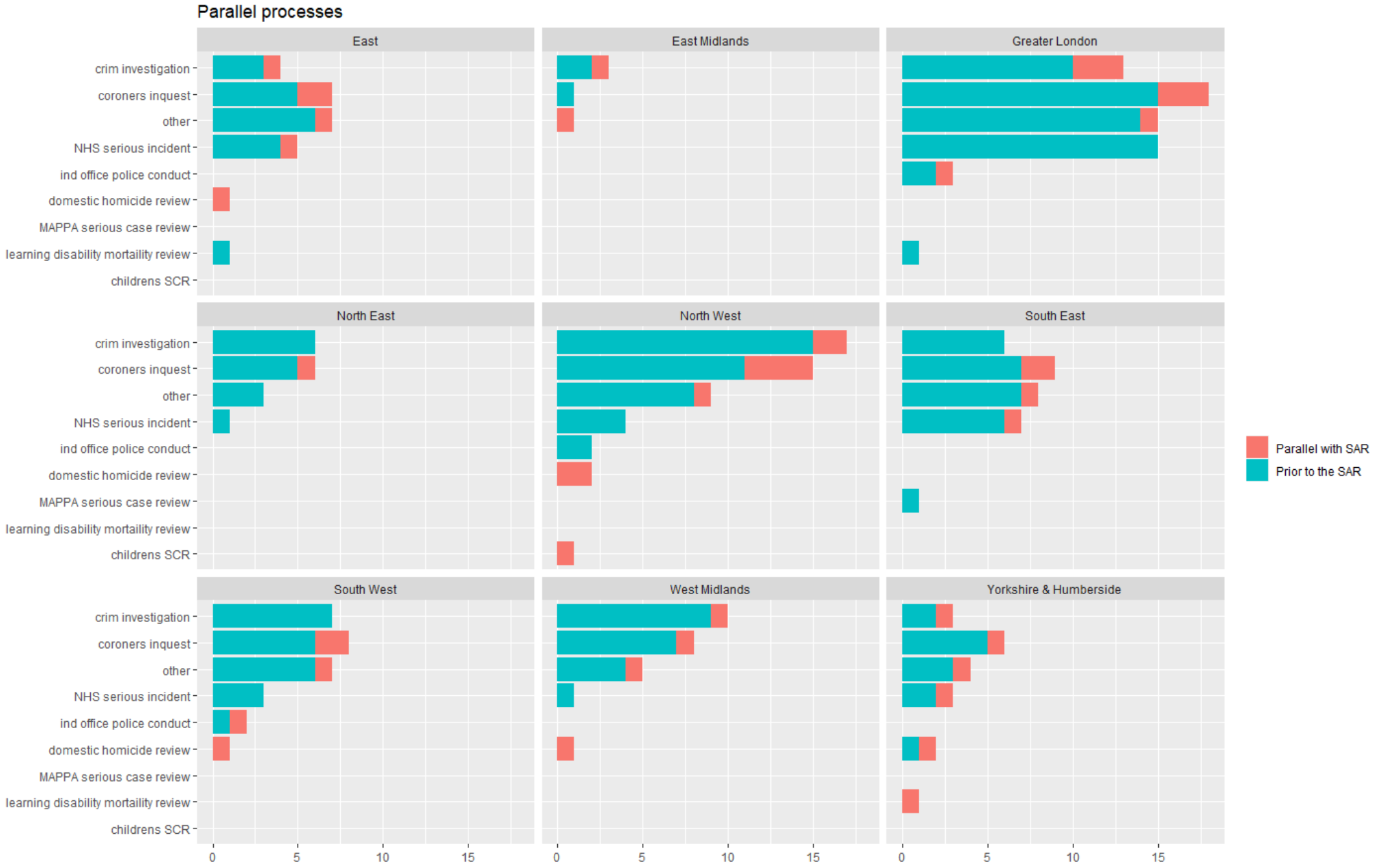
The length of time for which evidence was considered shows the mean length being 27 months (just over 2 years), but with high variation in this (standard deviation = 32.22 months).

Length of time for which evidence was considered										
Length of evidence considered (months)	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Mean	25.33	55.25	22.60	35.64	27.61	21.08	26.55	44.20	18.56	**27.20**
Median	24	62	12	19	26	17	19	13	16	**17**
Std Dev	18.53	34.59	27.43	33.08	17.79	16.20	24.43	78.88	17.39	**32.22**

As indicated above, one justifiable reason for SARs taking longer than six months is the avoidance of compromising a parallel process. The quality markers include reference to the importance of cooperation with all relevant processes to achieve the best fit in the circumstances and to avoid unnecessary delay and confusion for parties involved. Clearly SABs must give detailed consideration to when to initiate data collection and analysis, and to involve practitioners and managers in learning events and/or interviews, when parallel processes are known to be running.

Parallel processes could only be recorded in the data collection framework as happening alongside the SAR or prior to it, not both. It is important to note, therefore, that some prior processes may have continued also after the SAR began. The first chart below highlights that criminal investigation and coroners' inquest commonly had occurred prior to the SAR, as had serious incident reviews and other types of review. The second provides a regional breakdown of the data on parallel processes.

Parallel processes prior to and during the SAR		
Parallel processes	**Alongside the SAR**	**Prior to the SAR**
MAPPA case review	0	1
LSCB SCR	1	0
Coroner's inquest	16	62
Criminal investigation	9	60
Homicide review	6	1
Mortality review	1	2
Police conduct	2	5
Serious incident	3	36
Review none	90	13
Review other	8	51


Parallel processes
East
East Midlands
Greater London
North East
North West
South East
South West
West Midlands
Yorkshire & Humberside
crim investigation
coroners inquest
other
NHS serious incident
ind office police conduct
domestic homicide review
MAPPA serious case review
learning disability mortality review
childrens SCR
0
5
10
15
Parallel with SAR
Prior to the SAR

As the quantitative data indicates, the three main parallel processes involved were Coroner inquests, criminal investigations and NHS Serious Incident (SI) inquiries. Sometimes a SAR might be "paused" or "deferred" until other processes had concluded, such as referrals to professional bodies or adjudication of a complaint by the LGSCO. It was rare, however, for reports to clearly indicate whether parallel processes had run in tandem with the SAR or had preceded it. In any event, the conclusions reached by parallel processes, other than Coroner determinations, were not consistently reported, although there were occasional criticisms of an NHS Trust's Root Cause Analysis or SI for lacking detail or critical reflection.

There were examples where a SAR had been commissioned because a Coroner had indicated that there were lessons to be learned and instances too where a SAR report had been updated or a review panel reconvened because of matters being raised by a Coroner as requiring further investigation. Unfortunately, there were also instances when Coroner conclusions, MAPPA SCRs or SI reports had not been made available to SAR reviewers, despite the duty to share information to enable a SAB to comply with its statutory duties[54].

3.8. Annual reports

The statutory guidance requires that SAB annual reports provide information about any SARs either ongoing or completed within the reporting year[55]. SABs must indicate what has been done to act on the findings and, if particular recommendations have not been implemented, why. This is clearly one means by which the SAB can meet the safeguarding principle of accountability.

SAB practice here is not always compliant with the requirements of the statutory guidance. Indeed, not all SABs have yet complied with the requirement to publish an annual report[56] that details what has been done for one or both years included within this review. Where SABs have complied, the level of detail included is very variable, ranging from a few lines to six pages.

On the positive side are examples of 7-minute briefings being included in annual reports, or full details of the case, the learning points that emerged, the recommendations and subsequent action plans. Sometimes SABs in annual reports limit commentary to findings or learning themes, but in other instances indicate how SAR findings and recommendations have informed the SAB's strategic plan. Less common were examples where updates were provided in subsequent annual reports, although some SABs reported on dissemination events and outcomes of the implementation of recommendations.

Less positively there were examples where annual reports provided no reference at all to SARs that had been commissioned or completed, or made only brief and passing mention, possibly accompanied by a web page link, with insufficient detail to understand what a SAR had found and recommended. There were instances where annual reports did not name specific reviews or where the nomenclature for SARs had been changed, making tracking difficult. Sometimes an undertaking given in the 17/18 annual report to give an update in the following year was not honoured, even though the SAR had been completed.

[54] Section 45 Care Act 2014.
[55] Section 14.156 and 14.177.
[56] Section 14.136.

More usual was the failure to give any indication of what the impact of a SAR had been in terms of policy change or practice improvement. Doubt is then cast on the degree to which learning is continuous. The statutory guidance refers to a culture of continuous learning and improvement[57]. Annual reports are an opportunity for SABs to indicate how the focus on change and improvement is continuous but it may be a missed opportunity. Indeed, when SARs are published on SAB web sites but removed after a period of time, reminders of learning are lost and the danger emerges of a "start again" syndrome.

Improvement priority fifteen
SAB should review their reporting of SARs in annual reports to ensure compliance with the requirements of statutory guidance and the imperatives that learning is embedded, and the impact and outcomes of reviews evaluated.

Scrutiny by the Local Government and Social Care Ombudsman can focus on how lessons have been learned, how findings have been used and how recommendations have been implemented. Thus, in one instance, reasonable steps had been taken by relevant agencies to implement review recommendations, with clear time frames for completion and named individuals responsible[58].

3.9. Independence

The statutory guidance recommends that SARs should be led by individuals who are independent of the case and of the organisations whose actions are being reviewed[59]. The quality markers[60] also refer to a requirement for independence.

Where the reviewer's identity was specified in the SARs, most were indeed independent. Where SABs had decided to appoint reviewers drawn from amongst partner agencies, the rationale for this was generally not stated. A couple of reports commented that the lack of independence had created governance problems associated with a lack of challenge and acceptance of vague findings. With reference again to defensible decision making, reasons should be recorded when there has been a departure from statutory guidance.

3.10. Practitioner and agency involvement

The aforementioned statutory guidance advises that practitioners should be fully involved in reviews[61]. The quality markers[62] also refer to encouraging, enabling and supporting practitioners and managers to contribute directly to reviews.

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[57] Section 14.167.
[58] LGSCO and Nottinghamshire County Council (16 002 691) (2016)
[59] Section 14.167.
[60] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[61] Section 14.167.
[62] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.

Reports were generally silent on the contribution made directly by practitioners and managers involved in the cases being reviewed, and the support offered to them. Although, as the quantitative data has shown[63], learning events and/or interviews were common features of the SAR process, reports shed little light on what may be learned from the experience of participating, and facilitating participation, in a process ostensibly focused on learning but where practitioners and managers may be wary of reflective openness because of potential (disciplinary) repercussions.

More usual was commentary on agency involvement. Thus, on the positive side, reports comment on "lively and engaging" involvement and "positive commitment to the process." There are examples of IMRs being provided on time and to the openness of agency representatives to challenge, candour, self-criticism and learning. There are references to SABs offering guidance, briefings and/or training to IMR authors and/or panel members, and to agencies initiating changes quickly even as reviews were ongoing. There were examples, particularly in cases involving "whole home reviews", of cross-border cooperation between SABs and/or between local authorities, CCGs and other partners. There were also examples where SABs had cooperated with Community Safety Partnerships or Local Safeguarding Children Boards to ensure compliance with the requirements of different statutory mandates.

Agencies are under a statutory duty[64] to cooperate and contribute to SARs. There is also a duty to prove information when SABs exercise their power to request it in order to facilitate its completion of another statutory duty[65]. Quantitative data was collected on the number of agencies contributing to reviews. On average, 8 agencies provided evidence to each SAR.

Number of agencies contributing information to reviews										
Number of agencies providing evidence	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Mean	9.21	6.40	6.90	10.91	7.59	8.44	8.24	7.08	7.00	**7.88**
Median	8.5	6	7	7	7	9	8	8	6.5	**7**
Std Dev	3.21	2.30	2.48	10.86	2.86	2.84	2.44	2.33	2.31	**3.86**

Nonetheless, there were examples of practitioners such as GPs, specialist Police groups and agencies refusing to share information, complete IMRs or declining or being unavailable to attend learning events or "engage generally." One SAR described this as "puzzling and unfortunate" since it meant that information was lost to the review. Another referred to significant delay as a result. It was unclear how such concerns had been escalated through and by the SABs involved. Clearly SABs struggled to find effective ways of addressing a failure to cooperate, illustrating the limitations of SAB powers as codified in sections 44(5) and 45 Care Act 2014.

[63] Section 3.4.5 above.
[64] Section 44(5) Care Act 2014.
[65] Section 45 Care Act 2014.

Improvement priority sixteen
The national SAB network should engage with DHSC, ADASS, NHS England and Improvement and other national bodies responsible for services whose roles include adult safeguarding to reinforce agency and service compliance with their duties to cooperate and share information.

Particular obstacles arose with respect to reviews involving care homes, namely changes in ownership, providers ceasing to operate, poor recording or loss of records and/or staff leaving their posts. Poor or lost agency recording surfaced in other respects, such as inaccurate information being given or new information being uncovered after completion of the SAR, necessitating that the process be reopened.

There were mixed experiences of the interface between the duty to enquire (section 42 Care Act 2014) and the duty to commission SARs. On the positive side were comments that section 42 enquiries as a precursor were helpful in terms of fact finding and identifying immediate learning; on the negative side were concerns about the duplication of resources and delay whilst the enquiry was ongoing. Occasionally, there is reference to section 42(2) enquiries having begun but then being paused.

Sector-led improvement work has focused on understanding and implementation of the section 42 duty to enquire[66]. Further focus on the interface between the duty to enquire and the duty to undertake SARs may be helpful.

Improvement priority seventeen
Sector led improvement to consider whether further work on the interface between section 42 and section 44 Care Act 2014 would be helpful, especially in light of data from this national review regarding the frequency with which cases involving people who have survived abuse and neglect are reviewed.

The quantitative data specifically identifies whether the location of the abuse was regulated by the Care Quality Commission (CQC) and whether or not the CQC was included in the SAR. Across all SARs there were 80 reviews where at least one location of abuse was CQC regulated.

[66] See, for example, Hodson, B. and Lawson, J. (2019) *Making Decisions on the Duty to Carry Out Safeguarding Adults Enquiries: Suggested Framework to Support Practice, Reporting and Recording*. London: LGA and ADASS.

CQC-regulated locations of abuse by region										
Location is CQC regulated	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Yes	5	0	13	3	11	8	5	5	6	**56**
Some of the locations	1	1	9	0	3	4	1	3	2	**24**
No	11	6	40	12	23	15	16	8	8	**139**
Not specified	0	0	4	2	1	1	2	2	0	**12**

CQC involvement in SARs										
CQC involvement in SAR	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**Total**
Yes	1	0	5	0	3	2	2	3	1	**17**
No	8	5	11	4	11	13	10	5	4	**71**
Not specified	8	2	50	13	24	13	12	10	11	**143**
Total	**17**	**7**	**66**	**17**	**38**	**28**	**24**	**18**	**16**	**231**

Finally, reviews where one or more of the locations were CQC-regulated, and whether or not the CQC was involved in the review, can be analysed. This highlights that the CQC were only involved in a fifth (20 per cent) of cases where regulated locations were involved across all regions. However, the sample sizes here are low, and several regions had two or less cases where CQC-regulated locations were identified.

CQC involvement in SARs involving CQC-regulated locations										
CQC location AND CQC involved in SAR	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
N reviews	1	0	5	0	3	2	2	2	1	**16**
Percentage of reviews	17%	0%	23%	0%	21%	17%	33%	25%	13%	**20%**

It was rare for reviews to comment explicitly on whether the services involved were regulated by the CQC. Generally, there was little qualitative commentary on CQC's participation. On one occasion the SAR observes that CQC participated in the learning event and responded to questions. On another, CQC gave initial information but declined to be part of a panel or to participate further. Reasons for this were not specified. Reports focusing on whole home investigations gave most information about CQC involvement, identifying good practice and points for improvement in terms of cooperation with commissioners and providers, and use of statutory enforcement powers.

3.11. SAR quality

The quality markers[67] emphasise that analysis should be transparent and rigorous, with the report clearly and succinctly identifying its findings, including causal factors and systems learning. The report should illuminate the factors that enable good practice or increase risk in safeguarding practice. Analysis should refer back to the terms of reference agreed when the SAR was commissioned. Occasionally, the Local Government and Social Care Ombudsman has commented on quality standards. In one case[68], no fault was found with a learning review, which was judged to be thorough and proportionate.

The best reports demonstrated good concordance between the issues identified through analysis of key episodes or events and recommendations, made explicit use of the six adult safeguarding principles[69], and detailed how the SAB would be expected to monitor the actions arising from the SAR. The best reports were structured to illuminate findings, learning points and recommendations that clearly flowed from the case chronology and analysis, with sufficient examples to demonstrate what enabled and what obstructed positive practice, and what challenged the practitioners and services involved and their response.

The best reports drew on advice from experts and specialists, and drew in learning from other SARs, research and theory to underpin and reinforce the emergent learning. The best reports concluded the analysis and linked the findings and recommendations back to the terms of reference. The recommendations were SMART and CLEAR where the latter refers to recommendations that have established the case for change, are learning oriented, evidence-based, with responsibility assigned and review planned[70].

There were examples, however, of reports that lacked critical analysis and did not explore key lines of enquiry, for example the absence of safeguarding referrals[71], omitted risk management and safeguarding plans that had not been actioned, or delayed assessments and the challenges of working with someone who was very aggressive. There were examples of reports that did not refer back to or address the terms of reference, or that made no reference to family involvement or did not address all the family's reported concerns and questions. There were examples where it was unclear why the focus appeared to have changed from what was outlined in terms of reference. There were reports that gave incorrect dates and titles of legislation or perpetuated the incorrect belief that the Mental Capacity Act 2005 gives adults the 'right' to make unwise decisions. There were learning briefings that posed questions for readers but where it was not possible to infer whether these had arisen from poor or good practice. There were examples where recommendations were vague rather than SMART, for example "agencies should address Mental Capacity Act shortfall" or adopt a "person-centred" and "wider approach" to information-gathering.

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[67] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[68] LGSCO and Stockport MBC (18 014 455) (2019)
[69] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.13)
[70] Buckley, H. and O'Nolan, C. (2014) 'Child death reviews: developing CLEAR recommendations.' *Child Abuse Review*, 23(2), 89-103.
[71] For example, when an adult was continually placing themselves in situations of significant risk when dependent on alcohol and whose mental health issues appeared to impede attempts at safety and protection planning.

There were reports that were well organised and perceptive, reflective and informed by sound practice and research evidence. There were others where acronyms were not explained, where the report was not dated and did not appear to have been proof-read, and where how services were organised was unclear, leaving readers to fathom out how agencies were meant to work together.

These examples raise questions about where responsibility for quality assurance resides. There may be more than one answer for who has responsibility within each SAB partnership for "getting the governance right" but reviewing governance arrangements is important to ensure the standard of reports.

Improvement priority eighteen
SABs should review their approach to ensuring the quality of reports.

The emphasis above on findings and recommendations being evidenced-based reinforces an observation in the quality markers, namely that reports should be clear where knowledge about adult safeguarding comes from, and that research evidence about what constitutes good practice should be up-to-date and accurate. The quantitative data illuminates the number of SARs that drew on different types of knowledge in order to further understanding and analysis of findings. There were reports that made extensive use of research, guidance and theory. What is particularly striking, however, is that almost one quarter of SARs in the sample made no reference to any underpinning knowledge. Research on SARs involving self-neglect has expressed similar concern[72].

The evidence source most commonly referenced is statute, with 58 per cent of all SARs referencing legislation. This is followed by national statutory policy guidance, which was referenced by 47 per cent of SARs. Research findings and other elements of national policy are also well referenced, whist other SARs and inspection reports are not referenced frequently. The table below shows the frequency of referencing of differing types of sources by region.

[72] Preston-Shoot, M. (2020) 'Safeguarding Adults Reviews: informing and enriching policy and practice on self-neglect.' *Journal of Adult Protection*, 22, 4, 199-215.

Referencing of sources by region										
Sources referenced	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**Total**
Codes of practice	35%	43%	18%	24%	32%	29%	33%	22%	19%	26%
Inspection reports	0%	0%	15%	0%	11%	4%	21%	6%	13%	10%
Local policies	47%	29%	24%	24%	50%	43%	58%	11%	31%	35%
Other national policy	35%	14%	36%	18%	45%	39%	42%	22%	25%	35%
Other SAR diff SAB	0%	0%	11%	0%	8%	21%	42%	11%	0%	12%
Other SAR same SAB	12%	0%	9%	12%	0%	29%	17%	6%	0%	10%
Research findings	29%	14%	32%	29%	55%	64%	71%	39%	0%	41%
Statutory policy guidance	53%	29%	42%	24%	53%	54%	75%	33%	44%	47%
Statute	76%	43%	45%	41%	74%	57%	83%	61%	31%	58%
None	12%	57%	30%	53%	5%	21%	0%	17%	44%	23%
Other	53%	29%	29%	12%	26%	21%	38%	22%	19%	28%

Of particular interest, given the accusation in children's safeguarding of a failure to achieve effective change from SCRs[73] that sounds a warning for SABs, is the degree to which SARs draw on learning from other reviews completed locally and nationally. On the positive side are reports that look back to previous SARs locally and/or nationally and answer the questions of what is known about how prevalent or widespread particular issues are, and what best practice looks like. As one SAR commented, "this brings in relevant national guidance and research to contextualise the local issue in a national context."

There were terms of reference and SARs that explicitly referred back to previous reviews to explore where service provision had (not) improved, or to understand why learning from earlier reviews had not been embedded in practice. Thus, a focus fell on actions (not) taken by individual organisations and/or the SAB partnership. One report suggested strongly that the SAB should scrutinise reassurances that had been given previously by partner agencies and should work to embed and sustain change. Another challenged SAB partners as to why many of the recommendations arising from an earlier review had not been implemented.

However, alongside SARs that explicitly referred to other reviews, local or national, for cross-cutting themes, were instances where "other SARs" were referred to but not referenced or explored for their relevance. There were also instances where a SAR did not refer to previous reviews completed by the same SAB or other SABs on the same type of abuse or neglect, or to thematic reviews on different types of abuse and neglect that

[73] Wood, A. (2016) *Review of the Role and Functions of Local Safeguarding Children Boards*. London: The Stationery Office.

have been published. Examples here would include seminal reviews where the focus was on organisational abuse[74], self-neglect[75], hostile carers/family members who prevent access to an individual at risk[76], and hate crime[77] (discriminatory abuse). The risk, then, is that SARs are not informed by, building on and reinforcing the knowledge and evidence-base but, rather, are starting again. The incomplete national library or repository of SARs, and the absence of a search facility with which to explore the reviews that are contained therein, does not assist SABs and SAR reviewers to identify what may be relevant to a specific enquiry[78]. Equally, however, SABs must own their history and make available completed SARs to commissioned reviewers[79]. Commissioned reviewers should also conduct their own background research.

Moving beyond the use of other SARs, use of research and other evidence ranged from the very extensive to the very minimal. In terms of transparent analysis, there were examples where the Equality Act 2010 was quoted but where no details were given of the person's age, ethnicity and any other protected characteristics, and where there was no analysis of race, gender and culture. There were examples where references were listed in a bibliography but it was unclear how they had been used to inform the analysis. By contrast, there were instances where references were used in the text but not fully listed in a bibliography or in footnotes.

These quality issues suggest that SABs should be very clear what is expected from commissioned reviewers and from Board sub-groups that oversee management of reviews and/or panels that are specifically set up to support individual reviews[80]. The aforementioned quality markers refer to supervision and peer challenge. The only SARs in the sample that referred to supervision of reviewers were those where reviewers were using the Learning Together approach[81]. It does appear that, in some instances, the reviewer's background has influenced what they have focused on and/or that they have been more critical of the practice of their profession. Supervision and also input from a panel or SAR sub-group can help to avoid such pitfalls. Moreover, when the nature and complexity of the abuse and neglect being investigated are particularly challenging, as was evident in some SARs in the sample, supporting those responsible for the quality of the review will be especially important.

3.12. Publication

The section in the quality markers[82] on publication has not yet been completed. The statutory guidance simply states that SABs should consider publication[83].

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[74] Flynn, M. and Citarella, V. (2012) Winterbourne View Hospital: A Serious Case Review. South Gloucestershire Safeguarding Adults Board.
[75] Lawson, J. (2011) *Mr BB: Serious Case Review*. Westminster SAB
[76] Wood, T. (2014) *The Death of Adult D. Case Review Overview Report*. Newcastle Safeguarding Adults Board.
[77] Flynn, M. (2007) *The Murder of Steven Hoskin. A Serious Case Review*. Truro: Cornwall Adult Protection Committee. Independent Police Complaints Commission (2009) *Report into the Contact between Fiona Pilkington and Leicestershire Constabulary 2004-2007*. IPCC.
[78] Improvement priority 1 seeks to address this observation.
[79] Improvement priority 2 addresses the importance of SABs being aware of work undertaken historically.
[80] See improvement priority 18.
[81] Fish, S., Munro, E. and Bairstow, S. (2009) *Learning Together to Safeguard Children: Developing a Multiagency Systems Approach for Case Reviews.* London: Social Care Institute for Excellence.
[82] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[83] Section 14.179.

The quantitative data indicates that SABs published the full report in 82 per cent of cases (n=189/231). A variety of other publication methods were also used to disseminate findings and learning, most notably executive summaries, staff briefings and SAB responses. Attached to staff briefings in some instances were short questionnaires for practitioners and managers to complete to indicate how they would act upon the findings and learning for best practice in the SAR.

SAR outputs published by region										
Number of outputs by type	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Board response published	4	0	15	1	4	4	6	2	0	36
Exec summary in report	1	1	8	2		0	1	0	0	13
Exec summary standalone	6	4	18	3	4	4	4	3	2	48
Family resource	0	0	1	0	0	1	3	0	0	5
Full report	12	2	45	8	26	22	18	10	9	152
Other	1	0	7	4	3	3	4	0	1	23
Staff briefing	4	2	4	6	21	13	9	6	6	7

Here, outputs are shown as a percentage of SARs per region. A percentage of 50 per cent would indicate that a particular output type was available for 50 per cent of SARs in any particular region within the data set.

Outputs as a percentage of SARs per region										
% producing output type by region	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Board response published	24%		23%	6%	11%	14%	25%	11%		**16%**
Exec summary in report	6%	14%	12%	12%			4%			**6%**
Exec summary standalone	35%	57%	27%	18%	11%	14%	17%	17%	13%	**21%**
Family resource			2%			4%	13%			**2%**
Full report	71%	29%	68%	47%	68%	79%	75%	56%	56%	**66%**
Other	6%		11%	24%	8%	11%	17%		6%	**10%**
Staff briefing	24%	29%	6%	35%	55%	46%	38%	33%	38%	**31%**

is clear from the quantitative data that few SABs appear to have extended to family members the opportunity to provide their own commentary on the case and on the SAR process for publication.

Other means of disseminating SAR findings were principally publishing details in annual reports (10 mentions), PowerPoint presentations for seminars and conferences (5), and press releases (6).

Where a decision was made not to publish the full report, and sometimes also an executive summary, this was taken in order to protect the anonymity of the person and their family members. On occasion the decision was taken at the direct request of family members who had participated in the review.

Within this sample is at least one SAR where the SAB had maintained the person's anonymity but where, as a result of media interest, for example in the outcome of Coroner inquests and/or criminal prosecutions, the person's actual identity was already in the public domain. There are other instances where this has happened[84]. The relationships that SABs have established with the Crown Prosecution Service (CPS) and Coroners will be important here.

As the quantitative data also indicates[85], there was sometimes quite a considerable time lag between acceptance by the SAB of a report and publication. In their contributions to this national analysis, SABs did not comment on such delays although in a number of instances it was clear that their web sites were under development. What also potentially restricts learning is the decision by some SABs to remove their published SARs from their web pages after a period of time, often one year. Although usually archived and therefore capable of retrieval on request, in the absence of a comprehensive national library it is difficult to discern a rationale for this practice, when the focus should be on enabling a continuous conversation about what enables and what obstructs ongoing learning from completed SARs.

3.13. Improvement action

As one SAB commented in its contribution to this national analysis, "the real work begins once the review has been completed." The aforementioned quality markers point SABs towards consideration of what needs to be done to improve outcomes for adults and their families. However, the section on implementation and evaluation has not been completed.

SAB practice regarding the publication of (updated) action plans appears variable. Sometimes the final SAR report contains the first iteration of the action plan. Sometimes annual reports include (updated) action plans or accounts of what is proposed and what has been done to address a SAR's findings and recommendations. Sometimes SAB websites publish action plans and updates. Accountability as one of the six adult safeguarding principles[86] is especially relevant here. Sometimes there is no published information on how learning is being taken forward.

The same quality markers advise SABs to use a model of change that is wider than changes to procedures and training for staff. SARs themselves do afford some insight into how agencies have responded by indicating changes that services have begun to make as a result of their involvement through IMRs and other contributions to SARs. Within the sample 107 reports (46 per cent) gave some indication, sometimes quite extensive, of early

[84] For example, Luton Safeguarding Vulnerable Adults Board (2011) The Murder of Adult A (Michael Gilbert).
[85] Section 3.7.7.1 above.
[86] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.13).

action by agencies. Perhaps unsurprisingly, training (31 reports) and development or revision of policies and procedures (17 reports) feature prominently.

Within the practice domain, changes had been reported to assessment (23 reports); referrals, triage and pathways into provision (26 reports); recording (24 reports); hospital admission and discharge (11 reports); primary care, including responses to non-attendance and identification of high-risk patients (7 reports) and management of safeguarding concerns and alerts (6 reports). Within the domain of inter-agency working the change efforts mainly fell on enhanced working together (15 reports), use of multiagency meetings (9 reports) and information-sharing (15 references).

Within the organisational domain, changes were mainly reported on supervision, management oversight and staff support (15 references), and audit of practice (8 references). There were occasional references to changes with respect to staffing and commissioning. Within the governance domain were four references to changes implemented by SABs, five to services using the SAR for the purpose of learning and reflection, and eight occasions where SABs were advised to ensure that agencies had indeed implemented changes and to assess their impact.

SABs were asked when contributing to the national analysis to indicate what changes had resulted from the SARs that were included in the sample. 60 SABs (45 per cent) responded to this request for information. Once again, the development and/or revision of policies and procedures (42) and the provision of multiagency training (35) featured most prominently. In the domain of practice, there was a strong focus on improved referral practice and pathways to adult social care, adult safeguarding and/or mental health provision (20); assessments and reviews (17); hospital discharge arrangements (10); understanding and use of person-centred planning (8) and transition arrangements for care leavers (8).

Within the domain of inter-agency working, the main reported changes were improvements in joint working (22), including information-sharing, use of multiagency meetings, and understanding of roles and responsibilities. Recording and IT systems had also been enhanced in order to better identify and respond to the needs of adults at risk (10). Within the organisational domain, the main reported enhancements related to quality assurance and use of audits (20), and systems for commissioning and contract monitoring (15). Finally, within the governance domain, SABs reported changes in safeguarding partnership arrangements (13), including links with other Boards and Partnerships, and use of SARs for learning and practice and service development (10).

Whilst the feedback from SABs might be indicative of SAR outcomes, it is much less clear how sustained has been the focus on ensuring that changes have been embedded and sustained[87] and, therefore, what the impact has been on changing attitudes and beliefs, knowledge and skill acquisition, changes in practice, changes in organisational behaviour and, ultimately, benefits to adults at risk and their families[88].

Improvement priority nineteen
Sector led improvement to engage with SABs on how data can be captured on the impact and outcomes of review activity.

[87] Preston-Shoot, M. (2018) 'Learning from Safeguarding Adult Reviews on Self-Neglect: Addressing the Challenge of Change.' *Journal of Adult Protection*, 20(2), 78-92.
[88] Preston-Shoot, M. (2020) 'Making any difference? Conceptualising the impact of safeguarding adults boards.' *Journal of Adult Protection*, 22 (1) 21-34.

4. The Cases

4.1. Outcome of abuse and neglect

An individual had died in 188 of the 231 SARs (81 per cent) and survived in 39 (17 per cent). Note that in SARs focusing on the experiences of several individuals, 'alive' and 'deceased' may have been recorded therefore the total will not add up to 231.

Outcome of abuse and neglect by region										
Outcomes	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Alive	1	2	11	2	5	5	4	5	3	**38**
Deceased	15	5	53	13	33	23	21	13	12	**188**
Not specified	1	0	2	2	1	0	0	0	1	**7**
Total	**17**	**7**	**66**	**17**	**39**	**28**	**25**	**18**	**16**	**233**

The following table shows the types of abuse most likely to result in death, ie the likelihood of a type of abuse being in a SAR where a death was recorded. A figure of 100 per cent indicates that all SARs with the type of abuse recorded an individual as deceased.

Percentage of SARs recording death of an individual, by type of abuse and by region										
Type of abuse where death recorded as % of cases by type	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Discriminatory abuse	0%	0%	100%	0%	0%	0%	100%	0%	0%	**100%**
Domestic abuse	67%	33%	50%	0%	80%	50%	100%	33%	100%	**64%**
Financial/material abuse	100%	50%	100%	50%	100%	75%	88%	33%	0%	**80%**
Modern slavery	0%	0%	0%	0%	0%	0%	0%	100%	0%	**50%**
Neglect/omission	86%	100%	70%	100%	74%	83%	83%	80%	86%	**80%**
Organisational abuse	50%	0%	78%	100%	86%	75%	80%	100%	67%	**79%**
Physical abuse	100%	50%	83%	50%	82%	80%	71%	50%	50%	**71%**
Psychological/emotional abuse	100%	50%	100%	100%	67%	50%	50%	67%	0%	**68%**
Self-neglect	100%	67%	90%	86%	88%	88%	93%	75%	67%	**88%**
Sexual abuse	0%	0%	0%	0%	0%	0%	100%	40%	0%	**25%**
Sexual exploitation	0%	0%	0%	0%	0%	100%	0%	100%	0%	**40%**
Not specified	100%	100%	88%	50%	86%	67%	100%	100%	100%	**86%**
Other	0%	0%	100%	100%	100%	50%	100%	100%	0%	**91%**

The table shows how some types of abuse (discriminatory, financial, neglect, self-neglect) are more likely to be associated with the individual dying. (Note, however, SARs can feature several people (not all of whom died) and multiple types of abuse.)

Other thematic reviews[89] have also identified that the majority of SARs are commissioned with respect to individuals who have died. A future research question could explore whether cases involving adults with care and support needs, who have experienced but survived abuse and neglect, and where there is concern about how agencies worked together, are more likely to be referred for an adult safeguarding enquiry[90] rather than a SAR[91].

Where cause of death was reported by the SARs, the most commonly mentioned were:

Cause of death	
Sepsis	26
Heart and vascular disease, and cardiac arrest	26
Pneumonia	25
Fire	19
Suicide	16
Natural causes	15
Murdered	12
Malnutrition and/or dehydration	11
Alcohol intoxication and liver disease	11
Intestinal and bowel obstruction	9
Dementia	9
Diabetes	8
Kidney disease	5
Choking	5
Drug toxicity	4
Assault	4
Hypothermia	4
Road traffic accident	4

[89] For example, see Braye, S. and Preston-Shoot, M. (2017) *Learning from SARs: A Report for the London Safeguarding Adults Board*. London: ADASS. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.
[90] Section 42 Care Act 2014.
[91] Improvement priority 17 sets out how this question might be addressed.

There were also less frequent mentions of epilepsy, Parkinson's disease, hypothyroidism, cerebral palsy, cancer, respiratory failure, anorexia and peritonitis.

Two observations arise from the information provided by SARs relating to cause of death. The first is that in three cases cause of death could not be determined and in 7 SARs it was not recorded whether or not the individual had died. A theme throughout this section of the report will be that of imprecision.

The second observation is that, for a mandatory SAR to be commissioned, there must be a reasonable belief that the person died as a result of abuse and/or neglect[92]. The relationship between cause of death and abuse/neglect is not immediately apparent or commented upon explicitly in most reports. Rather, cause of death is simply stated descriptively.

Improvement priority eighteen addresses the issue of quality of reports. The examples of imprecision here and elsewhere in this section of the report can be factored into a review by SABs of their SAR governance arrangements.

4.2. Age and gender

Each SAR can feature several individuals, therefore for this analysis in total there are 263 people from 231 SARs. The quantitative data gives the breakdown of age and gender where this was reported in the SARs in the sample. The theme of imprecision emerges once more here. Sometimes age was not given or was described within a decade. Sometimes gender was not specified. It was hard to discern the rationale for such imprecision as SARs made no reference to it.

No gender was under/over-represented in the data. There were slightly more men featured, however this varied between areas.

Gender of individuals featured In SARs										
Gender	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Male	7	9	33	8	17	18	19	12	6	**129**
Female	10	4	28	6	23	13	10	5	10	**109**
Other / Transgender / Unknown[93]	1	1	7	4	5	1	2	2	2	**25**
Total	**18**	**14**	**68**	**18**	**45**	**32**	**31**	**19**	**18**	**263**

[92] Section 44(2) Care Act 2014.
[93] This category contains one case in which the individual was identified as transgender.

Gender can be contrasted to the national data from Section 42 enquiries. A ranked comparison of gender across all Section 42s indicates that the majority concern women (59 per cent); whereas for SARs, men are more prevalent (49 per cent). Statistical testing indicates **that gender differs significantly between Section 42 and SAR groups**[94]

Gender of people in SARs compared with gender of people in section 42 enquiries				
Gender	**Total s42**	**Percentage in s42 enquiries**	**Total SAR**	**Percentage in SARs**
Male	43280	40.2	129	49.0
Female	63785	59.3	109	41.4
Other / Transgender / Unknown	480	0.4	25	9.5

The average age in SARs was 55 years old (where age data was available). The average age varied considerable between areas and was shown to be statistically significant via a comparison of means (Analysis of variance[95]; $F_{8,187} = 2.64$, $p < 0.01$).

Age of individuals featured In SARs											
Age	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Number with age data available	15	12	50	11	33	26	24	13	12	26	**222**
Mean age	55.33	41.00	54.98	67.73	61.52	50.58	52.29	44.15	68.92	54.19	**55.07**
Median age	61	40.5	57	68	61	49	53	39	69.5	55	**55**
Std Dev age	23.66	18.34	21.86	21.53	25.47	19.64	21.62	19.28	18.90	10.32	**21.47**

[94] No correlation between ranks, Spearman's Rho p = 0.667

[95] Analysis of variance (ANOVA): A statistical comparison of the mean values between two or more groups which considers the mean and variance of data on numeric outcomes. For instance, the difference in age between men and women.

Number of individuals within each age group by region										
Age-group	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
0-17	0	0	0	0	1	0	0	0	0	**1**
18-29	4	4	7	1	4	3	5	3	0	**31**
30-49	2	3	13	1	4	10	5	4	2	**44**
50-69	5	4	14	4	9	7	7	5	4	**59**
70-89	3	1	12	4	11	5	6	1	3	**46**
90+	1	0	4	1	4	1	1	0	3	**15**
No age specified	3	2	18	7	12	6	7	6	6	**67**

Age can also be contrasted to the national data from Section 42 enquiries. For Section 42s the majority of enquiries are in the 85+ age group, with a decreasing number of enquiries as age become younger. Conversely, for SARs, the largest volume of reviews are in the 18-64 age range. Spearman's Rho[96] shows no correlation between the two populations ($p = 0.872$), **indicating that age differs significantly between Section 42 and SAR groups**. It should be noted that the age categories for Section 42 data are very wide, and do not allow for as detailed a comparison as the SAR dataset allows for.

Age of individuals in SARs compared with age of people in section 42 enquiries				
Age	**Total s42**	**Percentage in s42 enquiries**	**Total SAR**	**Percentage in SARs**
0-17	0	0.0	1	0.5
18-64	1128	3.5	120	61.2
65-74	2270	7.0	34	17.3
75-84	7031	21.7	16	8.2
85+	21973	67.8	25	12.8

[96] Spearman's Rho (or Spearman's rank): A non-parametric measure of correlation between two ranked lists of data. If the two lists are ranked exactly the same, there is a perfect correlation. The correlation strength is denoted by the r value ($r = 1$ is a perfect positive correlation), and the statistical significance by the p-value (if $p < 0.05$, the r value is significant). No correlation ($p > 0.05$) indicates that the two lists are independent of each other.

4.3. Sexuality and religion

The quantitative data gives the breakdown of sexuality and religion where this was reported in the sample. Very little religious data is recorded in SARs; however, unlike other categories, this may not be required unless relevant to the abuse / case.

Religion											
Religion	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Christian	0	0	3	2	3	1	1	0	1	0	**11**
Hindu	0	0	0	0	1	0	0	0	0	0	**1**
Jehovah's Witness	0	0	0	0	0	0	1	0	0	0	**1**
No religion	0	0	1	0	1	1	0	0	0	1	**4**
Not specified	18	14	64	16	40	30	29	19	17	25	**272**

Where people were, or had been, married or in a partnership with a member of the opposite sex, heterosexuality is usually presumed. In one review commentary on sexuality was avoided in the SAR, in a case involving a man and a male carer. The precise nature of the relationship emerged not in the review but in a presentation about the review's findings available online. Better and more consistent recording of sexual orientation in SARs would be valuable for diversity monitoring.

Sexual orientation											
Sexual orientation	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Heterosexual	4	0	1	1	4	3	0	0	0	0	**13**
LGBTQI+	0	0	1	0	1	0	2	2	0	0	**6**
Not specified	14	14	66	17	40	29	29	17	18	26	**270**

The theme of imprecision emerges again, therefore. The focus on sexuality emerges again in section 7, in the context of emphasising that practice should consider its impact on the concerns within cases and the responses to them. It is included as part of improvement priority twenty-three.

4.4. Ethnicity

The quantitative data reveals that in the vast majority of instances ethnicity was not recorded in relation to the individuals included in the cases being reviewed. Indeed, in 70 per cent of the SARs in the sample, ethnicity was not recorded. As such, minimal analyses can be conducted. Although the

primary category for cases where ethnicity data is provided is 'White', caution should be taken with the data, since it is not known what ethnicity people without specified ethnicity are. There may be a reporting bias that cannot be seen.

Ethnicity											
Ethnicity	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Asian / Asian British	5	0	2	0	1	1	1	0	0	0	**10**
Black / African / Caribbean / Black British	0	0	6	0	0	0	3	0	0	1	**10**
White British	0	0	0	0	0	0	1	0	0	0	**1**
White Irish	0	0	1	0	0	0	0	0	0	0	**1**
White	1	6	10	3	9	5	11	1	3	24	**73**
Multiple / mixed	0	0	0	0	1	1	0	0	0	0	**2**
Romanian / Roma	0	0	1	0	0	0	0	0	0	0	**1**
Not specified	15	8	46	14	33	25	15	18	15	1	**190**

This is a significant omission, not least because of the Equality Act 2010 and the obligations that this legislation imposes on public bodies to counteract discrimination. Indeed, sometimes SARs referred to the Equality Act 2010 but then failed to consider what impact race, culture, religion, language and ethnic origin may have had on the events being analysed.

To illustrate the imprecision, there were references to individuals who spoke "little English" or for whom English was their "second language" but without follow-up analysis of ethnicity and of how services responded. Again, one individual was noted to have come from the "Far East" and another from an unnamed "EU country" but without any further detail or analysis.

The lack of attention to ethnicity and other diversities has also been found in other thematic analyses of SARs and SCRs[97].

Improvement priority twenty

This research highlights the need for better recording of ethnicity in SARs. Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management, including recognition of unconscious bias.

[97] 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*. Bristol: South West ADASS.

4.5. Health conditions

The quantitative data demonstrates the range of physical and mental health conditions that were experienced by the individuals whose cases were being reviewed. People may have multiple conditions recorded; therefore totals may add up to more than the total number of people. The most commonly noted conditions were mental health and chronic physical conditions.

Health conditions in individuals featured in SARs											
Conditions	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Autism	1	0	3	0	5	5	4	3	0	2	**23**
Diabetes	4	1	10	3	5	4	6	1	0	0	**34**
Impaired mobility	7	0	17	4	6	4	2	1	1	4	**46**
Learning disability	2	5	11	3	5	11	5	7	2	6	**57**
Memory cognition	4	0	17	7	12	5	7	2	7	8	**69**
Mental	8	8	37	7	25	19	22	9	4	22	**161**
Physical acute	8	0	14	5	6	8	8	1	2	7	**59**
Physical chronic	12	2	32	9	22	22	9	5	10	7	**130**
Physical disability	3	1	7	0	5	7	0	1	2	1	**27**
Sensory impaired	3	3	2	1	3	1	1	0	1	0	**15**
Skin viability	5	0	8	1	4	7	4	3	2	1	**35**
Substances	4	4	14	5	11	8	7	3	4	4	**64**
Other	3	6	11	2	10	6	5	4	2	1	**50**
Not specified	1	0	5	3	2	0	1	3	2	0	**17**

Among the “other” health conditions noted in the quantitative table, the most frequently reported were epilepsy (11), Eating disorders and/or low weight (6), obesity (5), Communication difficulties (4), Incontinence (2), ADHD (2), Challenging behaviours (2) and alcohol-related disorders (2).

What emerges from detailed reading of the SARs is the complex interplay between physical comorbidities and between physical and mental ill-health, and the complex medical conditions which practitioners were called upon to manage. Such complexity illustrates the necessity of bringing together a bespoke team around the person. This complexity is illustrated by the following synopses drawn from SARs in the sample:

> “Problematic drug and alcohol use which had a highly detrimental effect on her mental health. Her lifestyle involved some offending behaviour leading to prison sentences and drug treatment orders. Her mental health needs and drug use significantly impacted on her levels of

dependency, susceptibility to coercion, her ability to appraise risks and to self-protect from abuse. When mental capacity assessments were carried out, she was deemed to have capacity for all decisions."

"X was visited by community nurses twice weekly to dress her legs and they used paraffin-based creams. She had recently been diagnosed with breast cancer, she had memory issues and compromised mobility. There was a history of domestic abuse perpetrated by her late husband; this left her with high levels of anxiety, which she minimised. Her son made a decision about discontinuing her care but her capacity had not been assessed and there is no indication she could not make these decisions herself."

"X had severe learning disabilities and autism. He was at risk of choking throughout his life and required a high level of staff support to maintain his wellbeing and safety. He had communication difficulties and mostly did not use verbal speech. X was diagnosed with epilepsy in childhood but had not had a seizure since 2007, developing these again in the last few months of his life. He had a 'club foot' which led to difficulties with mobility. As X grew older, he developed osteopenia, was unsteady on his feet and had numerous falls, resulting in fractures and bruising. He also had diagnoses of other complex co-morbidities including cataracts, chronic anaemia, vascular eczema, atrial hypertension and chronic atrial fibrillation. X had a number of capacity assessments and whilst he could make basic day to day decisions he was unable to make decisions about his heath, finances, treatment or accommodation."

"X had experienced an unprovoked and serious assault resulting in serious head trauma. As a consequence, he experienced a range of mental and physical health concerns immediately and over subsequent years, including slight cognitive impairment, depression (he was prescribed anti-depressants), drug and alcohol dependency, severe pain, epileptic seizures, heart disease and strokes, and double incontinence (catheter was fitted and he used continence pads). X was paralysed down his left side, with some mobility on his right side retained, leading to the use of a wheelchair and needing a hoist and two carers for transfers. He required access to 24-hour care, was largely bedbound on an airflow mattress, and needed assistance with all personal care tasks."

What also emerges from a detailed reading of the reviews is the significance of the impact of a life event, such as loss of a parent. That impact may well be hidden from view, at least initially, and highlights both the importance of time to establish a trustworthy relationship and skill in sensitively exploring emotional distress. The following synopses drawn from SARs in the sample illustrate these points:

"Kidney disease. Early emotional distress as a child; in early 20s depression, anxiety and bulimia. Type 1 diabetes diagnosed aged 15. On admission to hospital, lesions all over her body and pressure ulcers on knees and elbows."

"X became mentally ill in his 20s with psychotic symptoms. He separated from wife and daughter and lived alone, cared for by his mother and latterly his brother. He stopped taking his medication after his mother went into a care home in 2012 and reports of his misuse of alcohol began. By 2018 he was reported to be experiencing hallucinations and self-neglecting."

The theme of imprecision also emerges again when SARs are reporting on health conditions. In 13 SARs, vague or generic phrases, such as "poor health" were used. Such imprecision makes it difficult to establish links to types of abuse and neglect and to the care and support, housing and health needs experienced by the individuals themselves.

4.6. Living situation

The table below provides detail of where individuals were living. The most common living situations were living alone and living in a group situation. This was the same across most regions.

Living situation of individuals in SARs											
Living situation	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Alone	3	7	26	9	9	10	15	6	4	5	**94**
Carer	0	1	2	0	1	0	0	0	0	0	**4**
Children	2	1	5	1	4	2	1	0	0	0	**16**
Friends	3	2	0	1	2	0	1	0	0	0	**9**
Group	4	2	14	3	14	9	12	3	6	21	**88**
Homeless	1	2	2	0	3	4	2	0	2	0	**16**
Parent	4	2	4	0	7	4	0	1	0	1	**23**
Partner	1	2	6	0	9	1	0	3	2	1	**25**
Partner/children	1	0	1	0	1	0	2	1	0	0	**6**
Not specified	0	0	10	4	0	2	0	3	2	0	**21**
Other	0	1	6	0	2	2	0	3	2	0	**16**

Within the “other” category were instances of living in hospitals (3), residential colleges (2), shared tenancies (2), temporary accommodation (2) and with relatives (5).

There were twelve occasions where SARs recorded either past and/or present homelessness as characterising the person’s living situation, demonstrating that SABs are engaging with homelessness through the SAR process. The following extracts are illustrative:

> “After being evicted from his home X spent the next few months living in temporary accommodation before being made homeless and living on the streets in [place named].”
>
> “X had been living with her parents until a short time before she died. She left home and slept rough, then was given a temporary bed in local authority supported accommodation.”

What also emerges from the data is the instability of people’s accommodation and how quickly someone can become homeless. In respect of people experiencing homelessness, what the quotations below highlight is the importance not just of providing accommodation but also wrap-around support. The following extracts illustrate this instability:

"In the seven years covered by the SAR she lived alone but frequently had 'friends' staying; these people also exploited and abused her. In 2008 her home was taken over by drug users; in 2013 she was described as living in a drug den. She was intimidated and afraid. In 2008 she was described as subject to physical, emotional, domestic and sexual abuse by her 'housemates'. From 2014 she appears to be living alone but still subject to financial and possibly sexual exploitation."

"Persistently homeless after hospital and prison admissions. He was provided with hostel accommodation at least twice but was reportedly difficult and intimidating, causing damage on one occasion, so these placements did not last."

4.7. Accommodation of individuals featured in SARs

The quantitative data records the type of accommodation in which the people were living. Accommodation circumstances were not recorded in many cases. The most prevalent accommodation type where data was available was in a residential home, followed by accommodation let by a social landlord.

Type of accommodation of individuals featured in SARs											
Accommodation	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**No region given**	**All regions**
Homeless	1	2	2	0	1	3	2	0	2	0	**13**
Hostel	0	0	2	0	2	0	0	0	0	0	**4**
Owner occupied	4	0	3	5	8	0	2	2	2	0	**26**
Private landlord	0	0	2	0	5	3	1	1	0	0	**12**
Residential care	4	0	11	3	11	5	9	3	5	21	**72**
Social landlord sheltered	1	0	8	1	1	1	1	0	0	1	**14**
Social landlord standard	2	5	10	3	5	6	6	4	0	5	**46**
Not specified	6	7	30	6	11	11	4	5	7	0	**87**
Other	1	3	5	0	4	4	7	5	2	0	**31**

Within the "other" category, the main types of accommodation were noted as supported living (18) and hospital (6).

Once again there are examples of imprecision of description and/or analysis on whether accommodation was suitable for meeting the needs of the person. Equally, there are examples that highlight the importance of housing, health and social care practitioners working together to address a person's accommodation, health and care and support needs. The following extracts highlight these points:

"Poorly provisioned basement flat, poorly maintained, run down, damp, no shower facility. Landlord tolerant even when she had other drinkers there, Practitioners aware of her poor living conditions."

"X did move accommodation frequently as a result of racial harassment. He was also pursued for some time by a rent debt collection service, this caused him distress."

4.8. Location of abuse

Quantitative data records the different locations in which the abuse and/or neglect was experienced. As with type of abuse, multiple locations can be recorded. The person's own home was the most common location, which fits with the finding that self-neglect is the most common type of abuse.

Location of abuse										
Location of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Care/nursing home	6	0	8	3	9	2	4	5	4	**41**
Community (eg on the street)	2	1	2	0	0	3	1	0	1	**10**
Community service (eg day centre)	0	0	2	0	0	1	0	0	0	**3**
Hospital	3	1	5	0	3	7	1	3	4	**27**
Hostel/shelter	0	0	3	0	2	2	0	0	1	**8**
Own home – general housing	8	5	31	7	22	13	13	8	3	**110**
Own home – sheltered housing	0	0	7	1	0	0	1	0	0	**9**
Prison	0	0	0	0	1	0	0	0	0	**1**
Someone else's home	0	1	2	1	1	0	1	1	1	**8**
Supported living	1	1	4	0	3	4	4	1	0	**18**
Not specified	0	0	9	4	2	3	1	3	3	**25**
Other	1	1	6	1	1	2	1	3	1	**17**
Total	**21**	**10**	**79**	**17**	**44**	**37**	**27**	**24**	**18**	**277**

The principal recorded location under "other" was homelessness (5).

The same data is presented below, but as a percentage of the total number of SARs per area. However, because multiple locations can be recorded the percentages may not add up to 100 per cent by region. This table therefore provides a more balanced view of locations; for instance, that in the East Midlands, 71 per cent of SARs involved abuse in the home, compared to only 19 per cent of SARs in Yorkshire and Humberside.

Location of abuse as a percentage of SARs per region										
Location of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Care/nursing home	35%	0%	12%	18%	24%	7%	17%	28%	25%	**18%**
Community (eg on the street)	12%	14%	3%	0%	0%	11%	4%	0%	6%	**4%**
Community service (eg day centre)	0%	0%	3%	0%	0%	4%	0%	0%	0%	**1%**
Hospital	18%	14%	8%	0%	8%	25%	4%	17%	25%	**12%**
Hostel/shelter	0%	0%	5%	0%	5%	7%	0%	0%	6%	**3%**
Own home – general housing	47%	71%	47%	41%	58%	46%	54%	44%	19%	**48%**
Own home – sheltered housing	0%	0%	11%	6%	0%	0%	4%	0%	0%	**4%**
Prison	0%	0%	0%	0%	3%	0%	0%	0%	0%	**0%**
Someone else's home	0%	14%	3%	6%	3%	0%	4%	6%	6%	**3%**
Supported living	6%	14%	6%	0%	8%	14%	17%	6%	0%	**8%**
Not specified	0%	0%	14%	24%	5%	11%	4%	17%	19%	**11%**
Other	6%	14%	9%	6%	3%	7%	4%	17%	6%	**7%**

Once again there are examples of imprecision of description and/or analysis, as the following extracts illustrate:

> "It is not specified whether the self-neglect was in general housing or sheltered housing. The absence of any mention of housing related support staff would suggest general housing but it is not made clear."

> "It is not clear whose home it was when there was domestic abuse between X and a (former) partner and between X and their mother. Substance misuse took place in a variety of locations, including the street."

Data on location of abuse also highlights the challenges of adult safeguarding practice, as the summaries below indicate:

> "His self-neglect was apparent in every setting in addition to being homeless. He failed to attend appointments, did not comply with hostel requirements, would not engage with potential accommodation providers, and was often missing, with possible cannabis and other drug use in addition to alcohol."

> "Lived in housing association flat. Barred from the Housing Association office due to aggressive and threatening behaviour. Housing staff did not visit his accommodation for some time for the same reason. Some history of rent arrears. No reference in the SAR to gas checks."

4.9. Perpetrator of abuse

The quantitative data tables provide a statistical breakdown by region. The conditional highlighting of cells shows the most prevalent perpetrator type by region. For most areas this is 'self' (primarily related to self-neglect cases). However, in Yorkshire and West Midlands, care providers are more frequent (though note the smaller sample sizes here). The principal perpetrators under "other" were other residents, tenants or service users (7). In two instances system failure leading to neglect was recorded.

Perpetrators by region										
Perpetrator of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Care provider	5	1	22	3	11	8	6	7	6	**69**
Other professional	3	0	9	2	1	6	4	1	2	**28**
Partner/relative/friend/carer	4	4	6	2	15	3	3	5	2	**44**
Self	9	3	32	8	16	17	14	3	4	**106**
Social contact/acquaintance	1	2	2	3	1	4	4	3	0	**20**
Unknown to individual	0	1	1	1	0	2	0	2	0	**7**
Not specified	0	1	6	2	4	2	1	0	4	**20**
Other	0	0	5	0	3	1	2	2	0	**13**
Total	**22**	**12**	**83**	**21**	**51**	**43**	**34**	**23**	**18**	**307**

Perpetrator as a percentage of total cases by region										
Perpetrator of abuse	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**All regions**
Care provider	29%	14%	33%	18%	29%	29%	25%	39%	38%	**30%**
Other professional	18%	0%	14%	12%	3%	21%	17%	6%	13%	**12%**
Partner/relative/friend/carer	24%	57%	9%	12%	39%	11%	13%	28%	13%	**19%**
Self	53%	43%	48%	47%	42%	61%	58%	17%	25%	**46%**
Social contact/acquaintance	6%	29%	3%	18%	3%	14%	17%	17%	0%	**9%**
Unknown to individual	0%	14%	2%	6%	0%	7%	0%	11%	0%	**3%**
Not specified	0%	14%	9%	12%	11%	7%	4%	0%	25%	**9%**
Other	0%	0%	8%	0%	8%	4%	8%	11%	0%	**6%**

In the table above, perpetrator is shown as a percentage of cases by region: eg a care provider was the perpetrator in one third of cases in Greater London.

Imprecision is evident again here, as the following summaries of the data illustrate:

> "Unclear in the report but one allegation of physical abuse by the son, made by Mr X but subsequently denied by him, and concerns about pressure ulcer development and Mr X being left alone. Unclear to what degree the private care arrangement was implicated."

> "The available summary gives little detail other than the terms of reference that include a focus on domestic violence and the skills of the carer. The alert came from a school, concerned about the behaviour of one of the children."

Despite adult safeguarding enquiries and police investigations, it was not always possible to identify a perpetrator, especially where abuse or neglect occurred in institutional settings. In domestic abuse cases it was not always straightforward to distinguish between victim and perpetrator. Added complexity was evident when abuse or neglect was sustained from different sources. The following summaries illustrate these points:

> "Partner in relation to domestic violence although who was victim and who perpetrator is a question. Different agencies tried to support her but systemic issues prevented a better outcome."

> "The majority of perpetrators are described as friends or acquaintances, others as 'people' who may or may not be strangers to the person. The conception of the perpetrator as a 'friend' led to assumptions being made about the adult and their motivation/actions."

4.10. Relationships between variables

As well as looking individually and regionally at the nature of abuse, variables can also be combined. The tables (with heat map formatting) below show the relationships between abuse, perpetrator, and location. The formatting shows the highest frequency cells per row. For instance, in the first table, the formatting highlights that, where abuse is physical, the most likely perpetrators are partners (and relatives / friends), self, or social contacts.

One can also see that partner / relatives / friends were perpetrators in many of the different types by looking down the columns, although the most common perpetrator across all types is self (related to self-neglect cases). Due to the low frequency of observations in many of the cells, statistical comparisons would not be appropriate (observations do not meet criteria for chi-squared test[98]).

		Perpetrator by abuse type							
		Perpetrator							
		Care provider	Other professional	Partner / relative / friend	Self	Social contact	Unknown person	Not specified	Other
Abuse type	Discriminatory abuse	0	0	0	0	0	0	0	2
	Domestic abuse	2	1	20	9	5	1	0	1
	Financial/material abuse	5	1	13	16	12	3	0	1
	Modern slavery	0	0	2	0	1	1	0	0
	Neglect/omission	48	22	23	26	0	1	5	2
	Organisational abuse	27	4	1	6	0	1	3	1
	Physical abuse	9	2	19	13	14	3	1	7
	Psychological/emotional abuse	4	1	10	7	7	5	0	1
	Self-neglect	14	6	17	101	8	4	1	3
	Sexual abuse	2	0	4	1	6	4	0	3
	Sexual exploitation	0	0	2	2	5	3	0	0
	Not specified	12	3	3	5	0	0	13	1
	Other	1	1	1	5	3	1	1	1

[98] Chi-squared: A test of whether or not the data collected is as you would expect if there were no relationship between groups. The χ^2 value gives a measure of the independence of the variables, and the p-value gives a measure of statistical significance of the test. A p-value of less than 0.05 indicates that the groups are not independent.

The relationship between location and type highlights that the person's own home was the location in the majority of cases and across most types of abuse. The row-wise highlighting shows the most prevalent locations for different abuse types. For instance, abuse by neglect and omission was primarily occurring at home, but there were also a number of cases in hospitals and care homes. Sexual abuse on the other hand appears to happen across a variety of settings without being grouped around specific locations.

		Location by abuse type											
		Location of abuse											
		Care / nursing home	Community (eg on the street)	Community service (eg day centre)	Hospital	Hostel / shelter	Own home – general housing	Own home – sheltered housing	Prison	Someone else's home	Supported living	Not specified	Other
Type of abuse	Discriminatory abuse	0	0	0	0	0	0	1	0	0	1	0	0
	Domestic abuse	0	0	1	1	0	18	0	0	4	0	3	1
	Financial / material abuse	3	1	4	1	3	17	4	0	3	1	1	4
	Modern slavery	0	0	0	0	0	1	0	0	2	1	0	0
	Neglect / omission	26	1	1	15	0	42	4	0	3	6	2	1
	Organisational abuse	16	1	0	6	1	8	1	0	0	1	3	6
	Physical abuse	8	0	4	2	2	20	2	0	6	2	3	7
	Psychological / emotional abuse	4	1	3	1	1	10	1	0	4	1	0	1
	Self-neglect	5	1	8	8	6	68	5	1	3	5	11	5
	Sexual abuse	3	1	2	1	0	3	0	0	2	2	1	3
	Sexual exploitation	0	0	1	1	0	2	0	0	2	1	1	1
	Not specified	4	0	0	7	0	9	0	0	0	4	10	4
	Other	0	0	1	2	2	3	0	0	2	3	0	1

Finally, the relationship between perpetrator and location highlights the prevalence of self-neglect cases, and that these happen in many locations. The row-wise highlighting shows the most prevalent perpetrators for each location. For instance, in care homes and hospitals the primary perpetrators were care providers and practitioners, whereas in the home harm was mainly caused by the individual themselves or a partner, friend or relative.

		Perpetrator by location of abuse							
		Perpetrator							
		Care provider	Other professional	Partner/ relative/friend	Self	Social contact	Unknown person	Not specified	Other
Location	Care/nursing home	29	7	0	4	0	0	3	4
	Community (eg on the street)	1	1	0	1	1	2	0	1
	Community service (eg day centre)	1	1	1	8	5	3	1	1
	Hospital	15	13	1	9	1	2	2	0
	Hostel/shelter	1	0	0	6	2	1	1	0
	Own home – general housing	21	10	37	70	6	2	5	2
	Own home – sheltered housing	3	1	0	5	1	0	1	2
	Prison	0	0	0	1	0	0	0	0
	Someone else's home	0	0	7	3	4	2	0	0
	Supported living	7	3	1	5	2	1	2	1
	Not specified	4	1	3	11	3	1	7	1
	Other	7	2	2	5	5	1	0	2

4.11. Criminal prosecutions

The following table gives the statistical summary relating to criminal prosecutions:

1	Underway but not concluded		1.73%	4
2	No		53.68%	124
3	Not specified		28.57%	66
4	Yes (please provide details of outcome):		16.02%	37
			answered	231

Not all reports gave additional details of the outcome of concluded criminal proceedings, or why criminal investigations had been discontinued, highlighting again the theme of imprecision. However, the following outcomes were noted:

Outcomes of criminal prosecutions	
Custodial sentence	13
Suspended sentence	2
Section 37/41 Mental Health Act 1983	5
Conviction for wilful neglect	2
Conviction for murder	4
Conviction for sexual abuse offences	1
Conviction for serious assault	1
Acquitted	1
No charges brought	3

From the additional material included in SARs it is possible to discern several obstacles to obtaining criminal convictions, which are revisited in later sections of this report on poor practice and on SAR recommendations. Obstacles include:

- Procedural irregularities in adult safeguarding procedures can compromise achieving best evidence, indicating that those responsible for conducting adult safeguarding enquiries should be trained in achieving best evidence.
- Insufficient evidence to meet the criminal threshold, beyond all reasonable doubt, partly because of loss or inadequate recording, for example regarding changes in a person's behaviour in care settings.
- Insufficient use of special measures[99] to enable people with learning disabilities and people who have been sexually exploited, to access the criminal justice system.

[99] Youth Justice and Criminal Evidence Act 1999

- Inexperience of police officers and other staff in collecting and appraising evidence, including a failure to seek specialist advice, to consider the use of special measures (including advocates) and the lack of an investigation plan.
- Achieving prosecution was more likely if the victim was supported, cooperative and not abusing substances. Criminal prosecutions were less likely if there was no provision for the support of "vulnerable" witnesses during investigative interviews, over-reliance on self-report, limited agency recording of incidents and concerns, variable accounts from the people involved and inconsistent advice and support from practitioners.
- Lack of understanding of the impact of coercive and controlling behaviour on a person's willingness to disclose abuse or neglect.

4.12. Living situation, location of abuse and practitioner oversight

In 25 SARs in this sample, the individuals were either homeless or had experienced periods of homelessness. With the exception of the increasing number of SARs that include a focus on homelessness, the findings in relation to people's living situation and location of abuse is similar to that found in other thematic reviews[100]. Perhaps this is unsurprising given population demographics. However, it introduces an important question, namely whether reviews and oversight of care provision, in whatever setting it is offered, are sufficient robust, and whether health, housing and social care practitioners express sufficient professional curiosity and authoritative doubt when they have the opportunity to intervene to prevent abuse and neglect, or protect individuals from significant harm.

There were also examples where SARs focused on placements, mainly of young people and young adults transitioning out of children's services, which were neither regulated nor inspected. Mainly these young people were being placed in supported lodgings and semi-independent accommodation, often with inadequate information regarding whether they might present risks to other residents, or vice versa. As one SAB remarked when contributing to this national analysis, the outcome is that accommodation for some of the most vulnerable people is not overseen to ensure quality of provision. The outcome for some young people of inadequate commissioning and oversight of placements had been serious physical assaults and death. The subsequent section in this report on poor practice will revisit this concern.

Following sections on good and poor practice, and on SAR recommendations, pick up these threads.

[100] See, for example, Manson, S. (2017) *Report from a Thematic Review of Safeguarding Adults Reviews Within East Midlands*. East Midlands ADASS.

5. Themes and Recommendations

This section presents quantitative data on the key themes, observations on practice and recommendations made by the SARs for service improvement. SARs make many recommendations and reflections on both good and bad practice for multiple parties. These are categorised using the four domains of the analytic framework: direct work with the individual, interagency practice, organisational features and SAB governance. SARs may make recommendations relating to one domain based on good/poor practice identified in another: eg organisational domain recommendations as a result of poor direct practice.

The tables below show the number of good practice and poor practice comments per theme, as well as the number of recommendations made for this theme. Themes are sorted by the total number of observations and recommendations; the ratio of good comments to poor comments is calculated and colour coded. A ratio of 0.00 indicates that all comments on a theme were poor, and 1.00 indicates that all comments were good.

For direct practice, attention to mental capacity was the most prevalent theme. The majority of the observations in this theme were related to poor practice (19 per cent good practice comments). The ratio of good to poor comments highlights recording as a relatively prevalent theme in which almost all comments related to poor practice.

For interagency work, procedures and record sharing were particularly poor themes overall. Coordination and information-sharing were most prevalent and received the highest frequency of recommendations.

For organisational themes, a large number of SARs made no comments or recommendations at all. The majority of comments made were poor across all themes (mean ratio 14 per cent good comments). The most prevalent theme was organisational training, which related almost entirely to poor practice. Staff workloads was referred to almost exclusively in the negative and were a somewhat prevalent theme.

Fewer good/poor practice comments and recommendations were made overall for SAB governance and the majority recorded ‘none’. The most frequent recommendation was for sharing of the learning from the SAR, followed by quality assurance improvements. Policies and procedures related to self-neglect also came out strongly as a recommendation for SABs.

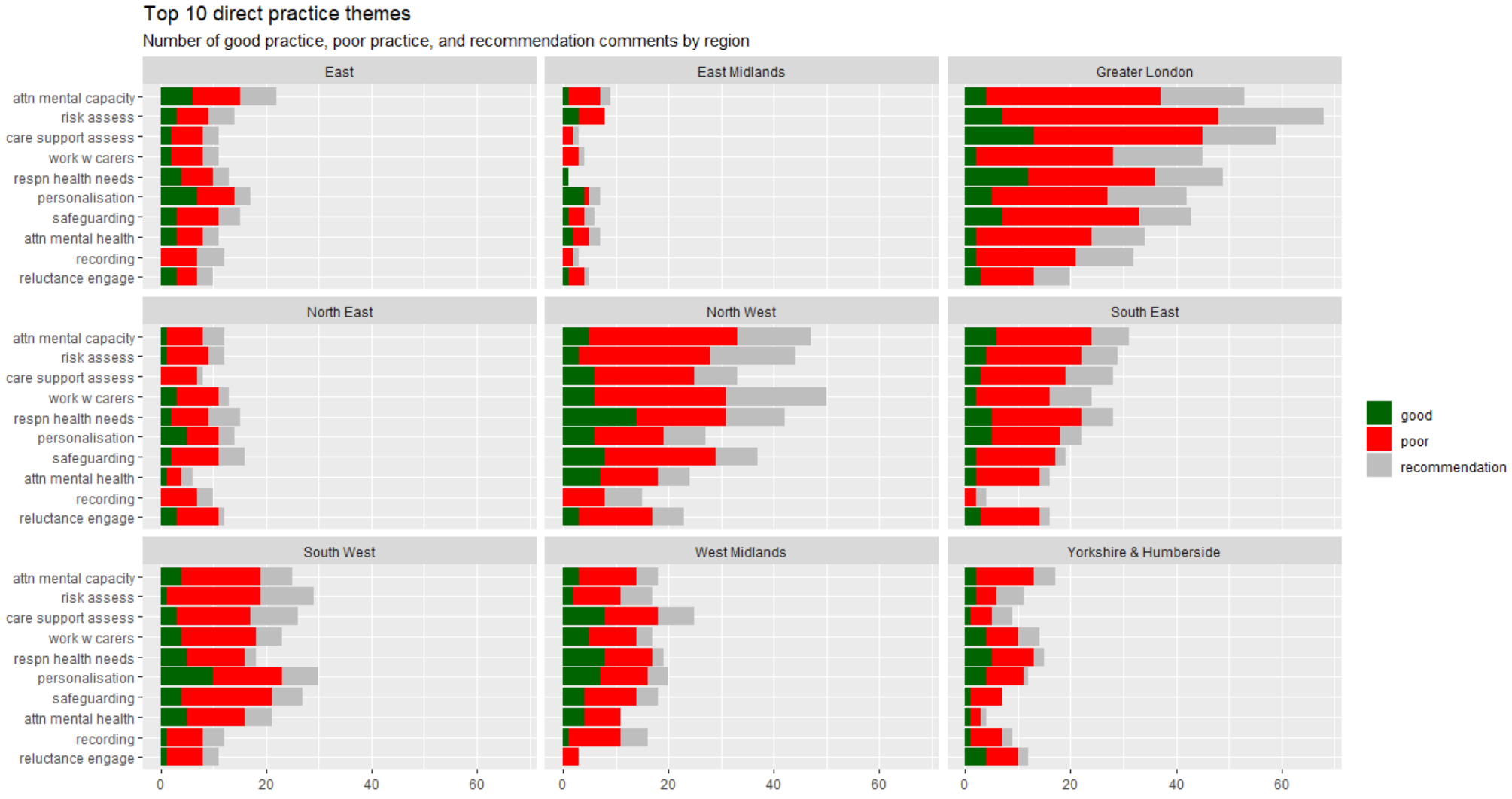
5.1. Direct work with the individual

Direct practice themes are sorted by the most frequently mentioned, and the top 10 are shown by region in the second chart below. The ratio of good to poor practice comments shows the percentage of comments that were good. For example, there were 5 good and 68 poor practice comments on ‘recording’ giving a ratio of 7 per cent. In total this theme arose 113 times (good practice, poor practice, and recommendations combined). On average, for all themes, 25 per cent of comments were on good practice and 75 per cent on poor practice.

The ratios direct attention to those themes where comments on practice were mainly negative, such as recording and understanding history. Other areas were more positive, such as continuity of practice, relationship-based work, and personalisation.

Most frequently mentioned themes in direct practice					
Direct practice theme	**Good**	**Poor**	**Recommendation**	**Total**	**Ratio good: poor**
Attention to mental capacity	32	138	64	**234**	19%
Risk assess	26	134	72	**232**	16%
Care support assess	36	110	56	**202**	25%
Work w carers	28	111	62	**201**	20%
Responding to health needs	56	99	45	**200**	36%
Personalisation	53	91	47	**191**	37%
Safeguarding	32	115	41	**188**	22%
Attention to mental health	27	76	31	**134**	26%
Recording	5	68	40	**113**	7%
Reluctance engage	21	66	25	**112**	24%
Use legal rules	11	56	30	**97**	16%
Hospital discharge	10	53	30	**93**	16%
Continuity	37	34	10	**81**	52%
Attention to living condition	14	42	18	**74**	25%
Advocacy	16	33	22	**71**	33%
Relationship based work	29	29	10	**68**	50%
Understanding history	5	46	15	**66**	10%
Responding to social needs	17	30	10	**57**	36%
Transition planning	6	24	18	**48**	20%
Attention to substance abuse	7	28	12	**47**	20%
Responding to domestic violence	7	21	14	**42**	25%
Responding to coercive control	0	17	8	**25**	0%
Responding to exploitation	3	9	6	**18**	25%
Attention to ethnicity	3	6	5	**14**	33%
Restraint	0	1	0	**1**	0%
Other	9	45	20	**74**	17%
Total	**490**	**1482**	**711**	**2683**	**Average = 25%**

The figure below gives the same information, split by region, indicating good and poor practice themes as well as recommendations. Bars that appear more red than green represent primarily poor practice in a given theme and region.

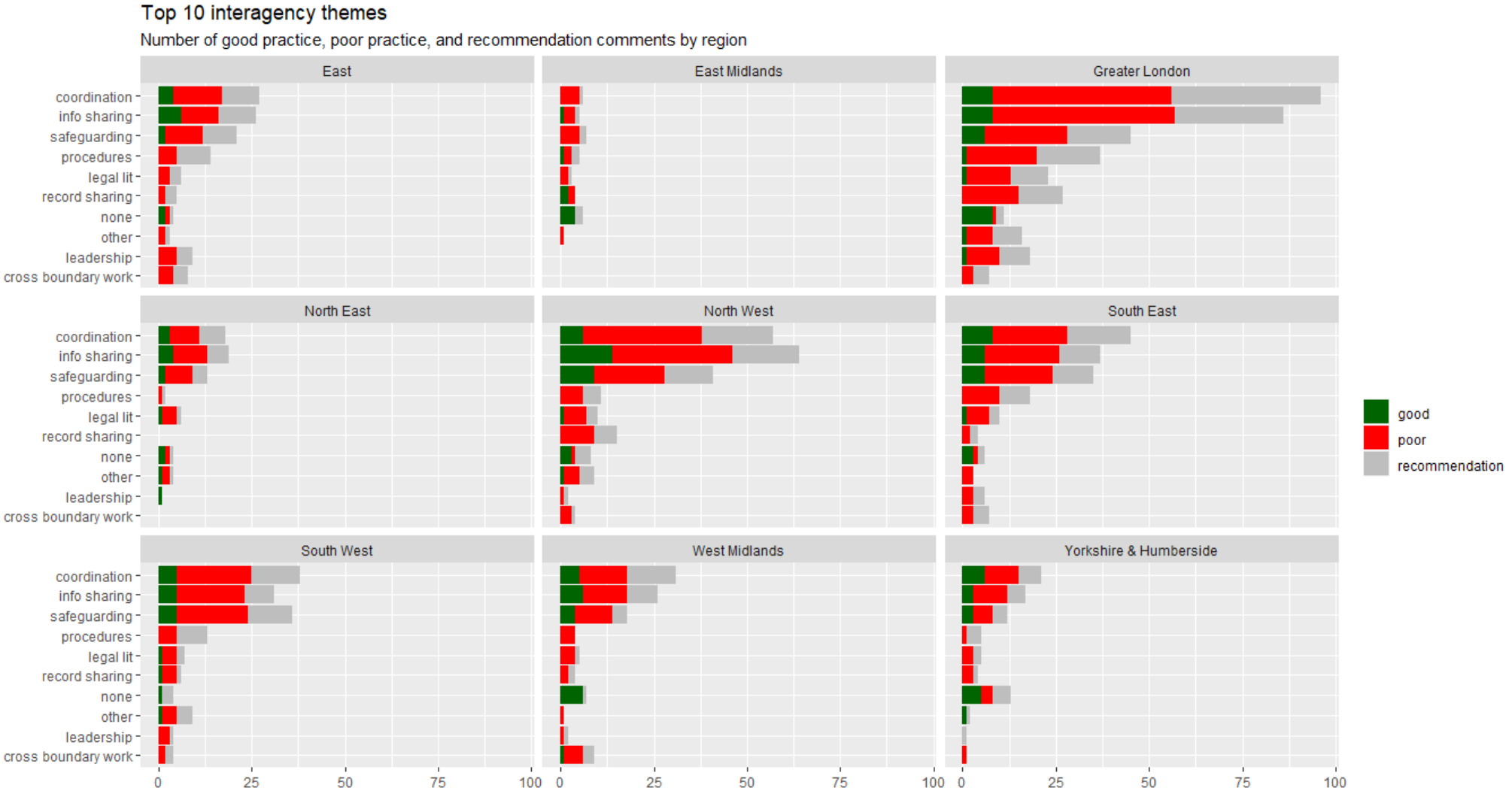


5.2. Interagency practice

Themes relating to interagency practice are sorted by the most frequently mentioned, and the top 10 are shown by region in the second chart below. On the whole, the majority of mentions were of poor practice. Those themes with high total scores and low ratios are of particular note, indicating where a theme is frequent, and consistently related to poor practice (such as interagency procedures and record sharing).

Most frequently mentioned themes in interagency practice					
Interagency theme	**Good**	**Poor**	**Recommendation**	**Total**	**Ratio good : poor**
Coordination	45	168	126	**339**	21%
Info sharing	53	162	96	**311**	25%
Safeguarding	37	115	76	**228**	24%
Procedures	2	53	54	**109**	4%
Legal lit	5	44	26	**75**	10%
Record sharing	3	39	27	**69**	7%
Leadership	2	22	19	**43**	8%
Cross boundary work	1	21	18	**40**	5%
Thresholds	0	12	8	**20**	0%
Other	5	24	19	**48**	17%
Total	**525**	**1633**	**794**	**1345**	**Average = 24%**

The regional breakdown shows where themes are positive / negative on the whole by region. It also identifies themes where a high number of recommendations were made, such as the large number of recommendations (grey bar) on coordination and record sharing in Greater London.

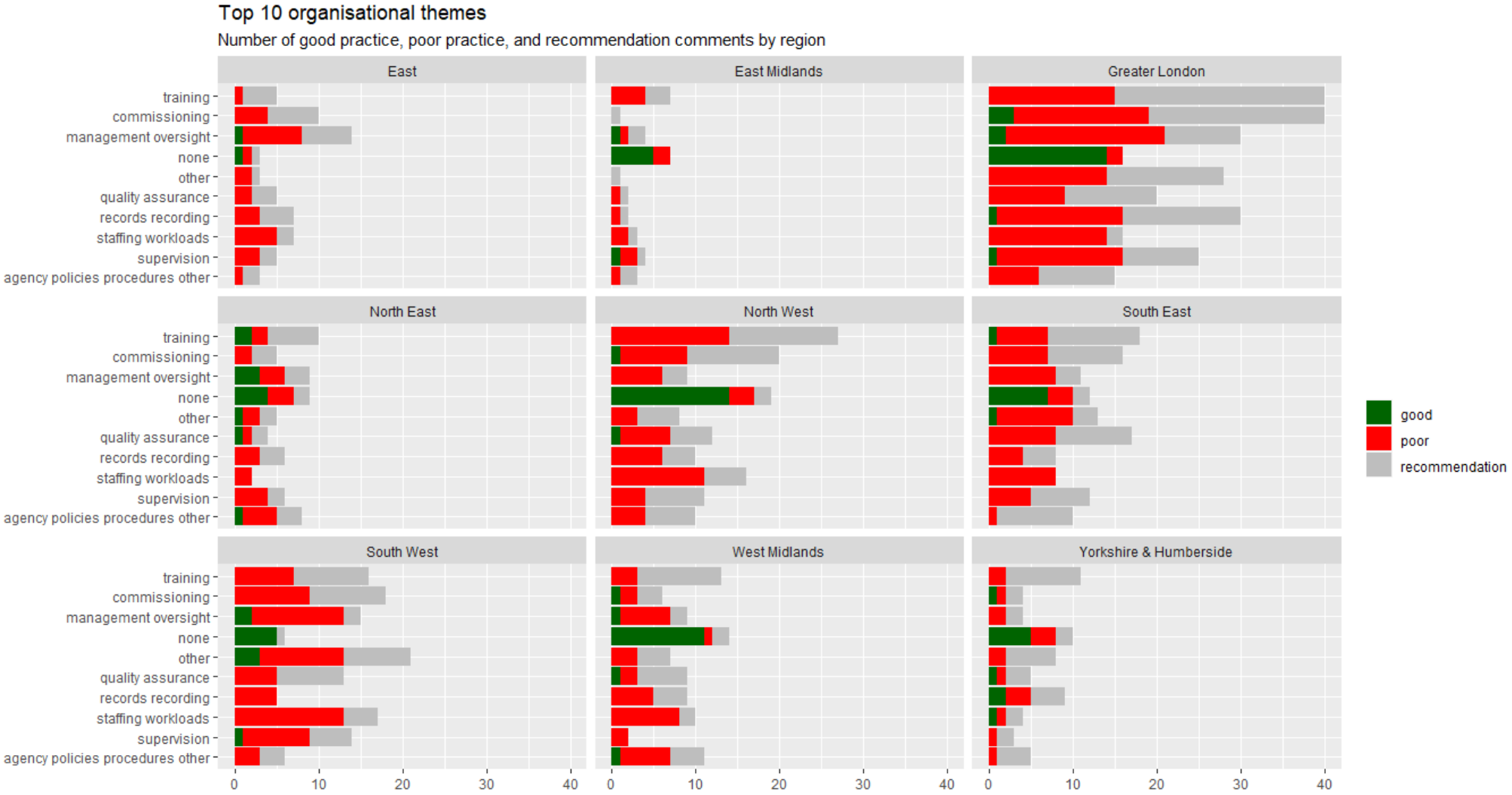


5.3. Organisational themes

On average, only 7 per cent of all comments on organisational practice were positive. Staff workloads and organisational resources were almost exclusively identified as poor practice, with more positive comments in other areas such as management oversight. A key recommendation was for organisations to provide training (the need for which could arise from findings about practice in other areas, such as direct work or interagency work).

Most frequently mentioned themes relating to organisational features					
Organisational theme	**Good**	**Poor**	**Recommendation**	**Total**	**Ratio good : poor**
Training	3	54	90	**147**	5%
Commissioning	6	49	65	**120**	11%
Management oversight	10	63	32	**105**	14%
Quality assurance	4	35	48	**87**	10%
Records recording	3	45	38	**86**	6%
Staffing workloads	1	64	18	**83**	2%
Supervision	3	44	35	**82**	6%
Agency policies procedures other	2	27	42	**71**	7%
Resources	2	49	20	**71**	4%
Staff support	4	30	34	**68**	12%
Agency policies procedures escalation	3	26	32	**61**	10%
Access to specialist advice	4	30	26	**60**	12%
Agency culture	0	31	20	**51**	0%
Agency policies & procedures IT systems info sharing	1	20	28	**49**	5%
Agency policies & procedures care pathways	1	18	29	**48**	5%
Agency policies & procedures risk assessment	0	21	23	**44**	0%
Agency policies & procedures assessment	1	14	26	**41**	7%
Agency policies & procedures hospital discharge	1	19	19	**39**	5%
Agency policies & procedures commissioning	1	17	20	**38**	6%
Agency policies & procedures self-neglect	0	14	18	**32**	0%
Agency policies & procedures mental capacity	0	11	14	**25**	0%
Agency policies & procedures transition	2	9	14	**25**	18%
Other	5	45	44	**94**	10%
Total	**57**	**735**	**735**	**1527**	**Average = 7%**

The top 10 themes are shown by region in the chart below

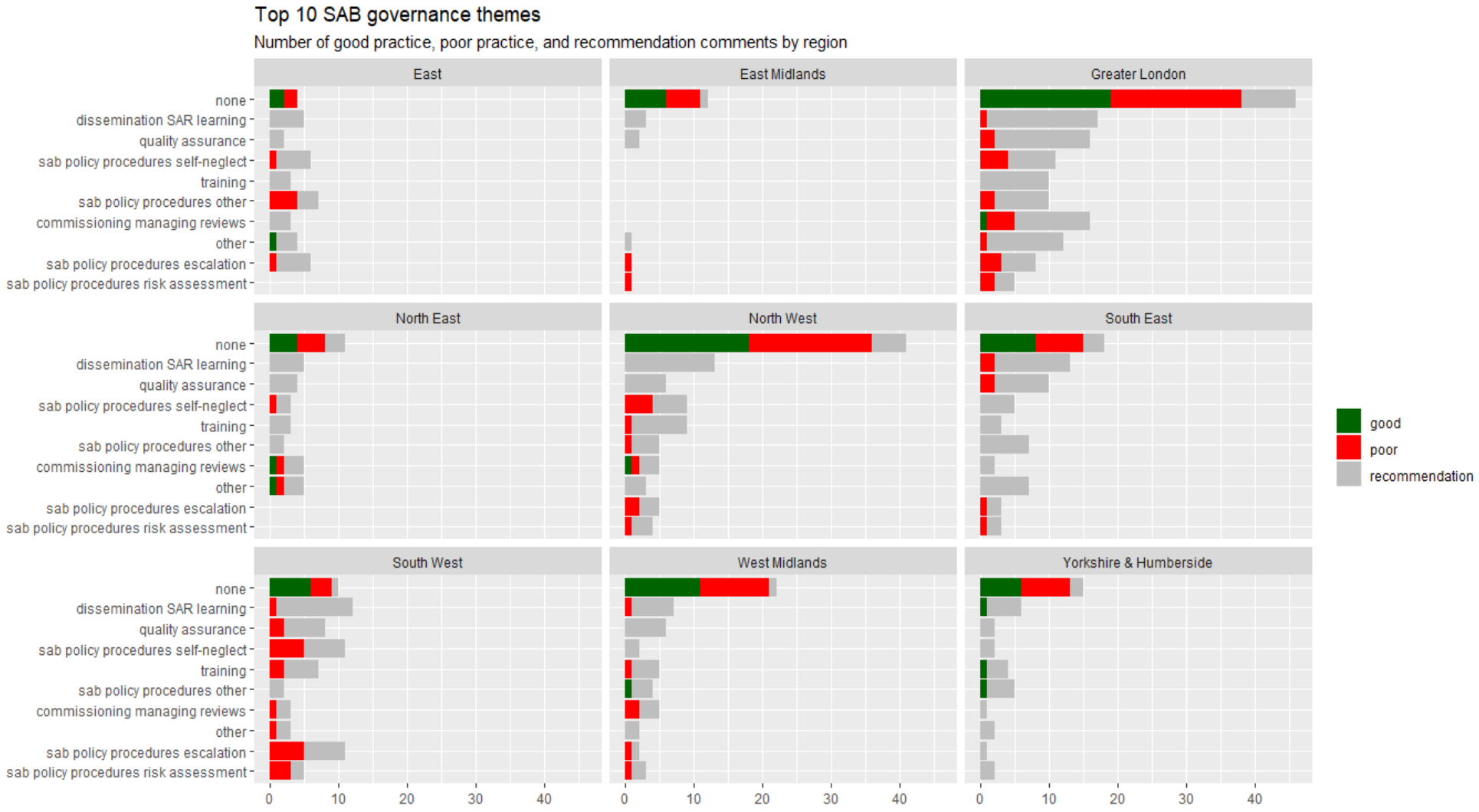


5.4. SAB governance

Finally, themes for SAB governance are recorded, and the top 10 are shown by region in the second chart below. Many SARs did not record any recommendations or comments on SAB governance and several of the themes that were recorded appeared only rarely so should be treated with caution in interpreting the table and the chart.

Overall, comments on SAB governance where mainly poor, with just 9 per cent of all comments on good practice. Particular areas noted for improvement were quality assurance, policies on self-neglect, and policies and procedures for escalation. Some areas received relatively few comments on good or poor practice but a large number of recommendations, such as the SABs' responsibility to disseminate findings. SAB recommendations could also arise in response to good or poor practice in other domains.

Most frequently mentioned SAB governance themes					
SAB governance theme	**Good**	**Poor**	**Recommendation**	**Total**	**Ratio good : poor**
Dissemination SAR learning	1	5	75	81	17%
Quality assurance	0	6	50	56	0%
SAB policy & procedures self-neglect	0	15	34	49	0%
Training	1	4	39	44	20%
Sab policy & procedures other	2	7	33	42	22%
Commissioning managing reviews	3	9	28	40	25%
SAB policy & procedures escalation	0	14	23	37	0%
SAB policy & procedures risk assessment	0	9	14	23	0%
SAB policy & procedures mental capacity	0	8	11	19	0%
SAB governance links	0	4	14	18	0%
SAB policy & procedures referral pathways	0	6	9	15	0%
SAB policy & procedures IT systems info sharing	0	5	9	14	0%
SAB policy & procedures assessment	0	3	3	6	0%
Leadership	0	1	3	4	0%
Membership	1	0	3	4	100%
SAB policy & procedures commissioning	0	0	4	4	-
SAB policy & procedures transition	0	0	3	3	-
SAB policy & procedures hospital discharge	0	1	0	1	0%
Other	2	3	34	39	40%
Total	**10**	**100**	**389**	**499**	**Average = 9%**


Top 10 SAB governance themes
Number of good practice, poor practice, and recommendation comments by region
East
East Midlands
Greater London
North East
North West
South East
South West
West Midlands
Yorkshire & Humberside
none
dissemination SAR learning
quality assurance
sab policy procedures self-neglect
training
sab policy procedures other
commissioning managing reviews
other
sab policy procedures escalation
sab policy procedures risk assessment
0
10
20
30
40
good
poor
recommendation

6. Good Practice

SARs sometimes commented on good practice observed across the four domains: direct work with the adult; the interagency team around the adult; features of the organisations involved; and the governance role of the SAB. At times the practice described was in line with what might be termed 'expected practice' rather than practice that exceeded expectations, but SARs by and large did not make this distinction and the analysis below includes all positive commendations given.

6.1. Domain A: The adult – direct work with the individual

The observations of good practice can be grouped into two broad categories: assessing and meeting needs, and making safeguarding personal. These are explored below, followed by a final cluster of diverse commendations.

6.1.1. Assessing and meeting needs

High standards of practice were noted across a range of practices: assessment of need and risk, provision of social care, responses to mental and physical health needs, management of risk and consideration of mental capacity.

Local authorities were commended for timely responses to referrals, thorough and detailed assessments, and quick decision making.

> "All requests that were made to ASC for support for X were allocated promptly and screened appropriately in terms of urgency and risk to inform response times. Decisions that were required to secure additional funding or increases were made quickly via the electronic systems workflow."

One SAR commented positively on how the impact of self-neglect on an individual's needs had been recognised and an appropriate plan made to address it. Another noted that an assessment prior to hospital discharge had been informed by a home visit. An occupational therapy assessment was noted as having been particularly thorough. In one case of privately arranged and funded care, the care agency was commended for a comprehensive set of assessments, which included

> "An assessment of X's needs, a risk assessment in relation to the home environment and an assessment of X's mental capacity in relation to key decisions. The assessment took place early in the day before he had drunk any alcohol … The quality of assessments was good, and considered his smoking, potential fire risk and issues of capacity (including executive and decisional capacity)."

Some SARs commented positively on comprehensive care and support plans that took a holistic approach.

> "The local authority care and support plan included not only physical elements such as promoting a routine for personal care and prompting X to undertake her insulin injections, but also psycho-social needs eg encouraging socialisation."

> "As well as addressing health needs the care plan included referral to the fire service for fire prevention checks, obtaining a gas detector, getting a telephone landline installed and access to Careline."

Several SARs noted that care and support plans had been reviewed and increased in response to changing circumstances. One commented on the significant time and investment made to improve living conditions in a person's home. Another noted the significant efforts of a district council to locate appropriate accommodation. Another commended the way in which moves between placements had been managed. In relation to younger people, good transition practice was noted, in one case involving consideration of a range of options and adherence to the young person's preference. In another, a clear pathway drew positive comment:

> "There is evidence of pathway planning as a care leaver, with a keyworker and pathway plan, support into training for employment and independent accommodation."

Health providers were commended for attentive responses to injuries and careful enquiries into their possible causes, timely responses by GPs to concerns about physical health, management of medication, annual health checks on a range of conditions, vigilance of nursing home staff about a resident's deteriorating health, timely hospital admissions, thorough medical and nursing care and timely mental health assessment.

> "During X's hospital admissions, a wide range of professionals assessed, and attempted to meet, her needs. Appropriate and timely attention was given to her mental health, including whether she might have an eating disorder or memory problems, as well as to her wide-ranging medical care needs."

Several SARs commented positively on parity of esteem and avoidance of diagnostic overshadowing:

> "The CPA assessment and plan included diabetes so there is evidence of physical and mental health needs being assessed."

> "The hospital sought a second medical opinion and were very concerned to avoid 'diagnostic overshadowing'".

Good practice by specialist services, such as those in the fields of drugs and alcohol, speech and language, and chronic pain, was noted in several cases:

> "Concerns about X's difficulties with swallowing and bolting of food … led to an immediate referral to the speech and language service and a prompt assessment was completed and a plan put in place. This was good practice."

> "The input … demonstrated a high level of specialist clinical analysis … The assessment made recommendations that, for the first time, provided a potential long-term avenue for addressing core issues … as opposed to treatment focused on addressing specific symptoms. The value of this service in helping local clinicians understand the problems they were dealing with should not be understated."

Other agencies commended for good practice in assessing and meeting needs included a residential school, the police and voluntary organisations - particularly those working in the homelessness field:

> "Significant effort was made by third-sector organisations working with X to provide support during his period of homelessness."

One SAR, reporting historical evidence that sexual exploitation offenders had been insufficiently targeted, explicitly considered whether Police decisions had been adversely influenced by factors observed in other areas, finding that it had not:

> "In (this case) decisions about taking action were not influenced by lack of concern or interest, misplaced fears about political correctness or fear of being seen as racist. Neither was there any evidence of ineffective leadership or inappropriate interference by senior officials or political leaders to prevent action being taken that have been a feature of reviews elsewhere."

Risk assessment and management by a range of agencies drew positive comment in some SARs. Examples include fire risk evaluation, police missing person risk appraisal, management of risks from food consumption, risk awareness by bailiffs, risk recognition by a RSPCA officer and joint action between police and ambulance crew.

> "Risk assessments were in place regarding locking things away, safety at mealtimes and mouthing inappropriate items and the risk of choking at mealtimes."

> "The concern, confidence and tenacity of the RSPCA officer who reported observations made at X's home of possible self-neglect when attending a report of possible cruelty to animals within the property … demonstrated good practice."

In several cases SARs commented positively on how risk had been discussed with the individual concerned:

> "[The social worker] undertook a sound assessment and explored X's understanding of risk in a sensitive and thoughtful way."

SARs commended safeguarding action that had been taken in response to risk. The Police were noted to have responded appropriately to domestic abuse incidents in several cases, including application for a Domestic Violence Protection Order and use of disclosure.

> "The decision to implement the Domestic Violence Disclosure Scheme meant that X would be more fully informed of Y's history when making future decisions about her relationship with him. This was good practice on the part of the Police and their MARAC partners."

Police officers were also proactive in relation to anti-social behaviour towards a family, provided funding to bring a homeless man back to their own area to protect him from abuse experienced elsewhere, ensured that a photograph of a man with dementia prone to wandering was on record, took a sensitive and proportionate approach to wandering, and recognised and referred individuals' support needs to Adult Social Care.

A hospital was also commended for exemplary practice in responding to domestic abuse.

> "The way this disclosure of domestic abuse was managed by staff … was exemplary, with several examples of good practice:
> - Providing the space and opportunity for X to make the initial disclosure;

- Following initial disclosure, the involvement of the Named Nurse for Safeguarding, who would have specific training and skills for this role;
- Conducting and accurately recording a robust risk assessment;
- Making appropriate MARAC and IDVA referrals based on the high-risk assessment."

Other examples of good practice relating to risk include: a direct payments team being proactive in responding to discrepancies between care plans and care delivered, working robustly to identify transferable risk to others; a GP increasing repeat prescription frequency to reduce risk of overdose; a GP listing a patient to ensure urgent home visit responses to all contacts; practitioners assessing environmental factors such as hygiene risks and checking for food storage and availability; a residential school implementing a rigorous risk management regime in response to forensic assessment findings. Emergency services were commended for quick, robust action and for thorough assessment of situations they were called to, including swift action to ensure the safety of residents in a care home where a resident had become hypothermic:

> "Assessments by Police and Ambulance crews were thorough, with attempts to link him with appropriate resources."

> "Once X's needs came to the notice of the ambulance service … the response was proactive, both in recognising and responding to the risks of her condition and in identifying and securing appropriate management of the risks to other residents."

In some cases, SARs commented positively on the formal reporting of concerns to the local authority's safeguarding team. Ambulance services, GPs and a local supermarket were commended for this.

> "The ambulance service demonstrated a systematic and robust approach to reporting and escalating safeguarding concerns."

> "Safeguarding referrals were raised appropriately by a range of people, including the local supermarket."

> "The GP practice demonstrated effective initiation of the Safeguarding policies and made contact with the safeguarding team for advice and support which was promptly given."

Attention to mental capacity received positive comment, SARs noting evidence that capacity (including fluctuating capacity) was considered at appropriate decision points, including those in which an individual was refusing support, that an 'asset-based' approach was taken, that best interests decisions were robust, including the need for DoLS to be applied, and that outcomes were clearly recorded. In one case practice was seen as exemplary in that it involved a joint approach (the adult social care decision maker taking advice from a specialist health practitioner), evidence of detailed discussions with the individual, and the assessment record clearly mapped against the Mental Capacity Act 2005 requirements and the guidance of the Code of Practice[101]. Another SAR commented on the fine-tuning that was applied to decisions of differing levels of complexity:

> "There is evidence from the records that agencies did apply the MCA to decisions that needed to be made. He was given as much control over his daily life as possible by support staff, such as choice of clothes or activities, but … action [was] taken to determine whether he had the capacity to make bigger decisions such as where to live or how to manage his finances."

[101] Department of Constitutional Affairs (2007) *Mental Capacity Act 2005: Code of Practice*. London: The Stationery Office.

6.1.2. Making Safeguarding Personal

Much of the good practice noted in the SARs related to how practitioners worked to 'find the person', seeking to understand their perspective and to make safeguarding personal. Although from a range of different agencies, the practitioners commended showed common personal qualities and skills.

Commitment, compassion and humanity were commonly used words in describing what was seen as good practice:

> "There were many examples of agency workers being tenacious and compassionate, often putting themselves in risky environments to try and provide support."

> "Some staff showed humanity in the moment in responding to his needs."

Perseverance, persistence, tenacity, and determination were noted as playing an important role when people were reluctant to engage. Practitioners persevered with efforts to intervene, continuing to extend offers of support, recognising the time needed to build trust, making multiple visits, sometimes despite a highly adverse environment and risk to themselves.

> "The evidenced attempts and commitment from community based and homelessness services … and their endeavours to overcome barriers, progress referrals and to support X in a person-centred approach should be highlighted and commended."

> "The Police showed commitment and determination to resolving the issue in the block, and committed a large of amount of resource, often visiting the housing block daily."

Flexibility: Practitioners were commended for being flexible in their approach. Sometimes this involved abandoning expected professional and practitioner routines such as surgery or office-based appointments in favour of home visits, mentioned as good practice in a number of SARs. When home visits didn't get a response, support workers used contacts in the community to monitor wellbeing. Practitioners were recognised for their creativity:

> "The GP and PCSO showed personal commitment (as opposed to being driven by procedural imperatives)."

> "The hostel worker recognised that X did not want to engage in emotional problem solving and focused target-setting conversations through playing chess with X – a good attempt at fostering engagement."

> "Some attempts to engage X were relatively successful. What worked well was seeing 'her' rather than the behaviour, and not being too concerned with eligibility."

Continuity was recognised as an important contribution to building trust. Some SARs commended a number of care agencies for their efforts to ensure continuity of care worker, and noted in one case how the GP, care coordinator, nurse, mobile meals service and a psychologist had maintained consistent contact with the individual. In one case, a supported living provider had purchased a bungalow to ensure they could continue to meet an individual's changing mobility needs and in two cases employment practices had facilitated continuity**:**

> "The hospital … employed carers from the residential home where he had lived for a long period, so they could support him throughout his hospital stay."

> "When a new care provider took over the support contract, three carers remained within the supported home with X, which demonstrates appropriate and considerate management of staffing."

Professional curiosity was commended as an important skill in gaining an understanding of the individual, recognising the significance of their history: childhood trauma, loss, bereavement.

> "These agencies understood his losses, frustrations, anger and hopelessness."

> "They knew of X's history of a childhood mainly spent in care with little stability."

On one occasion it enabled practitioners to secure agreement to provide access:

> "The professional curiosity and resilience demonstrated by the officers attending resulted in them gaining access to the property having tried persistently for over an hour."

Communication skills were recognised as a positive attribute, enabling practitioners to be creative and sensitive in their interactions with individuals. Several SARs commended the use of telephone-based interpreting services; one noted that a MCA assessment had been supported by a Roma interpreter. Respect and sensitivity in communication included choosing the right time to raise difficult issues with the individual.

Independent advocacy was commended as good practice, enabling the individual's perspective to be heard. In some cases, the SAR noted that an IMCA had been appointed; in others, the SAR did not specify the legal mandate for the advocacy but noted its positive contribution.

> "It was positive that an independent advocate was appointed to support X and explore his ambivalence about living with or without (his relative)."

> "The practice of the IMCA met and exceeded expectations … at a time when X was heavily sedated and unable to respond to any attempt by the advocate to engage with him or to carry out a capacity assessment. The IMCA read care notes, had five discussions about the implications of what was proposed, including talking to the surgeon and to X's sister and attended the safeguarding enquiry meeting."

Relationship was recognised in a number of SARs as being the result of the personal qualities and skills demonstrated by practitioners. Nurses, social workers, housing providers, advocacy services, voluntary organisations and care workers were commended for being proactive in building rapport, taking time for trust to be established and for being able to use the relationship as a vehicle for intervention.

> "The agency recognised the need to build time into the package to enable the support workers to develop a relationship with X and help to manage risks, rather than just to provide practical support."

> "(The service) provided X with a place of sanctuary and friendship where he felt safe and appreciated."

Making safeguarding personal: SARs noted that through exercise of the qualities and skills listed above practitioners were able to enact the principles of making safeguarding personal. Commended across a range of agencies, this involved working at the individual's pace in a way that was commonly described as a person-centred. Practitioners chose their time to discuss sensitive issues with individuals, ensuring privacy from others in their network, and found a time and place to suit their needs. They listened to, and took account of, people's views, wishes and feelings. They undertook small but valued practical actions, as when personal effects and medication were collected from a care home and returned to an individual. At times making safeguarding personal required departure from established ways working, or providing support to risky but chosen preferences, or juggling the competing imperatives of autonomy and protection:

> "During her hospital stay X did not like to stay in bed and became distressed so ward staff arranged for her to spend the day on a mattress on the floor, which was a good initiative on their part."

> "For 15 months, X remained at home safely, able to live life as she wanted to live it. This included outings to local shops and pubs as well as visits from her family and friends; supporting her to do this demonstrated good practice."

Practitioners were commended for involving people in meetings and for promoting active participation in decision making:

> "X was provided with opportunities to make informed decisions about his care and treatment in partnership with involved practitioners and his views were respected. Practitioners understood X's priorities and individually strove to provide personalised care and support whilst respecting these."

> "Within the provision of care to X, services did demonstrate a commitment to work in collaboration with him through active involvement in decision making and listening and responding to his wishes."

6.1.3. Other aspects of good practice in direct work

Working with families drew positive comment in some SARs, with practitioners commended for a 'think family' approach, for contacts with and support provided to family members and for attention to their needs:

> "Adult Social Care were responsive to the needs of X's daughter aiming to provide support to her quickly and reduce the risk of a re-admission to hospital by arranging alternative respite care, which can be identified as good practice."

Working closely with families enabled practitioners to source valuable information that contributed to work with the individual, for example in one case how to communicate. It also enabled them to make appropriate arrangements when provider failure necessitated changes of placement for a number of residents.

Extending beyond families to engage with community networks was also commended:

> "The police communicated frequently with the other tenants in the block and organised a meeting of tenants at the police station, which is good practice, to gather information and show the tenants the police were working to resolve the issue."

Family involvement was noted as having challenges of its own, however; in one case, practitioners received complaints from a family member about their prioritisation of the person's wishes and feelings and were commended for their persistence in keeping the individual at the centre of their efforts.

Use of legal rules: Several SARs commented positively on how legal powers and duties had been used. One SAR commended how the interface between the Mental Health Act and the Mental Capacity Act was understood and used effectively during and after a hospital admission. Other examples included appropriate DoLS authorisations relating to admission to care and to the use of medication, the speedy provision of legal advice, timely applications to the Court of Protection, and appropriate data-sharing without consent.

Recording practice was sometimes seen to be of good quality.

> "The recording and management of a safeguarding investigation was thorough; the file clearly evidenced all the steps which were taken to ensure that X was immediately safeguarded once the concerns had been raised."

There was particular comment on the quality of recording by specialist services such as speech and language therapy and dietary services:

> "The [practitioners] all recorded their visits and provided clear plans regarding their area of assessment and next steps."

Escalation: Finally, in relation to direct practice, several SARs noted good practice in escalating concerns. Escalation occurred in a number of different ways: a care worker was commended for keeping her manager appraised of an individual's level of distress; police officers took advice from their managers on a strategy for addressing the criminal behaviour of a vulnerable person's 'friends'; a practitioner escalated a concern to a legal panel for advice; another took legal advice on a particularly challenging mental capacity assessment. In another case staff challenged senior management decisions made in respect of an individual, using the agency's whistle-blowing policy to do so.

6.2. Domain B: The Team around the Adult – Interagency Working

SARs commented on a range of good practice in how agencies worked together in the case in question. Good practice in communication and information-sharing, coordination and the use of safeguarding procedures received the highest number of commendations. The examples explored below show the value of multi-layered communication channels, practitioners and agencies using both formal processes, such as meetings, and informal approaches to collaboration in which practised relationships play an important part.

6.2.1. Interagency communication and information-sharing

Practitioners in many agencies communicated and shared information appropriately with others. Examples included patterns of good communication about matters such as care plans, risk, standards of care, hospital discharge, medication, skin integrity and palliative care between:

• Adult social care, housing provider and benefits assessor • Adult social care and police • Adult social care and CQC • Adult social care and hostel staff • Ambulance, GP and mental health team • Ambulance and adult social care • Care agency, GP and district nurse • Care coordinator and support worker • Care home staff and Quest matron • Children's services and adult social care • Community MARAC partners • CPN and care home • CPN and social worker • District nurse and physiotherapist • District nurse, GP and care home • Drug & alcohol team, independent domestic violence adviser and MARAC network • GP and independent domestic violence adviser • GP and CPN	• GP and ambulance service • GP and memory clinic • GP and CCG designated safeguarding nurse • Head teacher, neighbourhood officer and police • Home local authority and host local authority • Hospital and care agency • Hospital social worker and psychiatric liaison team • Hospital staff and police • Hospital social worker and family support worker • Housing provider, occupational therapist and fire & rescue service • Learning disability nurse and district nurse • Local authority and CCG • Local authority, police and CQC • Mental health trust and acute trust • Police and mental health team • Police and safeguarding team • Police, RSPCA and environmental health • Prison authority and substance misuse service • Social worker, GP and learning disability team

Sometimes the communication was intended to facilitate provision of a service from the other agency:

> "When safeguarding was closed the case and handed to the Complex Care Team to oversee the on-going care management package, a comprehensive risk assessment and plan was provided."

> "The care coordinator made an appropriate communication with the hospital to facilitate X undertaking an MRI scan, sharing information they held in relation to his habits to identify a suitable appointment time to ensure attendance. This is identified as good practice."

In one SAR, information-sharing by family members was noted as a positive contribution:

> "There does appear to have been a good handover of information from the family to the supported living provider with respect to X's routines … and between the community and hospital dietician, and between the (community learning disability team and specialist support organisation) and the hospital."

Among the facilitators of good practice identified were a local information-sharing protocol, electronic records that produced alerts on reaching a particular threshold and access to historical information from other services.

> "[The ambulance service and the police] had information available to control centres on past history from other service areas."

> "The hospital electronic patient records show that several appointments were not attended; however, Trust policy was followed and the General Practitioner was informed of these non-attendances. This is intended to ensure continuity of care and communication."

> "… good inter-agency communication … was facilitated by the fact that they share the same computer system (SystmOne)."

One SAR considered whether information-sharing in the absence of consent had been appropriate:

> "Discussion took place at the Review Panel about whether or not the conversations with X's father and with the school were appropriate, given the lack of consent from X. The Review's conclusion is that while consent would be ideal, the difficulty in engaging with X at all meant this sharing of information on a proportionate basis, in the best interests of a child, was positive and should be seen as good practice."

6.2.2. Referrals between agencies

A number of SARs commended the use of safeguarding procedures by a wide variety of practitioners when abuse and neglect was suspected: ambulance crew, community and hospital nurses, care agencies, care homes, the police, tenancy support services, GPs, voluntary organisations, a local supermarket, a live-in carer and a tissue viability nurse.

> "The ambulance service demonstrated a systematic and robust approach to reporting and escalating safeguarding concerns."

> "The GP practice demonstrated effective initiation of the safeguarding policies and made contact with the safeguarding team for advice and support, which was promptly given."

> "The care agency did refer concerns on quickly to district nurses, safeguarding and GP and they did follow up when no response was received; they proactively offered to participate in any safeguarding process."

Beyond the use of safeguarding procedures, good practice was noted in other referrals passed between agencies. Examples included: an acute trust raising referrals with an independent domestic violence advisor and the mental health team, as well as with safeguarding; a GP practice going beyond physical health needs and referring a patient to specialist support services; property and utility concerns referred to patients' landlords; police reporting care home residents' reports of crime to the home's management and the local authority; an emergency duty team referring to an outreach service over a bank holiday; a GP referring to the complex care team; an ambulance service referring fire risk to the fire & rescue service; and hospital staff making appropriate MARAC and independent domestic violence advisor referrals as a result of their assessment of risk. In one case the ambulance service coordinated a comprehensive response:

> "There was good evidence of inter-agency working when ambulance staff liaised with mental health workers and X's GP, obtained a comprehensive assessment of his situation, and arranged for further visits from other agencies in an effort to assist him."

6.2.3. Interagency collaboration and coordination

Good interagency practice relied on use of mechanisms to coordinate the efforts of all involved, and sometimes leadership of a complex agency network by a single agency. It also involved joint working, as well as supportive input from one agency to another. Senior level strategic commitment was an important foundation.

Use of interagency meetings: Agencies were commended for their engagement in safeguarding meetings and in other forums for coordination of multiagency care and risk management. These provided opportunities for shared strategies of intervention to be devised and for case coordination and leadership to be established, as in this example:

> "Multiagency plans were outlined for trying to engage with X and for pursuing placement options, with lead practitioners clearly allocated."

SARs noted:

- timely safeguarding meetings: "*Th*e management of the Safeguarding Enquiry in January 2014 was an example of good practice. The multiagency approach was adopted and there were actions and protection plans created and distributed"
- good attendance at hospital discharge meetings
- a holistic 'think family' approach at a safeguarding meeting where education, housing and children's services provided important input
- a local hospital trust meeting at which frequent A&E attenders were reviewed
- timely discussion in MARAC meetings
- multiagency participation in best interests meetings held in hospital
- effective use of the care programme approach to coordinate multiagency involvement in a community setting
- collaboration and effective working together between an antenatal mental health clinic and a perinatal mental health team

- use of a complex case review meeting by a community matron
- GP surgery meetings in which practitioners from different disciplines participated: “The weekly GP practice clinical meetings and monthly multi-disciplinary meeting, where patients are discussed and concerns raised, demonstrated effective communication within the practice regarding higher risk individuals such as X. This is good practice.”

Joint working: Going beyond coordination of their respective efforts, some agencies engaged in hands-on joint work, practitioners teaming up together to bring a dual perspective during encounters with clients. Mental health practitioners and GPs, care coordinators and care providers, and mental health and adult social care practitioners were commended for sometimes multiple joint visits.

In other cases, SARs commended close collaboration between practitioners to find a way forward, for example when the police chose not to arrest an individual due to the involvement of mental health services, or when joint working enabled a particular challenge to be addressed: for example, when a learning disability physiotherapy team worked with hospital ward staff to facilitate the comfort and feeding posture of a patient. In another example there was good collaboration between the police, adult social care, the CQC and placing authorities in relation to concerns about a care home. In another, following concerns about abuse a direct payments team were seen to act promptly to suspend direct payments and worked robustly with adult social care to identify transferable risks to others and provided information to assist with a criminal investigation. Other examples include:

> “The social worker and CPN worked collaboratively when the family were in crisis and were tenacious in finding a solution and respite for the weekend. They both worked beyond the end of the working day to ensure a positive and safe outcome.”
>
> “The interface between social care team and the asylum team worked well and there was evidence of joint working to ensure that outcomes for X were appropriate and had taken into account his asylum status.”
>
> “Housing and community safety worked well together to find a place of safety after cuckooing.”

Two SARs singled out assessments under the Mental Health Act 1983 as having demonstrated good joint working.

> “The MHA assessment in particular demonstrates how experienced practitioners with expertise and legal literacy can work confidently together to make decisions in complex areas with compassion and focus.”
>
> “Review of the management of this mental health assessment and admission highlights that relevant policies and procedures were followed and that there was effective multiagency communication and timely joint working between involved practitioners.”

Finally, there was evidence of strategic level action between agencies to tackle problems that were feeding abuse and neglect; for example, a range of multiagency arrangements were put in place in one area to tackle the use and supply of drugs as an element of the strategy for responding to sexual exploitation.

Support between agencies: Several SARs commended the actions of one agency in supporting the work of another. For example, a CCG safeguarding lead supported GPs to manage a patient with complex needs. Care workers received training about posture care from the community learning disability physiotherapy team. At times the support contributed to staff care:

> "The police supported residents and staff with professionalism and compassion in the aftermath of a harrowing and traumatic incident."

> "(The social worker and continuing healthcare worker) continued to work together closely ... The Review Team noted the quality of the mutual support they provided, which was essential to help them manage the emotional demands that the case generated."

Facilitators of good interagency working: Some SARs noted features of the interagency landscape that acted to promote joint or well-coordinated work. These included effective strategic and operational leadership, embedded management strategies, strong role differentiation, and co-location of staff, which resulted in shared expertise and knowledge, good understanding of roles and responsibilities and a positive approach to information-sharing. Two SARs commented on the value of established relationships:

> "There is evidence that some agencies worked closely with one other agency with whom they already had an established relationship. For example, the housing association and the local police worked very closely together and were working hard to secure a better outcome for X and the rest of the tenants in the housing block."

> "In contrast to the procedures and pathways used for people who are self-neglecting, the work undertaken using the MHA is underpinned by years of experience, well-practised routines and close, understood relationships."

The value of strong cooperation at strategic level was noted:

> "A strategic meeting was held by the CCG and LA safeguarding leads and the operational community learning disability team to monitor progress in relation to safeguarding activity and the wider quality improvement work, and to agree further actions and clarify roles and responsibilities … This was a positive and proactive meeting which helped to move processes forward. The co-location and established culture of close working between these two agencies enhanced communication."

Strategic level action was also noted to have resulted in a strong and coordinated approach to disruption – police-led multiagency action to interfere with and disrupt the activities of perpetrators of abuse. In one review relating to sexual exploitation, the arrangements made are commended as an excellent example of proactive disruption that have had a very significant impact. The breadth of multiagency strategic involvement needed is illustrated here:

> "Disruption is an inter-agency responsibility and close working relationships have been established across city council departments and with partner agencies that have regulatory and inspection functions, including border agencies, Trading Standards, Licensing, Consumer Services, Environmental Health and the Fire Service. There is close liaison with children and adult safeguarding services."

Finally, two SARs noted that good practice in interagency working involved communications that were designed to challenge. A care agency, for example, was commended for challenging the adequacy of the care package they were asked to deliver. In another case, practitioners who knew an individual well challenged a mental capacity assessment undertaken by someone who did not know him.

6.3. Domain C: The Agencies around the Team – Organisational Behaviour

SARs commented on a range of good practice in the organisational behaviour of the agencies involved in the case in question. Aspects of the organisational structures, cultures, systems and practices of the agencies involved was seen in some reviews as a positive feature of the case, facilitating some of the aspects of good practice noted in earlier sections.

6.3.1. Policy/Procedures/Guidance

SARs commended some agencies for the availability and quality of their policies, procedures and other guidance. A safeguarding toolkit and guidance newly in place in one agency were noted to be comprehensive and Care Act 2014 compliant. Another agency had a review of safeguarding policies, procedures and practices underway, leading to significant changes that were in line with the review findings. A whistleblowing policy was used by staff in a local authority, leading to their concerns being taken up by senior management. A number of organisations had in place policies and procedures relating to diabetes, with a governance framework operational to regularly review and update these to support evidence-based practice. One SAR noted that most agencies involved had specific hate-crime guidance in place and another that policies and procedures for transition planning were evident.

6.3.2. Workforce

Staffing: Some agencies had staffing structures or practices that assisted the safeguarding work that was taking place. In some cases, these were already in place:

> "The GP Surgery does have a designated staff member whose role includes following up people who do not keep appointments."

> "The hospital had a 'vulnerability officer' who assisted with communication with X."

In other cases, staffing practice was adapted to meet the demands of the case:

> "The hospital employed carers from the residential home where he had lived for a long period, so they could support the gentleman throughout his hospital stay. This was an example of good person-centred care."

> "The county council involved itself in the (care provider agency's) responses to events … by creating an operational team in a process of scrutiny and review. The Enquiry Team worked with families, challenged the outcomes of the disciplinary processes and sought to impress on managers locally and nationally that the provider's actions prior to and following the whistle-blowing incidents were wanting. The creation of the team was a major undertaking and investment."

One SAR noted good practice in the degree of flexibility staff were able to bring to their dealings with the individual, attributing this to the status of the organisation as a charity rather than as a statutory organisation.

Training: SARs noted good practice in agencies' provision of training for staff, including the development of bespoke training materials and e-learning, with commendations for training on making safeguarding personal, the impact of trauma, legal literacy and sexual exploitation, in one case targeting community engagement:

> "[The] Police launched a bespoke Vulnerability Training Programme for staff in the night-time economy, door supervisors and staff in hotels. Recommended nationally as good practice, it has been adopted by the Security Industry Authority and is mandatory door supervisor training. Staff from (the Community Safety Partnership and Safeguarding Boards) have contributed to the delivery."

Staff supervision and support: Several SARs noted good practice in providing supervision and support to staff:

> "The supervision process was used to good effect in helping colleagues determine the issues which they were facing and agreeing ways forward."

> "It is good policy and practice that the hostel organisation provided supervision and support to help staff to manage their own grief while supporting clients. This good practice helped them to observe and support X."

In terms of specialist support, access to legal advice was noted as an important element to aid decision making.

Management scrutiny: Access to, and oversight by, managers was commended in some cases. The importance and value of managers being accessible for consultation and sighted on complex and high-risk cases was recognised:

> "The care workers faced making some very difficult judgements and in this case were well supported by their managers, who were available to discuss the situation with and were willing to support the care workers in the practice decisions they made."

In one case a care agency manager was commended for undertaking joint visits with care workers in order to engage with the clients. In another, the council had played a significant role:

> "[The] County Council demonstrated a proactive management role in ensuring the safety of … residents, challenging the (provider's) professional activity and that of the commissioners responsible for funding placements."

The accessibility and use of escalation routes to management were commended:

> "There were some positive examples of escalation, and it is clear that appropriate management scrutiny took place within the ambulance service and (the police) in terms of how those agencies exercised their responsibilities."

> "Family complaints after his death about the quality of care [were)] escalated to senior managers, leading to CQC and [the Police] being notified and safeguarding strategy meetings convened."

6.3.3. Commissioning and contract compliance

Good practice by commissioners, and by others with responsibility for monitoring compliance with contracts or with standards, was noted.

Commissioners and a contract compliance team were actively involved in monitoring and challenging providers' action plans for improvement. In one case, proactive checks were carried out on other residents and new placements suspended. The Care Quality Commission was commended for use of legal rules available to serve notice to remove registration and close two homes. In another case CQC and Healthwatch both conducted inspections and spoke with residents and relatives.

Commissioning teams were commended for their work in securing appropriate services:

> "Services for people with complex needs and a learning disability are commissioned creatively and effectively, allowing carers the flexibility to support service users in a person-centred way ... The overarching approach to commissioning health and social care is one that makes person-centred care more possible, and as such, it is in line with the vision of the Care Act and with the rights of the individual."

In some cases, the commissioning approach had been instrumental in a positive outcome:

> "Despite the changes to equipment contracting during the period of this review, services worked outside of current contract arrangements to ensure the appropriate pressure relieving mattress was delivered urgently to X."

> "Commissioning of a specialist agency to provide care staff for X, even though more expensive and not on the usual list."

6.3.4. Systems

A number of agencies were commended for having in place organisational systems that supported good safeguarding practice. In primary care, routine physical health checks for people with mental health needs, demonstrating parity of esteem, were commended, as well as arrangements for managing regular routine checks:

> "The GP practice has a strong governance policy/process in place in relation to chronic health conditions/surveillance checks and annual reviews. All of these are good practice."

In the hospital context, use of the Vulnerable In-Patient scheme to collate important medical information for people identified as having a learning disability was commended. In another example an integrated discharge scheme ensured follow-up on discharges. In a third case, an alerting system could trigger action once a certain threshold was reached in A&E attendance:

> "The hospital has arrangements for an ED consultant-led review to be undertaken when triggered by twelve presentations by an individual in a given period of time. Such a review would be aimed at ensuring stability in a health condition or ensuring appropriate arrangements and signposting where necessary, depending on the opinion. This is good practice."

In other cases, there was recognition of the value of systems that place alert flags on records:

> "[There is a] police victim code that includes agreeing a level and appropriate method of family contact during an investigation at the outset. The computer system then provides reminders for officers who cannot finalise the investigation until this has been completed."

> "The use of risk information on the priority housing list to look at housing in particular areas for someone at risk of domestic abuse, and the use of vulnerability alerts onto her tenancy."

6.4. Domain D: SAB Governance

A few SARs commented on aspects of good practice in the SAB's governance in the case in question.

6.4.1. Conduct of SARs

Examples of good practice in the conduct of SARs included collaboration between three Boards to carry out a review and strong cooperation in the SAR process by agencies. In two SARs, management reports provided by the agencies were seen to be of high standard, with candour and critical analysis leading to single agency recommendations for change that were described as SMART (specific, measurable, achievable, relevant and time bound). One SAR commended the SAB on its commissioning of a series of SARs on related topics (all pertaining to self-neglect), which would enable rich learning to emerge. Another SAR commended actions that a SAB had taken since completion of the SAR:

> "The SAB has held learning seminars, consultation events about the learning from the review, and workshops on law, professional curiosity and difficult conversations. It has reviewed multiagency procedures to ensure inclusion of the voice of the adult at risk."

6.4.2. SAB policies and procedures

One SAR considered whether any failing had occurred in the SAB's interagency policies and procedures, concluding that they were fit for purpose.

6.4.3. SAB cooperation with other governance structures

Two SARs commented on SABs' close cooperation with the Local Safeguarding Children Boards. In one SAR relating to sexual exploitation, their collaboration had exceeded expectations:

> “The [Children’s and Adults] Safeguarding Boards were established and functioned in accordance with statutory guidance and regulations over the period reviewed. Collaborative arrangements between the two Boards developed early beyond expectations in guidance, and as awareness grew were well-equipped to respond to challenges of child and adult sexual exploitation.”

In the other example, the cooperation related to missing vulnerable people, sexual exploitation and trafficking. Here the boards had also worked jointly to oversee a strategy for engagement of communities. The SAB had also worked beyond its membership to seek contact with key agencies such as CPS, the Police and Crime Commissioner, pharmacists and sexual health services.

7. Poor Practice

7.1. Domain A: The adult - direct work with the individual

The SARs commented on multiple aspects of direct work in the cases reviewed that fell short of expectations. These fall into four broad themes: understanding and responding to specific forms of abuse and neglect; assessing and meeting needs; making safeguarding personal; and practitioner attributes. These are explored in what follows, with each theme containing a number of sub-themes.

7.1.1. Understanding and responding to specific forms of abuse and neglect

Some SARs provided evidence of poor understanding or responses to specific forms of abuse and neglect, notably those that have more recently become the focus of safeguarding concern since implementation of the Care Act 2014 or where developments in contemporary awareness of risk and harm have brought the need for a sharper focus.

Domestic abuse: Some cases of domestic abuse did not receive appropriate responses. One thematic review collating evidence from a range of sources noted that domestic abuse of adults with care and support needs remains both under-recognised and under-reported. Practitioners lacked depth of understanding about the nature the abuse, why it occurs and why victims remain in abusive relationships, with attitudes that blamed the victim.

> "Remaining and on-going challenges can be broadly grouped as structural (limited and oversubscribed resources; compartmentalised practice), knowledge based (understanding and skill of practitioners) and attitudinal (negative views and assumptions)."

SARs noted a lack of awareness in primary healthcare, leading to missed opportunities to offer trigger protective action. There were failures to consider the possibility of domestic abuse, to recognise the impact of the abuse on all family members, and to understand how transitions such as release from prison can re-ignite abusive relationships. In some cases, there was a tendency to minimise victims' experiences of abuse and a reluctance to dig deeper. Practitioners accepted at face value accounts that minimised the abuse or failed to recognise trauma, showing a lack of curiosity and in some cases applying a rule of optimism. Practitioners appeared uncertain how to respond when both parties could be both victim and perpetrator, and concerns about domestic abuse were discussed with both the perpetrator and the victim together, exposing the victim to further risk. Notably overlooked was domestic abuse in later life, between parties of the same sex and relating to people with learning disability; in one case what took place within the sexual relationship was not recorded as domestic abuse, denying the victim access to specialist support. In other cases too, no referral to specialist services or an Independent Domestic Violence Adviser, or to a Multiagency Risk Assessment Conference, took place, where such referrals would have been appropriate. Risk assessment in one case was noted as: "Often inconsistent and incompetent, absent or not taking account of all relevant information". In another case available remedies, such as support to re-locate away from the local area through emergency assistance and re-housing, were not used: "That this had not been actively pursued by this time was a missed opportunity".

Coercion and control: Coercive and controlling behaviour in domestic abuse[102] and sometimes in other relationships did not, in the SARs reviewed, always receive due attention in practice. Several reports noted a lack of understanding of coercive control and its role in the exploitation of people who have particular vulnerabilities; individuals were seen as 'letting people into their house' without recognition of relationship dynamics. In other cases, the impact of coercion from adult children on the decision making of an older person was not recognised, despite that coercion and control being witnessed.

> "Capacity assessments were used to determine whether X's decision making about her finances was sound. However, it would have been beneficial to explore whether X was subject to coercion and control and whether this might have influenced her decision making. Action to safeguard X from financial impropriety was inconsistent and ineffective due to a lack of consideration of coercive and controlling behaviour as a factor in her decision making."

In one case a threat by a man to kill his female partner and bury her body was described as a 'verbal argument only', the SAR noting that this indicated little if any understanding of the nature of coercive control. He later went on to kill both his partner and her mother.

> "Given X's known criminal record, which suggested he could have been capable of carrying out this type of threat, this should have been recognised as a serious and significant incident, indicating a high level of risk."

Mate crime: Two SARs comment on how mate crime was not well-addressed, both pointing to low levels of awareness. In one case of a man killed by a 'friend' he had allowed to live in his home, the SAR comments that his vulnerability to exploitation was not seen as an abuse issue, despite a history of well-known risks from the other party. The other SAR takes its observation further, linking mate crime with disablist hate crime:

> "There is not consistent understanding or awareness of mate crime in the city, even from professionals with expertise in supporting adults with disabilities or vulnerabilities which place them at higher risk … There is not a consistent understanding of crimes that could be understood as mate crime being recognised as a form of disablist hate crime."

Sexual exploitation: A thematic review of sexual exploitation cases (relating both to adults and to children) in one city comments that there had been a history of placing insufficient focus on investigating, prosecuting and disrupting perpetrators. Efforts to safeguard within families, focusing on the behaviour of the victims had lacked the broader focus on perpetrator activities and contextual safeguarding. Noting the positive changes in approach made, the review comments that sexual exploitation of boys and men still remains less visible and that both legislative provision and assessment tools to assist the protection of adults are limited.

There was evidence of superficial approaches to assessment focusing on single issues rather than a systemic, holistic approach, and insufficient understanding of deeply ingrained cultural values. Practitioners did not fully understand the calculated erosion and removal of the ability to choose by perpetrators through grooming, alcohol and drugs, coercion and threats, and offers of food and shelter. Risk analysis and risk management also needed to be more fully demonstrated.

[102] The Domestic Abuse Bill 2020 proposes the inclusion of emotional, coercive or controlling abuse within a statutory definition of domestic abuse.

Self-neglect: Given the number of self-neglect reviews included within this analysis, it is unsurprising that a number of SARs comment on particular challenges in the cases involved. Self-neglect, both in itself and as a form of abuse and neglect within safeguarding, was not always recognised by practitioners. One review found no evidence of self-neglect or safeguarding understanding embedded in primary care, mental health services or commissioned health and social care provider staff. The focus on a specific need or behaviour could obscure recognition:

> "Self-neglect not recognised or named. X was assessed in hospital for detox. In this assessment practitioners are not looking for self-neglect, they are assessing alcohol misuse problems and risk assessing for immediate self-harm which may lead to a Mental Health Assessment, which suggests a different lens than would be used to identify if someone was self-neglecting. This raises interesting questions regarding how self-neglect is identified."

Even when self-neglect was recognised, it was little understood and poorly explored, lacking detailed personal history and exploration of the person's home conditions or health management routines. Refusal of services was not explored or understood. Professional curiosity was not exercised. Assessment, particularly in the hospital context, relied heavily on self-report, with home circumstances not observed. In some cases, assurances about actions the individual would take were accepted at face value, despite evidence to the contrary. Risk assessment did not take place.

> "There was no confidence that all agencies are able to recognise and understand the risks related to self-neglect, the legislative frameworks available to use in these circumstances should engagement fail, or their duty to report concerns to the local authority under the provisions of the Care Act 2014."

> "There were consistent misunderstandings related to self-neglect and mental capacity. Agencies were aware that X was self-neglecting, however they also assumed that X had mental capacity, and consequently (and erroneously) decided that an intervention was not possible. Such an inflexible approach to managing clients who are self-neglecting (with alleged capacity), runs counter to the Care Act Guidance that suggests individuals who are no longer able to protect themselves are still owed a duty of care."

Practitioners sometimes did not use local self-neglect policies and procedures, either because they were not aware of them or because they lacked faith in the outcome. So they did not refer self-neglect to safeguarding, but neither did they refer for care and support assessments.

> "There is no evidence of when and how awareness of self-neglect procedures influenced the action taken in response to X's presenting needs and the risks inherent in his situation."

SARs noted an absence of targeted intervention. In one case the individual was assessed as having no eligible needs, despite being unable to maintain a habitable home environment. In another, assessment did not lead to action:

> "Assessments, including use of standardised instruments, find poor scores consistently relating to self-care, management of physical health, living skills, mental health and cognitive functioning, and addictive behaviour but no treatment plan and no goals are set so his progress is not measured."

The concept of lifestyle choice sometimes contributed to failures to refer or pursue self-neglect, particularly where it was believed (either through assumption or assessment) that the individual had mental capacity and was choosing how to live. Autonomy was valued and promoted without attention to risk mitigation.

> "Practitioners made assumptions that his self-neglect was a personal lifestyle choice, despite the concerns raised by family and friends in relation to deterioration and presenting risk factors."

Poor recognition of risk meant that sometimes practitioners were simply not worried enough to take action.

Improvement priority twenty one
Consideration should be given to the dissemination of briefings on good practice regarding all forms of abuse and neglect but especially those newly highlighted by the Care Act 2014 within adult safeguarding, such as domestic abuse, modern slavery and discriminatory abuse (hate and mate crime).

7.1.2. Assessing and meeting needs

Responding to characteristics of the individual: Some SARs commented that practitioners had not paid sufficient attention to particular characteristics of the individual, with particular comment on gender, race and learning disability.

- Gender: In the one case involving a transgender person the SAR concluded that practitioners had not taken account of the individual's specific and very complex needs and vulnerabilities as a transgender person when making their decision about eligibility and allocation of housing. In another case, in which a young man killed an older, female co-resident in his supported accommodation, the SAR noted no action had been taken on a proposal for the house to be a single-sex property, despite increasing tensions between the two residents in which both gender and age played a part.

- Race, ethnicity and culture: Although mention of race, ethnicity and culture was largely absent in the SARs reviewed, a few reports did comment. One noted a lack of evidence that race and culture needs were considered. Another, reviewing the death of 23-year old man of mixed heritage who carried out what an inquest concluded was a 'deliberate act', noted that no consideration had been given to culture within the family dynamics or to the impact of racism on the young man. In a further case, involving the murder of an asylum seeker by a fellow resident in supported living, following prolonged victimisation, the review noted:

  > "The victimisation X was subjected to was racially motivated which increased the risks to his personal safety, and risk assessments should have considered this ... There is no record that the risks to X because of his ethnicity and background were considered as part of the decision not to proceed with a Section 42 enquiry."

This SAR also draws attention to the possibility of unconscious bias in how agencies respond to the designation 'refused' or 'failed' asylum seeker - whether it affects how other concerns are judged because it implies that the individual had an intention to deceive (ie they have claimed something to which they are not entitled).

A thematic review of domestic abuse notes deficits in both knowledge and attitudes: approaches to the complexity of different communities were seen to be underdeveloped, with examples that practitioners had been ill-informed in their responses, and practitioners were reported to show reluctance to challenges issues of power and control in cases involving Black, Asian and ethnic minority groups, reducing these to 'cultural issues'.

- Learning disability*:* Diagnostic overshadowing was noted in several SARs - physical symptoms (wrongly) attributed to the learning disability or autism, resulting in inadequate assessment and investigation and a lack of prompt treatment. Examples given included failure to recognise screaming as a response to physical pain, the significance of incontinence not being recognised or investigated and a failure to help an individual understand his early experiences of neglect, thus posing an obstacle to the achievement of good health outcomes.

In other cases, the reverse was the case and learning disability was overlooked:

> "It was identified that X had a diagnosis of emotionally unstable personality disorder and this alongside his substance misuse issues were considered his primary support needs and the reason why he was unable to engage appropriately with support or sustain his previous living arrangements. It is however now clear that X also had needs relating to his learning disability and physical health issues which no doubt exacerbated his behaviours and will have fed into his inability to effectively and emotionally regulate his behaviours. Much debate was had with regards the degree of X's learning disability, however, full assessment of these needs … and attempts to clarify diagnosis were significantly delayed."
>
> "Given what was known of X's forensic medical history, his presentation and vulnerabilities … a care coordinated pathway to address X's personality disorder should have been considered as a viable treatment option. At the same time when taking into account the recorded concerns about a learning difficulty and concerns expressed by some staff that X did not understand what he was being told, a plan to address this issue would similarly have been appropriate. Indeed, these two aspects should have been considered together since it is widely recognized that IQ level alone is not the main determinant of a learning disability and that intellectual impairment together with social or adaptive dysfunction should both be considered."

One SAR notes a failure to make reasonable adjustments for disabled people when focusing on the presenting medical emergency and comments that stereotyping of people with a learning disability and hidden attitudes may have affected the way in which practitioners dealt with the individual, resulting in a family member raising a complaint about prejudice. Several others note concerns about practitioners accepting a family member as the 'voice' of a person with learning disability, without assessment of ability to participate or enquiry into communication needs, and inappropriate methods of communication being used.

Improvement priority twenty two
Briefings should be published for practitioners and managers across all SAB partners on the implications for best practice in adult safeguarding of the requirements of the Equality Act 2010.

Assessment: A key element of direct practice scrutinised in SARs is the process of assessment – whether of health needs, care and support needs or risk. A wide range of examples of poor practice across the sector were given.

- Failure to assess: In some cases, there simply was no assessment. Examples included failure in several cases to complete an assessment prior to care home admission or prior to a move into supported accommodation, despite known vulnerabilities. In one case this led to an older person being admitted to a main residential area rather than a specialist dementia wing. In another, the suitability of a care home as a placement for a young disabled woman was not assessed. Two SARs referred to an absence of assessment under the Care Programme Approach:

  > "Despite X's CPA status and admissions to hospital, no full psycho-social assessment was recorded throughput his period under the care of the service. No CPA assessment was completed and there was no CPA care plan ... Nor was a (care and support) needs assessment undertaken."

  In one case a requested Adult Social Care assessment did not take place as the presenting need was deemed to relate to mental health, missing important care and support needs. In another, the SAR notes that the absence of assessment was due to assumptions that the person did not have eligible needs. One SAR comments: *"the failure to conduct and complete an assessment of his care and support needs is a significant omission and missed opportunity*". One SAR is clear that the absence of assessment fell short of expectations:

  > "Following her discharge from hospital … Adult Social Care did not consider X met the threshold for a Care Act Assessment. X was a person who appeared to have complex needs, was homeless and was autistic. Under the Care Act Local Authorities have a duty to carry out an assessment of anyone who appears to require care and support, regardless of their likely eligibility for state-funded care. Under the Autism Act 2009, young people with autism and the professionals supporting them have an entitlement to request a Care Act assessment. The decision not to undertake a Care Act assessment with X was practice that fell below expected standards."

  It is also the case that an absence of assessment noted in SARs may reflect sectors of the population that remain less visible to health, mental health and social care services. In one thematic review of rough sleeping, involving ten individuals, none were open to Adult Social Care when they died, none were known to mental health services and only one to alcohol support services. The report notes that although homelessness or rough sleeping do not of themselves constitute a need for care and support in terms of the Care Act, it is likely that many of the men would have had needs that warranted assessment, as well as mental health needs and needs related to drugs and alcohol that had not been addressed.

- Poor assessment: Where assessment did take place, sometimes after long waiting times, needs were not always seen holistically, or the complexities of the situation were missed. In one case, even when a range of eligible needs was identified, the solution was seen as accommodation, to the detriment of seeing the bigger picture of care and support needs. In another, aspects of an individual's needs related to drug use, and the behaviour that resulted from it, were allowed to dominate the decisions made about him. Individuals living together might be assessed individually but without consideration of the interaction between them. In one example, an individual's interdependent relationship with his frail, elderly wife, and the challenges he faced in coping with his own deteriorating health as well as supporting her, were not considered. Care and support needs were sometimes assessed without observation of the home environment, or without corroboration that the family were providing support. Health and social care needs were in some cases not assessed in an integrated way, with the result that in one case the individual had little idea of how different aspects of her needs were seen to fit together.

  Social isolation and social needs in particular were less prominent, and a number of SARs commented that the failure to consider social and community networks, even where it was known that a person had been in contact with faith and voluntary care organisations for some years, represented a missed opportunity.

  > "There is no evidence that X's social needs were addressed in his assessment/care plan, which did not place him in any social context or seek to identify support networks that might have existed for him or could have been developed in the community."

  > "Agencies would have been able to effectively deploy significant time to holistically support X through his period of self-neglecting through his package of care, friend, and the Church, mental health professionals and local GP practice had this been coordinated."

  Reliance on telephone assessment was seen as poor practice, particularly in cases where home circumstances were material to wellbeing due to inadequate or inaccessible space. Equally, assessment that was not informed by prior knowledge and history, or that focused on identifying inputs rather than outcomes, or did not take wellbeing as a guiding principle, came in for criticism. A care home fell short in not identifying the risk of falls for a resident being readmitted, thus omitting to trigger an enhanced care plan for staff to follow. In a few cases the most obvious circumstances were overlooked, such as the ability to undertake self-care following double amputation or the need for end of life care.

  > "The shift was not made by practitioners from offering help to reduce the drinking to help with end of life care, when it was apparent that X was nearing death."

  Moving and handling assessment came in for criticism: delays in assessment that led to delays in equipment provision, failure to review an assessment once it was known that a fracture had occurred, a care home's failure to seek advice on the need for a specialist sling, staff confusion about equipment, inadequate consideration of equipment and staffing required to safely move someone, and insufficient detail to ensure safe practice:

  > "Although (the) pre-assessment covered an adequate assessment profile, all sections were 'tick box' or yes and no answers. There was no in-depth description evident of any issues raised within it or identified where the information could be obtained. Within the mobility section it was identified that for transfers a full body hoist was to be used with a sling size of 'M'. However, it did not specify which make of sling was to be used or identify the equivalent 'M' to be used within (the care home)."

Poor assessment practice was also noted in a case involving an offender being managed by the Community Rehabilitation Company; required standards were not met as the sentence plan objectives did not cover the areas originally discussed at the start of the order and did not address any of the risks. The offender subsequently murdered a vulnerable adult whom he had befriended.

Care plans and reviews: Following on from assessment, a number of SARs commented on the quality of care planning and review.

- Absence of care plans: In some cases, care plans were absent, or having been agreed were not put in writing, making discussion and monitoring difficult. Examples within care homes included placements arranged without clear plan as to outcomes, a resident who had no care plan for a year after admission, and the absence of a diabetes care plan that could provide a framework for managing the resident's diabetes, including episodes of hyperglycaemia. Another SAR observes:

  > "The care plan provided to the home was lacking in detail. There are no descriptions of how assistance is to be provided and (it) contains statements of general intention rather than a practical guide of how assistance should be given … We found no evidence that any care plans were developed and implemented to address any of X's needs that had been identified at the pre-assessment stage or on admission."

  Examples from other settings include concern that the absence of a plan left practitioners without a strategic direction to guide them through the tension of promoting autonomy while also ensuring their duty of care towards the individual. Other omissions included end of life care planning in several cases and in one case an absence of consolidated care planning that detailed the contributions of different agencies, leaving it unclear to all involved who was providing what. In one case practitioners did not know how to define the individual's needs and therefore struggled to make a plan on the best way to intervene. Although there were many practitioners involved with him, he was offered limited support to assess or address his needs. The SAR comments that some practitioners may have seen him as someone living a chaotic lifestyle, who misused alcohol and drugs, and therefore labelled him as someone who was not able to change.

- Incomplete care plans: In other cases, care plans omitted key information such as medication, pain management, personal care, communication needs, management of fire risk, measures to develop independence, or goals to secure change and improvement. For one individual, while concerns about his binge eating were noted and crises addressed as they occurred, the absence of any plan or strategy to address the behaviour left him at risk. For another the care plan provided no detail on how an eating disorder was to be treated or managed. In another case the care plan did not specify how attempts at engaging the individual in addressing his alcohol use were to be made, leaving his health and the security of his tenancy at risk. Two further examples noted that the potential contribution of assistive technology such as GPS or door alarms were not considered in cases where an individual was at risk from leaving their home. In the absence of technology (dismissed in one case as a human rights infringement), no effective alternative strategies to manage their going out and going missing were implemented.

  Some SARs reported concerns about plans to address mental health needs. One SAR questioned whether the care plan reflected the precariousness and complexity of practice for adults with mental illness, especially how support was to be provided at times of crisis and to family members, including young people. Concern about the absence of contingency planning for crises that could be anticipated was expressed in another SAR also. One example noted:

> "Care plans for X should have been more specific, including being more goal oriented, and better focused on the evidence-based approaches. There also should have been a focus on possible alcohol (and previous drug) related cognitive deficits, and X's physical health."

- Care plans not followed: Some SARs noted that practice had departed from care plans in ways that were significant to the case. Examples include a failure to observe a care plan provision for a staff member to be present at all times in a care home's communal areas, to prevent falls; a lack of timely action to monitor and act on evidence that a young person's residential provider did not consistently follow the care plan; and relationship-building and socialisation goals being compromised due to the individual's reluctance to engage. In a further case the SAR noted that care workers had not alerted anyone to the fact that the person receiving their service was not complying with the care plan; as no one raised concerns it was assumed that the care plan was working effectively, when it was not.

- Failure to review and reassess: Some SARs noted that care plans had not been reviewed within expected timescales, or that there had been no response to adverse events such as assault, or account taken of changing circumstances that warranted review and reassessment.

> "Evidence indicates that the section 117 aftercare package had not been regularly reviewed. Expected practice in relation to the CPA was for X to have a multi-disciplinary review at least every six months. [At] the date of his death … X had not been subject to a CPA review (for 18 months)."

> "In the three months before his death there were increasing incidents of drug use, overdoses, requests for assessment and carer assessment but no effective plan to engage and intervene."

In one case, eleven requests by family and practitioners for an increase in a care and support package failed to trigger review. In a SAR relating to the death in a house fire of a man known to smoke in bed, the SAR notes that the prescription of morphine (and its associated drowsiness) should have prompted review of care and supervision needs, as should the notification that the individual could not be left alone due to his epilepsy. In two cases, including one in which care workers reported substantial difficulties delivering the care plan, refusal to use equipment that had been assessed as necessary should have prompted review of how needs were being met in the absence of equipment. In one case of care home failure, the SAR notes that the reviewing practices of placing agencies was not consistent with legislation: reviews were not undertaken or were poorly recorded or undertaken without other agencies' or the family's involvement. In another, no review of needs took place when an individual moved into independent living, having previous only been assessed when moving from his family home into respite care, when no discussion of independence had taken place.

> "It would have been good practice for [the Council] to have held a review meeting at the point where X was being offered a permanent placement or early into the move so that (his) progress and support could be considered. This may not be a statutory requirement but it was a significant missed opportunity … that there were no opportunities for review with the commissioning authority … At the time of his death X had been in placement for over three years and no review was undertaken."

Risk awareness and assessment: Closely associated with how needs were assessed and met is the question of whether appropriate account was taken of risk. SARs provided a range of evidence that elements of risk in the cases reviewed had not been addressed.

- Absence of risk awareness: Escalating risk took place in the lives of the people who featured in the SARs without risk-aware responses from agencies. Examples in include failure to note the risk implications of an escalating frequency of hospital admission, suicidal ideation, patterns of drug use, serious deterioration in physical health, uncollected prescriptions.

  SARs in a number of cases commented on fire safety, noting low risk awareness related to methods of heating, smoking and the impact of mobility and hearing impairment on the potential to exit.

  > "[Practitioners] saw smoking as X's lifestyle choice and did not question risk to herself or others in the vicinity."

  Often the absence of fire risk awareness arose from a failure to link together factors in an individual's situation, for example smoking and hoarding, or self-neglect and the use of dangerous electrical equipment or methods of heating and lighting, or smoking and the use of medical supplies like emollient creams, oxygen or an airflow mattress. The example below shows the complex range of factors involved in building risk:

  > "There was a significant risk of fire throughout the reporting period that was not on the radar of the involved agencies. The … care plans did not refer to a smoking risk or the need for supervision whilst smoking in bed. None of the involved agencies or X's partner were aware … of the risk of emollient creams spreading fire. It was known that X slept on an airflow mattress, which also presented a risk of spreading fire once it had been ignited … The smoke alarm on the premises was not working and a fire extinguisher was not accessible to X. [The] Fire Brigade missed two opportunities to offer fire safety checks, when crews were called to the address to assist in gaining entry due to missing keys. On both occasions, the attending crews were unaware that there was another vulnerable person in the home, or of the risk factors, and considered the calls to be routine."

- Absent or poor risk assessment: SARs gave numerous examples of missing or incomplete risk assessments, one SAR describing risk assessment as inconsistent and incompetent, absent or not taking account of all relevant information. One report notes that the vulnerabilities of a homeless man with mental health issues were not considered in cases of police contact with him and no vulnerable adult assessment was completed. Other cases note an absence of risk assessment by an out of hours service, by care homes on admission of a resident, by a young person's residential mental health facility, by emergency department hospital staff in relation to potential domestic abuse, by Adult Social Care despite safeguarding involvement, by medical staff in relation to risk from harmful drinking, by Police in relation to background checks on people with whom a vulnerable man was living, by ambulance personnel prior to withdrawing from a call-out, and by social care practitioners following an older woman's disclosure of abuse by her son. In a case that resulted in the murder of one resident by another, the SAR makes the point that risk assessment should have considered the risks of racially motivated victimisation and notes:

  > "The pre-existing concerns about X and Y's circumstances were sufficient to warrant a thorough risk assessment prior to X's placement. However, no assessment took place. Good practice would dictate that this would apply to all vulnerable residents but given the history of these two men a lack of risk assessment in their case was a fundamental omission."

In the case of a bedbound sheltered housing resident who died in a fire started by her smoking, despite a care plan that involved her smoking only in the presence of care workers, there had been no comprehensive and holistic risk assessment. In another case in which no action was taken on receipt of a Police risk notification, the response was found to be insufficient:

> "Neither the ASC nor the mental health social worker undertook their own risk assessment – this was a further missed opportunity to provide an integrated response to X's deteriorating situation."

> "X's likeability and vulnerability and fluctuation in cooperation may have served to diminish the concerns that justifiably attach to a disturbed young man of uncertain mental health and cognitive ability who often carried, and had shown willing to use, a blade. Had better risk assessments been developed and updated regularly, the extent to which they were insufficiency mitigated might have been better recognised."

One SAR raises the possibility that risk assessment is overlooked through attitudes that pre-judge alcohol-dependent individuals, seeing this as a cultural issue that results in failure to secure a focus on risk.

In cases where a risk assessment did exist, in one case it emphasised the individual's clinical presentation, omitting any assessment of the impact of alcohol on her life and relying on her self-reports about her wellbeing. In another a choking risk assessment had been incorrectly completed and calculated and was conducted only once without being updated monthly as required. In another, there was insufficient knowledge of an individual's history due to information loss during multiple moves, leaving staff to rely solely upon her own account. One SAR notes limited risk assessment of a 'dynamic nature', with individual risks considered in isolation, for example in relation to risk of pressure damage there was no joined-up consideration across equipment, nutrition, hydration, transfers and hoisting, and availability and delivery of care.

A further factor emerging in some SARs was the failure to link events together to form a cumulative picture of risk. This was raised in relation to patterns of attendance and admission to hospital, and to patterns of Police notifications on persons at risk:

> "The Merlin referrals appear to have been reviewed in isolation of each other. There is no reference in the later referrals to previous referrals and no reference to the increasing level of concerns."

A further example of partial risk assessment - relating to a man subsequently killed by someone who had befriended him - shows that while risks related to his mental health and long-standing drug use were considered, those related to self-neglect or being exploited or harassed were not. He had no plan for how he could summon help if worried. Here these omissions were compounded by poor assessment by the Community Rehabilitation Company of the risks posed by the man who killed him, and a failure to escalate risks to the National Probation Service.

Two SARs considered how risk was assessed and managed in cases involving the transition of young people from children's to adults' provision. In one case information about a young man's sexually inappropriate behaviour was not fully known when the decision was made to admit him to a residential college, which was followed by a series of assaults on another resident. In the other, involving a group living setting where one young male resident with a known history of sexually motivated assault killed a young female resident who had known vulnerabilities to exploitation and abuse, the SAR identified a number of flaws: experience of the male resident had been lost during the transition to adult services, adult mental

health services had insufficient oversight of the placement process; the care home was not aware of the reason for his previous placement ending and their own risk assessment was limited and did not reference the potential risk arising to female residents.

In a further case in which a woman was murdered by her male co-tenant in supported mental health provision, historical warning signs about violence had been downplayed and the risk assessment lacked detail in terms of the nature of his aggression and its triggers. It did not consider any possible risks of placing the two tenants together. When his behaviour escalated – an assault on his sister, aggression to staff raising concerns for their safety, his statement about the risk of stabbing his co-tenant and an observation that he kept a large kitchen knife by his bed - no consideration was given to the safety of his co-tenant

- Absence of risk mitigation: In some cases where risk was assessed and recognised, no actions were taken to mitigate risk. One SAR notes the need for greater clarity about the significance of terms such as 'red zone', questioning whether staff saw this as a simple flag to indicate risk or a trigger for escalation and additional action to mitigate it. Another noted the absence of mitigating factors to offset risks from the physical vulnerability of a homeless man in cold weather. Risk mitigation attempts were not triggered even in response to rapidly escalating evidence of harm.

> "X has been failed by services. Exposing her to sexual abuse by a third party, if appropriate steps – through care planning and risk assessment - were not taken, is professionally negligent and possibly a breach of the duty of care. The evidence suggests a possible breach of the right to respect for private and family life and potentially a breach of the right to protection from inhuman or degrading treatment."

In some cases where fire risk was evident, the expertise of Fire & Rescue Services was not sought:

> "He was not referred to the Fire Brigade for a Home Fire Safety Visit. Primary care plus GP had identified the fire risk but did not use agreed escalation procedures to follow up."

And even when fire safety equipment was available, it may not be accepted by the individual. Here one SAR notes that resistance to using fire-retardant bedding and clothing was not factored into the risk management plan. Another notes the absence of any safety measures to contain known risks of smoking.

In a SAR relating to the murder of two women by the male partner of one of them, the report notes a series of failures by the Police, Adult Social and others to recognise and act upon sustained evidence of risk towards both the women, one of whom was disabled. It comments that a more proactive policing response to breach of a restraining order would have given a clearer message:

> "The lack of prompt and assertive police actions in relation to this incident was a missed opportunity … (to) deliver a message that repeated breaches of restraining orders (now in force in relation to both women) would result in enforcement actions and adverse consequences."

Other examples include a man subject to detention under the Mental Health Act 1983 left alone while a bed was found without any risk minimisation for the interim period, during which he left the house and died in a car accident; a young person left unprotected by any contingency plan for mitigating the risk of harm from his mother's behaviour once he was discharged from children's safeguarding; a young person's residential

school not reporting to the Police a sexually motivated attack on a staff member by a resident, wishing to manage behaviour within a therapeutic setting without criminalisation; and a care home where staff misunderstood the purpose of actions being taken under the risk framework:

> "Waking night staff should have made a difference but was likely to be undermined by the ongoing confusion about exactly what the staff were for: some thought to address concerns about mobility issues and the risk of falls, others that it was to address the concerns about binge eating. In the absence of clarity about this and a lack of clarity about X's mental capacity, the waking night staff were likely to believe that they could not prevent him from helping himself to food."

- Reasons for low risk awareness and poor risk management: A few SARs reflect on why risk awareness and risk management were poor. Several comment on the influence of the 'rule of optimism' – an unconscious bias towards a favourable view of the situation making it less likely that practitioners will imagine (and prepare for) the worst. One SAR notes the possible impact of de-sensitisation:

> "Managing risk over a fairly lengthy period requires a watchful approach in which staff are trained to notice differences or variations from the norm. This did not appear to happen in X's case, with evidence that over time staff became de-sensitised to the risks he faced … The 'protection plan' in place was never reviewed or updated in the face of escalating risk."

Other reflections include how the insight that an individual might show when not intoxicated could lower practitioners' perceptions of risk, and the possibility that practitioners did not recognise the impact of a person's disabilities on their ability to keep themselves safe. Equally, the focus on making safeguarding personal in one case deflecting attention from risk in the face of an individual's assurances that risks were manageable, and in another it create dilemmas for staff wishing to support a young woman to have a quality of life yet also to manage her risky and challenging behaviours.

Safeguarding action

A key question related to risk is whether safeguarding procedures were appropriately used in the cases considered. SARs here make a number of observations.

- Referrals to safeguarding: SARs frequently find that no or few referrals to safeguarding were made in cases where such referrals would have been warranted. Examples included a Police report about mental health concerns being screened out in the MASH due to an absence of apparent risk, medical staff attributing injuries to health conditions, exploitation not being seen as requiring safeguarding, vulnerability to financial abuse not being considered to be safeguarding, a GP seeing a relationship between a vulnerable adult and his informal carer as abusive but not pursuing this, a hospital emergency department that identified necrotic pressure wounds but made no referral, and self-neglect not being recognised as a safeguarding issue. Thus some situations were simply not seen through a 'safeguarding lens'.

> "The history of trauma, and substance misuse and self-harm, low mood and anger management issues were well known but there were no formal safeguarding concerns although the police raised a welfare concern and the health visit made multiple referrals to different services."

> "Only the ambulance service raised safeguarding referrals. Other agencies also had opportunities to raise safeguarding concerns based on their observed concerns, which they recorded in their records, although this was not done. Repeated safeguarding referrals may have acted as a marker of risk and therefore highlighted care needs."

The absence of referrals could mask the level of concern that could need to be applied to evaluating safeguarding risks:

> "Most incidents where X was harmed, harassed and unsafe from herself or others were not seen as requiring formal safeguarding referrals to the safeguarding team and subsequently there were very few referrals made over the period for this review."

- <u>The safeguarding response:</u> SARs are sometimes critical that safeguarding referrals made were not taken forward as safeguarding enquiries under section 42 of the Care Act 2014. In some cases, this was because it was believed that risk had already been managed: an incident in which a resident bit another, although referred, did not progress because the risk assessment relating to the perpetrator had already been amended. Thus the opportunity to reveal quality of care deficits, which were discovered later, was at that point lost.

  The application of criteria to determine whether the section 42 duty to enquire was engaged clearly influenced the safeguarding response, and SARs sometimes question this. In one example a decision was made that the individual did not meet the criteria for safeguarding, despite at the time weighing less than 6 stone, being diagnosed with COPD and living with the partner who had assaulted her. The SAR speculates that her addictions may have affected the decision that she was not in need of care and support.

  In three examples, shunting referrals between teams or agencies resulted in the safeguarding referral being taken forward. Instead of being pursued a safeguarding enquiry, one referral was sent straight to another agency, with the result that no assessment (in this case of self-neglect) took place. In another case, the safeguarding team proposed that the concerns be addressed through care and support assessment, but the referral to the community adult social care team was not allocated, so no assessment was done and two further referrals from district nurses for urgent support were not picked up. In the third case:

  > "EDT received the [ambulance service] safeguarding referral. Details of financial abuse were not evident in the referral. Self-neglect issues were deemed addressed as she was in a hospital/intermediate care bed, so the referral was sent to Adult Social Care for a care and support assessment. The social work team assumed she had capacity as a self-funder and there was no further action."

  In some cases, the decision not to proceed was arguably erroneous. A referral stating that a vulnerable young man was frightened of someone he had lent money to was not pursued because he hadn't given consent. In another case a referral triggered by alleged controlling and abusive behaviour within a domestic relationship was not pursued for lack of evidence that the female partner was unable to protect herself. In a referral for self-neglect, the response was that the case did not warrant safeguarding as the individual had mental capacity. In one example the SAR overly challenges the decision that was made:

  > "There are two broad areas in which one may have raised safeguarding concerns or queries. The first broadly relates to self-neglect: by virtue of his alcohol use X's physical health care was significantly impacted and he did not manage his physical health well. The second broadly relates to the potential concerns of financial abuse in relation to the community fundraising activity and money collected on his behalf. Three

safeguarding referrals did not progress to s.42: With the benefit of hindsight, and an understanding of the interaction between alcohol and mental health needs, one might reasonably reach the view that Frank's ability to protect himself was indeed not fully within his own 'control'. Part of the reasoning for one safeguarding referral to not proceed to a s.42 enquiry was that X was stated to have 'no apparent care needs'. It is hard to understand this reasoning in the face of the presenting mental health needs, which are then specifically identified by the professional reviewing the referral."

Sometimes reviews were unable to determine the reason for action not being taken, despite evidence of the need:

> "No effective action was taken with respect to the evidence of physical and financial abuse, the latter according to X's relatives running into many thousands of pounds."

Even where safeguarding enquiries did proceed, SARs were sometimes concerned about standards of practice. In some cases, practice departed from policy and procedural expectations:

> "Although recorded as an adult safeguarding concern no actions consistent with either the SAB Safeguarding Adults Policy or the Self-Neglect Policy appear to have been taken."

> "Safeguarding practice was not in line with (the) safeguarding policy and procedures or standards as defined under section 42 of the Care Act 2014. There were delays in coordinating safeguarding responses and ensuring that individual safeguarding concerns were fully assessed so that identified risks were managed."

There were delays in responding, in one case for months. Sometimes safeguarding gave only a partial response. In two cases in which both financial abuse and self-neglect had been reported, only the financial abuse was taken forward. In another where safeguarding was closed out of respect for the individual's wishes, no action was reinstated when he subsequently declined care and support assessment. A hospital referral detailing a range of concerns did not result in comprehensive follow up. In a case involving injury in a care home, the police and safeguarding investigators did not initially assess the nature of the bruising, nor did the care home monitor its progression; when the incident was escalated to safeguarding and criminal prosecution, no interim protection plan was made. In a case of serious domestic abuse, the response to the risks the family faced was described as superficial and over-optimistic and in another the needs of children who had witnessed domestic abuse were not followed up. One SAR notes that a series of safeguarding referrals raising concerns about financial abuse and coercive and controlling behaviour from an adult son to his mother were not appropriately actioned. A further SAR notes that staff failed to take action even when information suggesting significant risk was placed directly before them in the course of their work:

> "The records evidence that involvement lacked continuity, that concerns were not followed through, and that connections were not made. Some social work staff seemed to assume that without criminal court level evidence no safeguarding could be undertaken – not even a plan to support and protect someone could be put in place."

- <u>Patterns emerge as significant:</u> One SAR notes that numerous opportunities to start safeguarding earlier had been missed. Another notes that a series of safeguarding referrals did not result in accurate identification of the individual's needs for support with the conditions of his home

environment and he was deemed to be able to meet his own needs without support. In one case, all six safeguarding referrals did not receive a robust response. In others, a history of referrals was not considered. In one example each episode was seen in isolation, the safeguarding was closed and the case handed back – the individual concerned went without protection from harassment, abuse and cuckooing over several years.

There were also examples where the SAR concluded that safeguarding had been closed prematurely, before a robust risk management framework was in place.

> "The decision to close the safeguarding referral … was taken prematurely without a full appreciation of the facts. The view that X was able to protect himself from harm because he had … contacted the police in the past was an unsafe assumption. Even if correct, it implies that the risk of X being further assaulted by Y remained and this is not an acceptable conclusion for a safeguarding concern. X's needs (should have been considered) in more detail … his risks and vulnerabilities as an asylum seeker, a vulnerable adult, and victim of racially motivated hate crime over several years."

In another case the risk of choking remained and a safeguarding plan to manage that risk was not in place. Even where a plan was in place, there were challenges. Protection planning in response to sexual exploitation was seen to lack effectiveness, with no detailed planning taking place. The safeguarding plan was not always successful at containing risk of harm, particularly in cases where the individual was unable to fully engage with the protective measures attempted, and in such cases safeguarding was not always re-visited.

Attention to specific aspects of the individual's circumstances

The circumstances of the cases reviewed by the SARs contained a number of features in relation to which practice required improvement. These related both to aspects of the individual's presentation (for example, their health, mental health or mental capacity) and to key processes (for example hospital discharge or transition). Evidence of shortcomings in how these were addressed are considered here.

- Finance: Several SARs noted that the individual's financial situation did not receive appropriate attention. Self-funding status threw up some challenges. In one case, no care and support needs or financial assessments were carried out following a period of reablement because of assumptions that the individual would be self-funding his care. In another, there was no review of the individual's self-funding status; she was not given information about the possibility of reassessment if her care needs increased. In fact she was not self-funding but was paying full costs, but in the absence of reassessment this error was never corrected. In addition, there was no investigation of financial abuse or of her capacity to understand and manage her finances. Another SAR makes the point that a person who would be self-funding was still entitled to assessment:

  > "Despite the family's ability to self-fund, this should not have impacted on her entitlement to a full assessment that was robust in informing the care package that the family would be paying for. A more robust approach to discussing the implications of self-funding was needed, and a financial assessment should have been offered."

  In other cases, direct payments posed challenges. Examples include annual review visits not made annual review performance below required expectations and inadequate monitoring of payments.

Elsewhere the impact of financial and housing concerns was significant. In one case, inappropriate, cramped accommodation in poor condition created despair and domestic instability but the impact on health and wellbeing was not fully appreciated. In another, failure to ensure that a replacement property was suitable for an individual's mobility and care needs resulted in her maintaining her original property, paying two rents and running up substantial debts. It was unclear that she understood the financial commitments she had made, although the local authority pursued her for debt recovery.

- Health: *Some* SARs criticised poor attention to health concerns, in primary care noting a lack of formal medication review, missed annual learning disability reviews, and an absence of healthcare risk assessment.

> "X had only infrequent reviews from his GP, despite experiencing a range of chronic physical health conditions. Of course, X did not … reliably seek out such support or contact … One factor that may have complicated the situation was that X was not registered with a local GP …for some time. (His) chaotic life situation will also have contributed. Had it been possible to offer more assertive input at a primary care level, this may have worked to prevent some of X's hospital admissions."

Sometimes rigid expectations about surgery or clinic attendance ruled out the possibility of health practitioners making home visits, even when a pattern of non-attendance emerged. In one case a GP was unable to examine the individual as the surgery had nothing in place to support people who needed to use a ceiling hoist and a home visit was not requested or suggested by the surgery. Non-attendance at appointments was not routinely followed up.

> "There was only one home visit made by his GP as there was an assumption that because X was mobile this wasn't required. This was a missed opportunity to consider X in his home environment and make an informed assessment of his needs."

In residential and nursing care also concerns about how medication was handled, with long periods between review, blood tests not completed on time, administration of medication poorly recorded. In one case delays by a care home in sourcing prescribed medication meant that it was never administered before the resident died.

As for people with learning disability, parity of esteem issues arose in relation to mental health and physical health: in several cases mental health concerns overshadowed physical health, with the latter poorly attended to; in one case a mental health team did not refer to the individual's GP for investigation, despite evidence of poor physical health. The interaction between mental health and physical health was not always recognised:

> "Although he was closely monitored in hospital, it is not clear how all these assessments and reviews, including of his emotional wellbeing and mental health, came together and the impact of his emotional health on his physical wellbeing and vice versa."

Other examples of healthcare needs not addressed included a lack of investigation of the reasons for sudden immobility, poor attention to diabetes and diet, no system for monitoring vital signs or dehydration, incorrect assumption that constipation was the cause of symptoms, incorrect use of a catheter bag, failure to recognise the significance of a high output functioning stoma, departure by a registered nurse from the recognised response to choking, failure to identify hearing impairment, failure to monitor serious weight loss and to implement weight loss care plans, and a lack of regular dental checks:

> "Lack of regular dental checks resulted in pain and acute need. He was indicating pain by gestures, vomiting and eating less but such changes were not seen as significant or serious. Gestures and behavioural changes (were) attributed … as 'behavioural' rather than triggering an attempt to understand what was being communicated."

Poor skin integrity and pressure ulcer care featured in several SARs, with district nurses focusing on equipment checks without examining pressure sites, delays in nursing visits following hospital discharge, failure to visit at the agreed frequency, deficits in care resulting in pressure ulcer development, a failure to use recognised assessment tools or grading of pressure wounds, reliance on care staff reports to monitor skin integrity and apply treatment, and pressure care risks not integrated with care and support plans.

Some treatments that would have been appropriate, for example support for smoking cessation or detoxification, were not offered. The impact of health conditions on self-care was not considered:

> "During the period when concerns were being raised by the brother and the solicitor, the implication of a potential interaction between a decline in X's ability to look after himself and his diagnosed diabetes was not considered."

Conversely, one review was critical of a GP's decision to prescribe community detoxification drugs without a package of support first being in place, in breach of policy and guidance[103].

- Hospital discharge: Many SARs raised concerns about the process of hospital discharge. Discharge planning was found to be inadequate. The discharge sometimes took no account of key needs, such as the inability to bear weight and to mobilise, or the suitability of accommodation to which discharge was being made, such as the presence of stairs for an individual who could not use them. In one case a woman who could not use the telephone to summon help was discharged without her pendant alarm. Key equipment was not arranged, in one case leaving someone with a double amputation unable to cope in what the SAR describes as an unsafe discharge. One SAR notes that deterioration in health was attributable to poor discharge having taken place. Sometimes facilities were not checked:

  > "X was discharged … to the homeless bus in his pyjamas with a supply of incontinence pads when it was uncertain whether he could be accommodated there due to his incontinence. No multiagency discharge planning meeting was held."

  Indeed, a thematic review of rough sleeping comments that discharge arrangements for rough sleepers were often problematic, with insufficient planning for care and support needs, challenges of self-discharge, non-compliance with medical advice and medication and a lack of contact details.

  In several cases, an absence of home visits prior to discharge impeded planning:

[103] Department of Health (2017) *Drug Misuse and Dependence: UK Guidelines on Clinical Management*. London DH.

> "Despite X being the subject of a safeguarding concern for self-neglect and the report from the ambulance service about the state of his property, no check was made with his landlord as to the condition of his flat during the five days that he was in hospital. He was seen by a hospital occupational therapist but no home visit was planned pre-discharge, in line with hospital discharge policy."

Some SARs noted an absence of risk assessment, for example no fire risk evacuation plan for an immobile individual accommodated upstairs. In other cases there were missed opportunities to reassess care and support needs, and in one case to conduct a comprehensive risk assessment prior to discharge where one was warranted due to a complex situation; here a family's subsequent avoidance of contact resulted in no practitioner contacts being possible in the months before the individual died. One SAR notes that the discharge of a woman to a residential care home while still undergoing larvae therapy for wounds to her leg was inappropriate.

In some cases, there was poor liaison between hospital and community teams. Discharge summaries were sometimes incomplete, failing to note pressure sores, to include moving and handling plans or to provide information about medication, the management of wounds and dressings, and monitoring requirements for a patient with acute kidney injury and high stoma output. As a result, community agencies and care homes were always not well-informed about health status. In one such case a district nurse logged an unsafe discharge.

> "X arrived home alone by taxi at 19.45 with dressings on his head, arm and foot. The care provider states that there was no information about managing these dressings. A bag of medication was enclosed and one indicated it should not be taken with insulin. Insulin was therefore withheld. (The following day) the care provider contacted the district nurses as the hospital, when contacted, had advised that they were expected to change the dressings daily. The nurses were unaware of this and said that he would have to go to the surgery, as he was 'mobile'."

Agencies were not always notified; in one case a care agency had no knowledge that a care package needed to be re-started, nor were the family advised, and no arrangements were made for activating heating. Hospital teams were not well-informed about home circumstances. Discharges took place in the absence of necessary care and support being in place and there were delays in providing medical follow up, occupational therapy and physiotherapy assessment. Informal support networks were not activated either:

> "The Hospital Discharge Team assessment failed to gain an understanding of the significant role that X's informal support network played in meeting his needs."

Some SARs note that repeating patterns of discharge and readmission continued, without changes to processes that clearly were not resulting in stability:

> "Discharge planning arrangements do not appear to have changed despite repetitive patterns surrounding his admissions to hospital, often seriously ill with sepsis, infected wounds and uncontrolled diabetes, and with a history of rejecting services."

- <u>Housing/homelessness:</u> Many of the above themes are reproduced with respect to people experiencing homelessness, especially missing or delayed assessments of mental health, mental capacity and risk/vulnerability, and discharges to no fixed abode. Also referenced here are failures to consider the range of legal powers and duties that might assist in meeting an individual's needs, including when they have no recourse to public funds, and lack of clarity about referral pathways.

- Mental capacity: Attention to mental capacity was one of the most frequently noted deficiencies in direct practice in the SARs in this analysis, with concerns about how assessment, best interests and deprivation of liberty were addressed.

    - Failure to assess: There were numerous mentions of failure to assess mental capacity when to do so was warranted. These included examples in which mental capacity was assumed, and other in which it was simply not considered even in the face of chaotic choices and persistent risk:

        > "[There was] no formal mental capacity assessment when his cognition was poor, affected by his mismanagement of diabetes, disturbed sleep patterns and mental health problems."

        > "No detailed assessment appears to have taken place – this should have been indicated due to his fluctuating capacity (alcohol), known health needs and chaotic lifestyle, appearance of self-neglect and inability to follow through on decisions."

        Further examples include a failure to consider the mental capacity of parents to meet a young person's needs, to consider the capacity of a man with dementia to consent to surgical procedure, to consider capacity in the face of health deterioration yet continued refusal of support, to consider a care home resident's capacity to make choices about the food he ate, to record a capacity assessment before issuing a Do Not Attempt Resuscitation order, and to assess the mental capacity of a man whose mother's decisions resulted in his care plan not being implemented (along with consideration of whether she was committing an offence under section 44 of the Mental Capacity Act 2005). In some cases, there was reliance on a capacity assessment undertaken some years previously, in breach of the time and decision specific requirements in the Act; in one example this precluded assessment of a man's ability to make decisions about involvement in a relationship that was also coercive and exploitative.

    - The assumption of capacity: Several SARs comment on how reliance on the assumption of capacity served to close down awareness of the need to monitor decision making ability in the face of escalating risk and frailty. One SAR notes that it was unclear to staff where the threshold for setting aside the assumption lay: how concerned should they be before an assessment is warranted. Another finds that an assumption of capacity led to an individual's resistance to medical examination and care refusal not being challenged at all. Sometimes the failure to assess capacity defied all the evidence:

        > "A striking feature of this case was that in face of the evidently unwise decisions, increasing risk and self-neglect by X, and the dedication of a small group of professionals, how readily professionals both assumed he had mental capacity to make those decisions and avoided actively engaging with him in more probing discussions about the decisions and their consequences."

    - Shortcomings in capacity assessment: Where assessment did take place it sometimes fell short of expected standards. One SAR notes that assessment by an ambulance crew was 'cursory'. Others find that assessment toolkits provided for staff were not used. A further SAR notes that assessments did not appear to have considered all relevant information, one in particular noting that the ability to 'use or weigh' relevant information had not been explored. In one case an occupational therapist was noted as having considered capacity but the SAR comments that an assessment of orientation to place, month and day does not constitute a satisfactory assessment of capacity. In another

case there was confusion about whether a young man had capacity in relation to decisions about nutrition, hydration and medication. Sometimes links between alcohol use and capacity, or between mental health and capacity, were not considered, and risky decisions not evaluated through a mental capacity lens:

> "Overshadowing of mental health meant that unwise decisions were left unassessed in terms of the impact of depression on … decision making."

SARs note the need for better understanding of 'the diagnostic test', which was seen to be both misunderstood and applied in a rigid way. In one case the absence of a diagnosed mental disorder became the reason for not proceeding with the remaining elements of a capacity assessment and for failing to consider other possible reasons for her decisions. Other SARs called for consideration of both fluctuating and situational capacity, for more clarity on the decision for which capacity is being tested, for better attention to the need to carry out repeat assessments in the light of changed behaviour. In several cases the SAR notes a lack of evidence that an individual's understanding of the implications of making a risky decision was tested.

A number of SARs discuss the question of executive capacity, noting that faced with unwise decisions practitioners sometimes relied on an assumption that the individual was making a 'lifestyle choice' rather than exploring whether had difficulties carrying out decisions even when they had stated the intention to do so. One notes that it was easy to overestimate comprehension and overall cognitive ability, particularly in the presence of verbal skills. Others concluded that insufficient attention was given to factors, such as the cognitive deficit of chronic alcohol dependence, that could explain the gap between stated intention and actual behaviour.

> "Executive capacity (was) not considered in the light of his history, mental health, capacity and (the) concept of 'lifestyle choice' (was) predicated without risk assessment."

> "There was a lack of recognition that X was unable to carry out his own good intentions … Instead there was a presumption of mental capacity throughout, even when he was clearly not coping or when sepsis and other infections were present."

One case illustrates well the complexity of the factors that could need to be considered to make a robust assessment of capacity:

> "X appeared to understand the impact of eating excess sugary foods at the time he was being told about it but he may have been unable to internalise the information and act upon it when he was alone. It is possible that he had difficulty with abstract concepts such as 'too much sugar will make you ill', especially when he was unaware of any ill effects. He simply continued to do what he had always done throughout his life. Whilst it is not for this review to make judgements on his likely capacity to make decisions about his diet, it seems probable that he did not have the executive skills to understand fully the implications of eating sweet food and weigh up the information about his condition, compounded by his resistance to following instructions generally."

Such shortcomings sometimes had significant influence on the degree to which protective action was taken. In one case, the view that the individual had capacity:

> "Appears to have sometimes been viewed by services and professionals as a limitation on their ability to intervene to prevent the neglect or abuse. At times the issue appears to have been conceptualised as an active choice on X's part to be abused or neglected; or at least, an active choice not to seek treatment or intervention that might ultimately lead to a betterment of her situation. This unfortunately echoes findings in previous safeguarding reviews where self-neglect has been conceptualised as a 'lifestyle choice'."

- Records: Recording of capacity assessment in some cases were noted to be poor: one ambulance service record did not state what decision the individual lacked capacity to make, another made no capacity record about a hospital admission refusal. A psychiatrist's assessment was not formally recorded. One SAR interprets the lack of records as an indication that assessments were not robust:

> "Professionals say they did assess X's mental capacity on occasions but there is no formal record of this and from information before the review these may have lacked the requisite formality. It would therefore seem that professionals thought they had fulfilled their duty to assess when actually a more detailed consideration was required. There are some references to mental capacity in a number of agency records but no detail about whether a formal assessment was done, by whom, how this was tested or how conclusions were reached and in consideration of which factors. This is surprising given X's complex needs and the challenging nature of the assessment. Professionals across the services do not fully understand the potential complexities of a mental capacity assessment for an individual such as X and all the factors that needed to be taken into consideration."

- Staff understanding and confidence in applying the MCA: In considering the reasons for these observations some SARs mentioned confusion and misunderstanding of the Mental Capacity Act 2005 among staff, and uncertainty about their role as decision makers. There were disagreements between agencies about whose responsibility it was to undertake assessment. In one case the Police and the National Probation Service were said to have a limited understanding of the MCA and their role within it. One SAR found that practitioners avoided making capacity assessments even where they had concerns about capacity:

> "Currently the practice appears to be that MCA (assessment) is undertaken only when it is almost certain that the adult at risk lacks capacity … Practitioners also avoid completion of a capacity assessment because of a perception that this is a time consuming activity outside of their main role rather than it being fundamental to their support of service users. In effect they see capacity assessment as an 'add-on' rather than a fundamental aspect of their role."

This SAR concludes that practitioners will abide by the principle of presuming capacity even if they suspect the service user lacks capacity, particularly if the result of the assessment is uncertain or if the person agrees with the practitioner's opinion about the decision. A further observation was that practitioners will defer to somebody they perceive to be an expert on mental capacity, despite having greater knowledge of an individual's lifestyle and habits.

- Best interests decisions: Best interests decision making also attracts adverse comment. Some SARs note an absence of formal consideration of best interests, of consultation, of advocacy and of recording. In one example legal advice to use a best interests balance sheet to aid decision making was not followed. One SAR notes that in making decisions about diet for an individual who lacked capacity his wishes and feelings, which were clearly demonstrated, were not taken into account, another that NICE guidance on covert medication in care homes was not followed. In another case a decision to provide palliative care only, due to the individual's poor physiological state,

was not supported by any evidence of a best interests process. One SAR records that it remained unclear whether a young woman who moved multiple times between placements, and between placement and hospitals, had consented to the moves or whether they had taken place as best interests decisions.

Other SARs noted an absence of appropriate consultation during best interests decisions. One SAR found that a decision not to attempt resuscitation in someone who lacked capacity had been made without sufficient consultation with appropriate people who could have provided a voice for the individual. In a further case, an amputation was carried out as a best interests decision without consultation with a sibling and without an Independent Mental Capacity Advocate. An IMCA was similarly missing in a decision to discharge an individual to residential care as opposed to returning him home when he himself lacked capacity to make that decision. In a further case where a Lasting Power of Attorney was involved, decisions were made without the attorney's involvement and despite practitioners' awareness that she was struggling to fulfil her duties due to geographical distance they did not advise the Office of the Public Guardian. A further feature in this case, which involved a man who died of systemic sepsis as a result of untreated leg ulcers (amongst other conditions) was that his refusal of treatment had resulted in no treatment being given, despite his lack of capacity to make that decision:

> "Despite the conclusion that he … lacked capacity to decide on care and treatment, his refusal of care and treatment on a daily basis in the nursing home was respected by staff ... Given he was deemed to lack capacity to give agreement, this is a paradoxical position."

- Deprivation of liberty: Situations involving deprivation of liberty also drew criticism. In some cases, no DoLS authorisation had been sought, resulting in arrangements that were unlawful. In one case:

> "X was not able to leave the hospital at will and would be considered to have been deprived of his liberty. There is no record that his capacity to consent to this deprivation was assessed. Whilst he was not restrained physically, he was prevented from leaving the hospital through distraction and persuasion … It seems probable that his capacity to consent fluctuated, indicating that a referral … to consider authorising this deprivation under the Deprivation of Liberty Safeguards would have been appropriate."

In a further case, staff did not fully understand the scope of the DoLS. They believed that the individual was not allowed out on his own, but in fact there was no legal authority for this.

- Court of Protection: Several SARs note an absence of application to the Court of Protection for assistance in assessing capacity or determining best interests, particularly where the latter was disputed between parties or raised particularly complex issues. In one case no application was made because it was anticipated that the court would find the individual had capacity

- Capacity outside the MCA: Finally, even where an assessment resulted in a finding that the individual had mental capacity within the meaning of the Mental Capacity Act, there was sometimes insufficient recognition of the possibility that decision making was being impaired by third party influence, coercion or control, as in the case of a man who was unable to sever relationships with people who were abusing him and the perpetrators were known to be violent, threatening, manipulative and controlling.

- Mental health: SARs presented evidence that in some cases mental health had not received adequate attention. There were some circumstances in which mental health assessment had not taken place. In one case the focus remained solely upon physical ill-health. In another, no assessment took place to determine whether not eating was an acceptance of death or a sign of depression. In a further case the absence of assessment impeded all other work being attempted with the individual:

  > "The mental health social worker did make several attempts to see X … When this approach proved unsuccessful it was determined that X did not have a mental health need. This is surprising given the weight of evidence to support this - as evidenced by his psychiatric history and his presenting behaviours. A fundamental difficulty for all the agencies working with X was the absence of a fully informed and agreed assessment of his mental health and learning difficulties."

  Access to mental health services was a difficulty noted in several SARs. One person was deemed ineligible after a telephone assessment in which it was likely she minimised her difficulties, but the history was known nonetheless. A thematic review of rough sleeping notes that the majority of the rough sleepers experienced mental health problems but none had recorded contact with mental health services, which with their centralised base and no outreach were seen as insufficiently inflexible for the needs of this population.

  Once accessed, mental health treatment was sometimes found wanting. In one case treatment of bi-polar disorder appeared not to engage with the patient's trauma and suffering or with her underlying physical pain and discomfort. Her behaviour was seen as bad behaviour, not behaviour indicating distress. In another case the refusal of treatment and missed appointments did not result in mental health review and only once was the person recalled, despite the existence of a Community Treatment Order. In a further case the absence of a crisis plan meant that agencies lacked an understanding of the signs and symptoms of relapse and of the actions that should be taken. In others, suicide risk assessment was poor and did not factor in all the stressors apparent in the individual's life. A further SAR notes absence of attention to very poor home conditions. In another case conflicting mental health diagnoses and the lack of sustained involvement from community and hospital specialist mental health services meant that the interventions offered were unable to obtain any consistent "grip" in addressing the individual's mental health needs. Personality disorder was not always well served. One SAR notes that early specialist input would have been very helpful in providing closer case management at a clinical level. And in another case, where the individual was discharged from secondary mental health services because of 'an absence of any clear consistent or significant presence of severe psychosis, mania or depression', the review notes that their diagnosis of personality disorder would have been sufficient justification to have access to the service.

  Dual diagnosis, for example mental health and alcohol dependence) was not always recognised. Drug and alcohol support serviced did not link the individual's behaviour back to mental health issues, which were beyond the service's remit. This SAR notes that despite the provision of support for immediate presenting problems, substantive input for his mental health condition in the years prior to his death was lacking:

  > "Specifically, it does not appear that he received any specialist assessment of mental health needs by mental health services in the local area, contrary to a clear NICE recommendation for this to occur for people where there are 'clinically important symptoms' of PTSD and there is no evidence that he received any evidence based psychological treatments for PTSD … The lack of input for his mental health problem is notable and appears a significant potential missed opportunity for intervention."

In one case there appears to have been some confusion between a mental health assessment and a Mental Health Act assessment, with the GP believing they had requested the latter, but the mental health team proceeding with the former.

The Care Programme Approach was not used robustly in several cases. In one case a lack of continuity arose in another case as a result of a change of care coordinator, which resulted in a loss of contact.

- Transition: Transition in this context covers a range of different changes that can occur in an individual's life. One that figured in a few SARs was the transition between children and adult services. In one case, planning had faltered on the issue of eligibility criteria for adult social care:

> "Transition planning for X may have been significantly improved by earlier and closer working between Adult and Children's Services ... The focus of planning seemed to fall down upon attempts to meet the threshold criteria for adult services as X clearly did not demonstrate the skills to live independently. It does not appear that any significant formal safeguarding and/or risk assessments were undertaken in relation to X once she became an adult."

On another case, poor transition planning for a young person posing known risks of sexual assault to others resulted in their risks and needs as an adult not being planned for. Their placement on leaving specialist care did not reflect their known needs and risk assessments were flawed, failing to take account of risks to others in the care setting. Risk management was crude and not understood, monitored or reviewed in the provider setting.

Another form of transition considered in a few SARs is that between different forms of accommodation. Here SARs noted a lack of coordination between services when a person moved and questioned whether the transition process was robustly managed between institutions. In one case practitioners failed to recognise the impact of moving on the mental health of the individual

Working with families and significant others

- Failure to engage with families: SARs noted that in some cases there was limited contact with family members and often a failure to recognise their needs. Examples included carers' needs being overlooked by a range of agencies – police, ambulance, mental health trust, adult social care - including an absence of carer's assessment, a failure to recognise a family member's own vulnerabilities. Often despite their close involvement with an individual, family members were not invited to multidisciplinary meetings, were not asked to contribute to risk assessments, were denied the opportunity to contribute views to best interests decision making. They were not kept informed about changes in care and treatment, care plans or safeguarding referrals and concerns about risk.

> "X's family had not been informed of the safeguarding referrals the provider states they made to the safeguarding team, nor of the concerns from the previous nine months in relation to exploitation and mate crime."

SARs sometimes referred to these patterns as an absence of a 'think family' approach – a failure to consult with siblings, children, parents, even when they were providing significant levels of support and in one case a failure to consider the risks of children's exposure to alcohol misuse, mental ill-health, isolation and domestic abuse. In one case, an individual's self-discharge from hospital and subsequent refusal of services when

living in conditions of severe self-neglect – a move that had serious implications for her parents and her children - did not initiate a proportionate response from services. This was compounded by poor recognition of a child carer's perspective:

> "There was a lack of a joined or focused up approach to supporting him and understanding the impact of this role on his emotional wellbeing and on his day to day life. Agencies seemed to have little understanding of what he wanted or hoped for during this episode and his views about what would be best for his future were not apparently sought."

In another case, a family's exclusion compromised the level of support an individual received when making a transition to independence:

> "There is no evidence that his family were involved by professionals in any planning to support X toward independence, or indeed in any aspect of his support. As family members they may have been able to advocate for (him), as well as support him. They had been very involved with reviewing and planning his support prior (an earlier move) but after this point they were not invited to meetings or informed of any element of his progress. X continued to spend time with his family on holidays and extended visits, but they were excluded from all aspects of his interaction with services."

Several SARs recognise that practitioners may have had concerns about confidentiality but note that such exclusion represented missed opportunities to improve an individual's wellbeing. In one care home staff were unclear what could be communicated to relatives, and families were not informed about a CQC's intention to close the home, with subsequent distress for residents and relatives. In another case a woman at acute risk of pressure ulcers remained confined to her bed despite an assessment having established that she could, and needed to, transfer to a chair; here the assessment had not ensured that the family understood the risks of her remaining in bed and failed to take account of their reluctance to rearrange the room or purchase different furniture.

In some cases, the involvement of the wider community, even where the individual had a significant presence or was highly visible, was not sought. Practitioners sometimes did not recognise the potential contribution of significant others:

> "It does not appear that this neighbour was recognised as a carer or the extent established of the care and support that he was offered. It does not appear that this neighbour was asked for information regarding X's past and present living situation when he might have held useful information."

> "The solicitor had offered to undertake a joint visit with (adult social care); this would have been a vital opportunity to see X's living conditions and try to establish the possibility of a relationship with him. The offer, recorded on the concern form, was not noticed, and never taken up."

One SAR comments that agencies working with the individual denied themselves opportunities to make the most of his relationships with people in an informal support network, not simply as a means of obtaining information about him but also in planning and providing interventions to support mental health recovery and rapport-based engagement with his self-neglecting behaviours.

- <u>Poor communication:</u> Even where families were involved, SARs noted problems. Disputes between practitioners and family members were not uncommon but sometimes remained unresolved. One family who had been told that no information could be shared with them without the

individual's consent complained about 'obstructive and rude' communications from professionals. Several SARs found that insufficient weight was placed on information the family had provided. One SAR noted that the family became the 'de facto' coordinator of services, having to take responsibility for stimulating communications and decisions. In another case a family struggled to know who to contact and were passed from agency to agency.

Communication was sometimes problematic due to a failure to provide interpreters, with reliance placed on family members or a family friend. One SAR notes that one such family meeting was attended by one and possibly more perpetrators and the police, although a bailed suspect was present. Another notes that although a family member had been told he could not attend a safeguarding meeting about his brother because it would also discuss information about other residents, yet he subsequently received the minutes without information on the other parties redacted.

- Absence of attention to family dynamics: A number of SARs had concerns about failure to explore and understand complex family dynamics. In some cases, there was a lack of clarity about what relationships within a household were like, with a number of SARs noting unrecognised co-dependency:

  > "Although (the mental health team) knew the couple over several years there were different views about the relationship and who was victim/perpetrator, and whether there were damaging interdependencies."

  > "X and Y minimised the nature and level of abuse and denied being either victim and/or perpetrator. On the final day the attack may not have been preventable or predictable but the co-dependency of the couple had not been recognised ... within CPA, safeguarding or care management processes and was not addressed."

  In one case, an individual's ambivalence towards her parents, and concerns that they might be undermining her care plan, were not resolved. The need for a contract covering the frequency and nature of her contact with them was discussed but not fulfilled.

  In other cases, power relations within a family or household were characterised by coercion and control that was not identified, or if recognised was not challenged. In different cases a mother, a husband and a son had been allowed to control conversations and questions, without the individual's view being sought. In some cases, the power and control in the relationship with practitioners lay with the family member, with implications for evaluation of risk.

  > "After his return home, mother was not challenged about her inability or unwillingness to cooperate with X's care plan, which meant she had power and control. There was no professional questioning of her capacity to make decisions for her son and whether intentionally she was depriving him of necessary medical treatment."

  In another case, the SAR notes very little focus on seeing the individual, who lived with his mother and sisters, alone; staff accepted the mother's terms in order to preserve some contact with the family. Despite recognising the mother's concern for her son, the SAR concludes that he was living in a closed and restricted environment with possibly inconsistent access to vital medication. In a case in which allegations of rape, financial exploitation and assault had been retracted, the SAR comments that insufficient consideration was given to who was with her when she did so. A

further SAR notes the barriers that a friend who resided with the individual consistently placed between the household and practitioners were never satisfactorily addressed.

> In one case, despite knowledge of a complex relationship between two men residing in the same household, practitioners responded to their individual needs without addressing the interdependencies; the stresses of their living together were not addressed, nor were their mutual caring roles.

- Absence of challenge: A final theme relating to family involvement arises in cases in which practitioners did not challenge the views or behaviour of family members. There were failures to address a range of circumstances: a mother's minimisation of the risks her son posed through sexually inappropriate behaviour, which masked his real needs; barriers an informal carer raised to the delivery of reablement services; a family's opposition to a resident's move to a ground floor room; a family's opposition to recommended measures to prevent pressure ulcers; a claim to hold next of kin status that was fabricated; and an unchecked claim to hold Lasting Power of Attorney for both finance and health and welfare.

Recording

SARs noted a number of deficits in recording practice in the cases under review. In some cases, there were no records relating to key decisions or intervention; examples included the ambulance service, care agency records and care home providers:

> "There are many gaps in the provider's monthly reports and other information submitted by them. There is repetition and evidence of 'cut and paste'. Their notes only convey biographical fragments."

In one case, disciplinary action was taken against care home staff for poor recording that did not keep track of bruising. In another, where a resident's death was in part attributed to hypothermia, there were no records of agreed regular checks being taken on residents' temperatures during the cold night before she died in a care home with boiler failure and no heating. Poor record keeping in another home led to a resident being given solid food, which he aspirated, when he needed a puréed diet.

In other cases, the quality of records is questioned, with a failure to reach professional standards. Examples included records of the process of safeguarding, where the review noted that the rationale and relevant evidence for decisions made were not recorded. Nursing records contained insufficient information about pressure ulcers, skin integrity, grading and Waterlow scores and body mapping. Community health services recording was described as "sparse and sometimes inaccurate". A care home's records had gaps in key sections of an assessment, such as weight, skin integrity and mental capacity, and recorded incorrectly that the resident used an electric wheelchair, whereas in fact she was immobile. Another had not recorded pressure injuries or provided a body map when the resident was admitted to hospital. Other care home records were described as below standard: they contained inaccuracies and were "largely aspirational and practical, hand-written and scant, repetitive and using stock phrases". In some health records vital details, such as absence of information about a Lasting Power of Attorney, next of kin or family contact, were missing. In one case the name of the alleged perpetrator was not recorded, leading to difficulties in the subsequent abuse investigation. In another, meetings were not clearly recorded.

One SAR notes a striking of absence of information about the individual in practitioner records. In one case this related to practical information about what the individual could or could not do and what carers were providing. In another, records relating to a life in care had been lost, along with the knowledge they contained of the person's early life experiences. In another, hospital records had not been updated in a timely way, resulting in a social worker not being aware that the individual had been discharged home. In another the records of an individual had not been linked with those of a close family member, resulting in incomplete understanding of their situation. In some cases, the quality of recording compromised the ability to share information with others or to clearly identify actions and responsibilities. More generally some records did not contain the rationale for practitioner decisions that had been made.

Several SARs also note the need for better recording on mental capacity assessment processes and outcomes, as well as on the client's wishes.

7.1.3. Making Safeguarding Personal: Finding the Person

Another major theme is how, in the assessment and meeting of needs explored above, practitioners fell short in respect of making safeguarding personal. There are a number of aspects to this: engagement (and reluctance to engage); relationship-based practice; understanding of history; promoting participation and voice; and personalising intervention.

Engaging with the individual

Practitioners often experienced difficulty securing sufficient engagement with the individual and SARs note an absence of strategies to address this. In some cases, there was insufficient persistence – sometimes agencies, including adult social care, mental health and substance misuse services, were noted to take refusal at face value and too quickly cease their attempts.

> "When she did not engage, some agencies withdrew."

In one case practitioners did not try creative attempts to engage on an individual's own terms, despite evidence that he could have been willing to do so. Practitioners were uncertain what pathways could be followed when someone declined care and support, had complex healthcare issues and poor housing conditions. 7.1.13.3. There was a lack of planning and consultation on what could be done and the risks from declining services were sometimes poorly assessed. In one case the SAR notes that refusal should have led to mental capacity assessment but did not.

Some agencies had policies and procedures for responding to non-attendance at appointments or refusal of access but practitioners failed to follow these. SARs noted a need for practitioners to be more proactive when faced with consistent lack of engagement, factoring communication needs into account, taking account of possible barriers such as disorganisation of lifestyle, involving specialist agencies and using significant events (such as hospital discharge) as opportunities to effect change and persist.

Using relationship

A number of SARs note limited attempts at relationship-building and state that more focus could have been placed on building a relationship of trust with the individual.

> "Had statutory professionals been able to build a trusting relationship with X it might have been possible (although not certain) by negotiation and persuasion to have assisted him to make safer choices."

> "There is now a growing body of evidence to suggest that by working with people who have a personality disorder and by developing with them an optimistic and trusting relationship the distress they experience and outcomes can be improved. It is difficult to understand why this approach was not attempted with X."

One SAR notes a missed opportunity to appoint a key worker, where the opportunity to work closely with one person could have helped develop a better understanding of his needs. In another case, the individual had far stronger relationships with his informal support networks of church and friends than with practitioners, making it less likely that he would approach agencies for support when he needed it. In a case involving a young person in supported living the SAR notes that no practitioner had built up a sustained relationship with him over time – a relationship that could have provided insight into his experiences and feelings. Another individual was noted not to be engaged with any agency sufficiently to enable work to support her to make changes in her life. The SAR notes that while practitioners understood that relationships were vital to help effect change with a person who is self-neglecting, they varied in their understanding of how such a relationship could be used in practice.

Knowledge and understanding of history

Knowledge of the individual's history was sometimes lacking, making it difficult for practitioners to understand the reasons for their present behaviour and limiting their ability to make a personalised response. SARs comment in several instances that further exploration of life-biography may have highlighted experiences that could explain current circumstances – for example in one case how behaviour was linked to the need to manage feelings of abandonment. In one case, a woman in her 50s had spent her whole life under the care of services, yet:

> "The absence of a credible life story is stark, that is, one which goes beyond setting out X's likes, dislikes and challenging behaviour … Her life-long history of being supported by services is reduced to a dishearteningly short list of home-based activity … X's life story is not known - the relevant parts of her past and present have not been recorded. The services to which (she) is known appear not to have any processes for eliciting stories about her and her family as a means of connecting her life to her present circumstances and the people who are significant."

In some cases, the impact of adverse childhood experiences, significant events, trauma and bereavement was not taken into account, although linked to experiences in the present:

> "The impact on both X and Y their (the) death and subsequent loss of their family home could similarly be seen as bereavement but the consequences were never addressed by any agency."

> "None of the agencies involved in providing support to X or safeguarding her children knew very much about her former partner, the children's father, the circumstances of their separation or much about the domestic abuse to which she had referred ... Even less was known about her hopes, her fears and her possible shame around the interventions that she was experiencing."

One SAR comments on a level of naiveté and lack of understanding of the history in a case, making it unlikely that repeating patterns would be addressed. In fact, a number of SARs comment on how practice engaged in 'more of the same', despite historical evidence that approaches had been ineffectual in the past.

Even where history is available and known, it was not always drawn upon. One SAR, noting that significant risk information had been lost over the years because practitioners did not check back over historical documents, identifies what it calls the "phenomenon of people who outlast the systems that support them".

Promoting participation and voice

A key aspect of making safeguarding personal is ensuring measures to promote the individual's participation and voice in decision making. SARs gave a number of examples of a failure to consider an individual's wishes and feelings in a variety of settings, including A&E hospital departments, hospital wards, mental health services, care homes, community health teams and adult social care.

> "No evidence of discussion with X about whether he saw any future for himself, or whether he could see no other way out than death."

> "Statutory agencies did not meet X as part of the safeguarding investigation, therefore there was no direct information relating to her capacity to be involved."

On occasion the individual's element of choice was removed. Several SARs notes that practitioners consulted not directly with the individual but with their family, without having their consent to do so. In another case a communication plan did not record clearly what the individual had consented to have shared with his family. In other cases, an assumption of capacity was made, without the individual being seen, on the basis of information provided by his brother; an assumption that an older woman was safe and well was made on the basis of an interview with her son; many decisions were made in the absence of direct input from the individual, who was seen rarely without her mother:

> "It is hard to conclude that clinicians ever gained a clear understanding of what X's views and wishes would have been in the absence of her mother's control."

Several SARs comment on individuals lacking support to take part in assessments and safeguarding processes. In some cases, translation services were needed but not arranged. In others, although practitioners recognised the need to make reasonable adjustments to support the individual to participate in key decisions about his care, these same adjustments were not subsequently used in discussing fire safety and the risk of harm from smoking in bed. In another case communication needs were poorly met:

> "There were issues of communication between X, his support staff and his wider support team. There was no evidence of a communication plan, no evidence of the use of advocates, no evidence of any easy read documents or the use of video. On this basis the conclusion has to be that there was not effective communication between support staff, the wider team and X. Employed staff at all levels needed to be comfortable to talk to X in language he understood ... There was no evidence this happened."

The absence of advocacy was notable in a range of circumstances where an advocate could have made a significant contribution - in assessments, safeguarding enquiries, health-related decisions and best interests decisions. In one case attempts to secure advocacy were frustrated when the advocacy provider refused on safety grounds to work in the house, which was infested with bed bugs. In another, where a daughter was ostensibly the person's advocate, the SAR found that the daughter was in fact representing her own views rather than the views, wishes, feelings and best interests of the individual. There was no observation or consultation with the individual, and reliance on her daughter's views potentially constituted a conflict of interests:

> "As such it is hard to identify how assessments and interventions reflected the wellbeing principle of the Care Act which should underpin person centred interventions and approaches."

What these shortcomings amounted to was a lack of voice for the individuals concerned:

> "X's voice was not central to assessments and reviews. He was not given opportunities to disclose. He was always seen with his mother and usually in the family home. His mother was present at all medical appointments. His mother was X's voice."

Personalising intervention

The personalisation of intervention is at the heart of making safeguarding personal. The SARs reviewed show two key ways in which practice diverged from the principle. First was the absence of intervention that reflected knowledge and understanding of the person, their goals and sought outcomes. Approaches were described as not person-centred and not informed by the individual's wishes. In one example they did not reflect personalised assessments of nutritional needs or ways of responding to challenging reactions. In another, risk assessment and risk management were not fully discussed with the individual to seek understanding of her resistance. In another, the moves of residents following a care home failure were badly planned and frightening for the people involved, with families not involved in supporting the transition. A further SAR notes that a focus on process, eligibility and thresholds stopped practitioners taking a person-centred approach when assessing needs and seeking to mitigate risks. The 'personal' was not identified:

> "At this point in his life X was extraordinarily isolated. He had lost his two key supports in life. He had feelings of intense grief. His family home was being sold, and although he had been able to negotiate the retention of a part of the property to stay in, he is reported to have been unhappy about the sale. No activities were undertaken to 'find the person'."

In one case the SAR is critical of a failure to be frank and open with the individual about his approaching death.

> "It would have been good practice to support X in understanding his impending death and help him to prepare for it and to die with dignity … A striking and tragic feature of this case was how everyone avoided saying directly to X at the end that he was dying and instead the energy and focus of service activity remained on further assessment, diagnosis and treatment."

The second divergence is what one SAR called a misunderstanding of making safeguarding personal through what another calls an over-reliance on self-report. Here, making safeguarding personal was interpreted as deferring to the individual's choice. The claim of a woman with a double

amputation to be able to manage her personal care was accepted at face value without observation to identify challenge she might face. A man's statements that he was happy with the care he was receiving at home were not triangulated with concerns expressed by the family and evidence from elsewhere that the provider was struggling to improve from an 'inadequate' CQC rating. In several cases, behaviours such as excessive alcohol consumption and refusal of service were assumed to be from personal choice and unquestioningly accepted, closing down exploration that could have provided greater insight. One SAR found that the potential for an individual's disengagement led staff to avoid important conversations that would provoke her disagreement, leaving her views prioritised above other important considerations:

> "This is natural but is unhelpful on a long-term basis and the avoidance of those discussions seen during this episode laid the foundations for the dynamics within and the way in which X's relationships with agencies functioned."

> "There is evidence that perhaps the balance between X's autonomy and the risks he posed to himself and his wife whilst they shared accommodation was skewed towards X's independence, allowing the risks posed to remain unchallenged."

7.1.4. Practitioner Attributes

The fourth and final major theme among the shortcomings of direct practice noted in SARs relates to practitioner attributes that draw comment. These focus on practitioners' knowledge, skills and confidence, on their legal literacy, and on their professional curiosity.

Knowledge, skills and confidence

Some SARS commented on gaps in practitioners' knowledge and understanding. Some practitioners were said to struggle to understand the nature of domestic abuse, why it occurs and why victims remain in abusive relationships. Other examples of knowledge gaps included type 1 diabetes, personality disorder, borderline personality disorder and autism:

> "Across the agencies, there was a great deal of disparity of knowledge of X's personality disorder or whether she had mental illness at all. Some agencies were genuinely surprised to learn that X had a personality disorder and many professionals did not understand what that meant for their work with (her) or how this might need to influence how an individual may need to be managed."

> "It did not appear that all professionals who had contact with X fully understood her complex needs and in particular her autism and therefore the best way to communicate with her."

Other SARs identified circumstances in which practitioners' knowledge or skills had been challenged: knowing when a threshold for escalation to emergency services was reached; responding to challenging behaviour; providing support in using social media to an individual who was coerced and exploited through forming inappropriate relationships when using it; and interpreting family chronologies.

> "The very nature of neglect means that good recording and good skills in interpreting chronologies are vital practitioner attributes. The joint review did not receive information that indicated that this work had taken place with this family."

SARs attributed these observed gaps to staff being unqualified or unsupervised, or both, inexperienced, or lacking confidence. In one case they questioned whether staff in supported living accommodation were sufficiently qualified and experienced to meet the needs of the resident.

Legal Literacy

Knowing and using legal powers and duties in the pursuit of practitioner goals is a central element of practice. The SARs noted many instances of shortfall here. One SAR refers to the Care Act 2014 being used as a process rather than as a tool; needs were not considered holistically through observation of prevention and wellbeing principles. Several note that section 9 assessment did not take place as individuals were believed to be self-funding and make the point that eligibility for assessment still applied.

In relation to safeguarding, there is reference to a safeguarding concern about a young man being fearful of someone to whom he had lent money was not pursued because he hadn't given consent. A housing department did not raise a safeguarding concern because there was no third party involve, the SAR commenting explicitly that this represents a misunderstanding of section 42 of the Care Act 2014. A review relating to sexual exploitation notes that some of the difficulties in tackling this form of abuse and neglect relate to the fact that:

> "Application of law and standards of practice on consent, capacity and right to choose is complicated and uncertain."

The Mental Capacity Act 2005 and the related Deprivation of Liberty Safeguards gave rise to some misunderstanding in some cases. A housing provider had stated that assessment of mental capacity was not a statutory duty for landlords. A care home had not correctly identified the nature of a Lasting Power of Attorney, believing it to be for health and welfare when in fact it was only for finances. Three care homes were noted to have had no authorisation in place for individuals deprived of their liberty. A man was evicted from sheltered accommodation when he may have lacked capacity to litigate and when deputyship for his financial affairs would have been appropriate. In one case there was poor understanding across agencies of the interface between the Mental Capacity Act 2005 and the Mental Health Act 1983 in facilitating treatment for a physical health condition that was associated with a mental disorder.

Several other SARs note a failure to make application to the Court of Protection, in one case for management of finances, in another to secure access to a man living with his mother who had become invisible to agencies. In a further case, the SAR notes that the Court of Protection should have been considered as an avenue for resolving disputes between the practitioners and the family about how assertively a young man should be treated in the context of his refusal of nutrition, hydration and medication. A further SAR notes that no legal advice was sought and no court action considered to secure treatment for a man in nursing care whose skin integrity breakdown had not been treated due to his persistent and aggressive refusal, despite being assessed as lacking capacity to make that decision.

Where an individual had capacity, one SAR notes practitioners' frustration about unwise decisions, feeling unclear what legal options there might be to safeguard her wellbeing. Another notes:

> "It was felt that there was no legal framework to apply safeguarding despite concerns about exploitative relationships and risky situations, which were deemed to be her choice."

In one case where court action in either the Court of Protection or the High Court had been identified as the only way to resolve a longstanding situation, there was little urgency applied to taking an application forward:

> "Unfortunately, this recognition of the need to request such intervention did not translate into any actual referral to a court. In the last few months of X's life, it seems that more focused efforts were being made to gather appropriate information to make such a referral. Unfortunately, this was to be too late."

In another case, the impact of coercion and control from another party was not considered as a reason to consider application to the inherent jurisdiction of the High Court. In other cases too there was a failure to seek legal advice.

Other areas of uncertainty included the location of responsibility for carers' assessments, and the use of section 136 of the Mental Health Act 1983; here an ambulance service wanted the police to use section 136 to detain someone in a hotel room, which the police (supported by the interpretation in the MHA Code of Practice) believed was inappropriate. One SAR noted that law had not been used effectively to control perpetrators of domestic abuse and sexual violence again an individual. Another noted the need for improvements in applying the Human Rights Act 1998 and the Equality Act 2010.

One case demonstrates how central legal literacy is to safeguarding; here a systemic lack of legal literacy created a confluence of factors that militated against effective practice. The SAR notes that across agencies there was a lack of awareness about the range of legal options available; it was believed there were no powers of entry that could be used; there was a lack of understanding among some practitioners, including in social care, about the role of police welfare checks; application to the inherent jurisdiction of the High Court was not considered; there was poor understanding of when a best interests decision should be referred to the Court of Protection; and fears if over-reaching legal authority.

Professional curiosity

A practitioner attribute that draws frequent comment in SARs that note its absence is professional curiosity. Often this related to practitioners' failure to probe the circumstances with which they were faced. Examples include an absence of curiosity about the reasons for refusal of care and support or healthcare, for the neglected state of someone's home, for a reluctance to return home or for the retraction of allegations of abuse. It might relate to a failure to explore inconsistencies and mixed messages, or the impact that an individual's life experience might have on their current decisions.

> "There is no evidence that anyone sought to understand the rationale behind any of X's decisions."

SARs found limited evidence of professional curiosity in relation to risk assessment, carers' needs and capabilities, family dynamics, the identity of someone claiming to be a next of kin, chaotic lifestyle, rapidly escalating health needs, repeated hospital attendance, or dropping from visibility. In one case a safeguarding outcome was found not to be robust because through a lack of professional curiosity it was based on inadequate information. In cases involving self-neglect, the lack of personal or domestic care was noted but without progressing to an awareness of the risks arising. In some cases, practitioners missed the obvious: one resident in a care home with a broken boiler was so cold that she had to be wrapped in a blanket to warm her before a GP could take a blood sample, yet no temperature check was made and the implications for other residents were not considered. In another case care staff and managers had missed the significance of a strong smell consistent with necrosis. Sometimes the focus

remained solely on practicalities, such as a request for housing, or providing equipment, or transport. One SAR called this a minimalist approach with questions of eligibility dominant. At times a response to immediate risk was made without engaging with the bigger picture.

> "Taking time to develop a more profound understanding of her mental health needs, derived from consideration of trauma and her behavioural presentation, and insight into her lived experience, which included disrupted attachments and loss, might have informed assessment and decision making."

Cumulative and repeating patterns were not always identified or used to build understanding but were treated in isolation. In one case a series of Police notifications to adult social care about a vulnerable adult at risk received the same response each time, merely being forwarded to an agency believed (wrongly) to be in contact with the individual:

> "This shows a significant lack of professional curiosity, poor risk assessment and lack of using historical context when reviewing referrals by adult social care."

One SAR attributes the absence of professional curiosity to a range of factors, including practitioners feeling they lacked time or a mandate to ask more than 'essential' questions, concern about an individual's hostility, potential lack of cultural awareness or misplaced concerns about causing offence, lack of belief in the importance of understanding the wider context, beliefs that other agencies already had these in hand, and the impact of very immediate health and welfare concerns. Others refer to a culture of professional optimism that prevented practitioners looking beyond the presenting circumstances to address 'why' questions, and to a prioritisation of autonomy and lifestyle choice over risk and protection.

> "Workload pressures, when combined with individuals who appear to have capacity to refuse treatment and/or care and support, may result in insufficient (time for) professional curiosity and an emphasis on respecting a person's autonomy rather than persistence in raising concerns about risks of significant harm."

7.1.5. Looking back and forward planning

With varying degrees of emphasis, all the concerns regarding poor practice when working directly with individuals and their families have been reported in previous thematic analyses of SCRs and SARs[104]. SABs individually, regionally and nationally should engage in dialogue about what makes adult safeguarding practice so challenging and change so apparently difficult to achieve.

[104] For example, 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*. Bristol: South West ADASS. Manson, S. (2017) *Report from a Thematic Review of Safeguarding Adults Reviews Within East Midlands*. East Midlands ADASS.

Improvement priority twenty three
In light of the reporting by SARs of poor practice in direct work with adults at risk, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to improvement across their partnerships. Based on SAR findings, priorities for attention include: 1. How needs and risks are assessed and met (addressing specific forms of abuse and neglect; responding to gender, race, sexuality, learning disability; assessing, planning and reviewing intervention; risk and safeguarding; factors such as finances, housing, health, mental health, mental capacity; key processes such as hospital discharge and transition; working with families and significant others; recording); 2. Making safeguarding personal (securing engagement; relationship-based practice; knowledge and understanding of history; promoting participation and voice; personalising intervention); 3. Practitioner attributes: Improving knowledge, skills, confidence, legal literacy and professional curiosity.

7.2. Domain B: The Team around the Adult - Interagency Working

Key aspects of interagency working fell short of good practice in the SARs reviewed. Themes relate to an absence of case coordination and leadership, the use of complex case management frameworks, information-sharing, interagency referrals, use of interagency safeguarding procedures, understanding between agencies of each other's roles, out of area placements and finally a disconnect between separate organisations providing linked services

7.2.1. Case coordination

The cases under review typically had involvement from multiple agencies but many SARs drew attention to silo working within those agencies, missed opportunities to engage a multidisciplinary approach and a failure to establish a shared perspective or goal.

> "There was a lack of robust, effective individual and coordinated multiagency work to manage his complex needs that had a cumulative impact and amounted to systemic organisational neglect."

Sometimes this adversely affected the quality of risk assessment. SARs noted the absence of any rigorous and jointly owned/shared risk assessment, even though each agency individually was concerned from their own perspective. One SAR notes that agencies used different risk assessment tools and lacked a shared, common language around risk – even the term 'risk assessment' had different meanings in different agency contexts. Others noted that each agency had undertaken its own risk assessment according to their area of interest but none had initiated a multiagency risk assessment. One SAR explicitly refers to the silos in which agencies worked.

> “Agencies are planning and reviewing service users’ complex needs with limited interface with other professionals, so that risk assessment for service users takes place in silos rather than being holistic and coordinated. Every agency working with X conducted reviews and risk assessments but did not involve other agencies in those reviews.”

One SAR, reviewing the fire death of a woman with a history of house fires who received all her care while confined to bed, where she smoked, notes the failure of coordination in how risk was managed: adult social care reviews focused on her care package, not on risk management or coordination of provision; the Fire & Rescue Service undertook home fire safety visits without drawing on information about her fire history and without knowledge that she used an Airflow mattress and emollient creams; district nursing staff were not aware that she smoked in bed. The chosen approach to reducing fire risk relied on her smoking only when care workers were present, yet she was known to hide cigarettes and lighters; the care agency did not escalate its concerns about the effectiveness of the strategy; no agency had taken action to secure fire retardant bedding. The SAR comments:

> “It is hard not to conclude that comprehensive and holistic risk assessment, particularly of the risks arising from her smoking, was missing.”

SARs provided multiple other examples of failure of coordination. Multidisciplinary assessment of an individual with multiple diverse needs and trauma was not provided, resulting in a lack of understanding and shared perspective. The lack of a fully defined care pathway with appropriate senior clinical oversight, early specialist input, close case management and multiagency understanding meant that an individual’s care fell outside the national expectations and guidance for personality disorders. In several cases there was reliance on assumptions that someone else, in some other agency, would be doing what was necessary, whether that was risk assessment, mental capacity assessment, safeguarding or liaison with the family. Such assumptions were sometimes unfounded:

> “Assumptions were made that mental health care coordinator would arrange post discharge care, but mental health teams had little experience of adults of working age with health needs, or how to arrange care packages.”

In a case in which a pressure mattress failed, leading to the individual spending several months in hospital for pressure sore treatment, the SAR notes a failure to coordinate a pathway for equipment maintenance between the various agencies involved in its prescribing, commissioning, reviewing and monitoring. Assumptions were made that it was someone else’s responsibility and there was no coordinated process from beginning to end that was easy for the user to negotiate.

In a case involving the hypothermia-related death of a woman in a care home, the SAR notes substantial debates between agencies about who should act, to which lack of clarity in a national Memorandum of Understanding between CQC, the Health & Safety Executive and the LGA contributed:

> “The days that followed the first reports of the care home’s boiler failure … were a critical point at which interagency communication, information-sharing and coordination were required. Instead, this period was characterised by delay and lack of clarity about who could and should be taking what action, and who could and should be coordinating the efforts of the agencies involved.”

The lack of a shared perspective led to agencies responding in different ways to the individual. In one example the person accidentally started a small fire in their kitchen. The fire service recognised her vulnerability, raised an internal safeguarding alert and also spoke to the integrated mental health

team with concerns around safety and mental health. The police arrested the individual on a charge of arson with intent to endanger life. A further SAR notes that the absence of a coordinated strategy left agencies managing crises after crisis reactively.

> "X's case was approached essentially in crisis management mode rather than through a coordinated response focusing on prevention and protection."

Even where systems to promote coordination between services existed, lack of clarity could inhibit their use:

> "The SafetyNet management system to aid the coordination of partnership activity (Police and Community Safety) does not work as effectively as it might due to its lack of use by key potential partners. And there is a lack of clarity on how it should be used to manage vulnerability and track risk."

There were also failures to coordinate services during transitions. In the case of a disabled child in transition from children's to adults' services the two services worked within their own silos, failing to engage sufficiently with each other. In another young person's case agencies did not coordinate their individual efforts to find a smooth pathway; threshold criteria became obstacles and communication between agencies dropped off once the individual reached 18. A further young person's transition was informed only very late in the day by a contribution from adult mental health services. In a further example, this time in mental health where responsibility for funding was being transferred from continuing healthcare to section 117 of the Mental Health Act 1983, and therefore from the clinical commissioning group to the mental health trust, the breakdown of communication and coordination between the two agencies resulted in an absence of mental health reviews and no robust plan or review of the individual's care needs. The SAR observes that for good case coordination clarity about funding arrangements is essential. The transition between hospital and community was a further pivotal point at which failures of coordination could have adverse consequences. One SAR notes how, even in repeat hospital admissions that should raise curiosity, the impact of home circumstances can be overlooked:

> "There is a lack of multiagency coordination and investment in discharging vulnerable adults who present and are repeatedly admitted to hospitals. This risks patient(s) being assessed as clinically fit for discharge without addressing the underlying reasons for their presentation at hospital."

The absence of shared risk assessment and a shared perspective on what intervention was therefore needed led in some cases to a failure to consider the legal powers and duties available to all agencies, as for example in the case of a man with mental capacity who died in a fire in his severely hoarded house, where the enforcement powers of environmental and public health had not been considered. In other cases, in relation to individuals who lacked capacity, the duty to make best interests decisions was not observed, leaving risk unresolved. There was too confusion between agencies about the interface between the Mental Capacity Act 2005 and the Mental Health Act 1983 in relation to securing admission to hospital of a man who lacked capacity, had a mental disorder and required lifesaving treatment for a physical condition. One SAR comments that knowledge of the law was inconsistent across agencies. Another recognised that poor understanding of statutory duties affected the response that a homeless individual received.

A further barrier to developing a shared perspective and case strategy was an absence of interagency challenge, allowing a dominant perspective to determine a way forward through others' lack of confidence to challenge perceived expertise. In one example a housing support worker, who knew a

woman well disagreed with a social worker about her mental capacity to make decisions about giving money to park 'friends', did not feel able to escalate her disagreement, deferring to the social worker's perceived status. In another, care workers found it difficult to challenge the opinions of clinicians on care and treatment, even though they knew an individual well. A further SAR noted a negative professional hierarchy amongst some practitioners, which resulted in the outreach workers rarely being invited to case conference meetings at a hostel:

> "The outreach workers felt the hostel workers did not value the information that they held or the importance of the relationships they established. This led to poor practice as information was not shared."

In other cases, divergence of opinion within the interagency network was not uncommon. In one example, disagreements about how risks to residents in a care home should be managed where there were serious health and safety concerns formed an interagency context in which the care home was able to take considerable leeway in whether and when it met deadlines for improvement. In another, fundamental differences of perspective between mental health and social care staff remained unresolved. Here an individual's discharge from hospital (close to his 18th birthday) was regarded by the external practitioner group as premature and increased the pressure on a mother who was unable adequately to meet her son's needs.

7.2.2. Leadership

Contributing to a failure of coordination between services was a lack of leadership where multiple agencies were involved. In several cases no agency held responsibility and ownership for the management of the risks presented by the individual. The absence of case management in many cases meant that there was no coordinated approach to understanding the full risk picture and agreeing a shared strategy that could then be monitored by a lead practitioner, a deficit exemplified here:

> "The opportunity to have allocated a named worker to coordinate and 'pull together' the various strands of assessment and intervention, including involvement of informal support networks and friends, was an opportunity missed."

In a further example the SAR, noting a positive step of referral for a care and support needs assessment, nonetheless concludes that:

> "Consideration could have been given to this much earlier and a lead agency identified to coordinate information and determine the most appropriate actions."

One SAR notes that the role of the lead practitioner within a multiagency plan was not always understood by all the participating agencies. Another notes a key difference in adult services when compared with complex casework with children and families:

> "There is no absolute description in guidance about the role of a lead professional and there is no concept of team around a family or team around an adult as practised regularly in children's services."

In another case, however, where a child was living with his mother in circumstances of serious self-neglect and neglect, the SAR notes that children's services responses to his revelations about his home life were not in line with statutory guidance and that no core group was convened to coordinate efforts to support him.

In one case where there were serious concerns about the care provided to a young woman by her mother in conditions described as "unsanitary, unhygienic and malodorous", the absence of a lead practitioner was seen to have a negative effect on planning and decision making regarding both health and social care provision:

> "The lead professional would have been vital in a complex case such as this as it would have helped ensure clearer communication between agencies, and also would have allowed better 'triangulation' of the wide range of information received about X from many different sources. This may have helped improve the quality of decisions made by professionals. Unfortunately, in the absence of strong clinical leadership X's mother was able to fill the role as decision maker."

7.2.3. Use of multidisciplinary meetings and complex case management frameworks

Several SARs noted that no multiagency complex case panel had been established outside of safeguarding,

> "In the absence of the safeguarding process there was not a formal system for partners to share intelligence and information and to jointly assess and respond to risk. Any professional could have initiated a multiagency team meeting but without a clear protocol nobody took the lead for arranging a meeting."

Where multiagency complex case and high-risk forums had been established, a number of SARs noted a failure to use them for multiagency consultation and coordination.

> "Under the self-neglect policy, the lead agency can also convene a 'multi agency risk management meeting' which can provide a forum for all agencies involved, and the adult themselves together with their representative, to consider a proportionate response to the risks identified and make a plan to address these. This didn't happen."

> "The absence of "whole system" meetings (including the family) to consider how to manage the challenges is a significant oversight."

In another case of severe self-neglect neither of two available frameworks that could have prompted information-sharing and case coordination – the Care Programme Approach and a local risk management forum – was used. There were a number of other examples in which the CPA was not used as a framework for holistic interagency assessment or intervention, remaining dominated by a focus on mental health treatment and failing to consider wider social care needs. In one case there was no care coordinator appointed, and other cases CPA meetings and reviews did not take place. One care coordinator did not have all relevant information from other agencies and was not advised by them about increasing concerns; the local authority's financial management team, responsible for managing the individual's finances, was not involved in CPA reviews. In other cases, there was confusion between the role of care coordinator and that of care manager, or uncertainty about who might be coordinating care:

> "CPA includes allocation of a care coordinator to facilitate review of service provision and communication between agencies … (but) there was limited clarity about who should be coordinating the care for X. There was no lead professional identified by agencies involved in his care and … no single point of contract for his family."

In another case where past convictions and a pattern of escalating domestic abuse, violence and intimidation were evident, referral to MARAC was not made in a timely way and when it was made adult social care were not represented, a significant omission given there was an adult with care and support needs in the household. Subsequent repeat incidents did not attract a further MARAC referral.

Elsewhere the system for convening multiagency risk management meetings, or the threshold for doing so, were not well known or understood. One SAR identified a plethora of risk forums, resulting in practitioners being unsure which was appropriate or even being unaware of their existence. Another notes that a forum was used by staff for convenience, because it was available and practitioners with expertise were in attendance rather than because it was the right forum in which to discuss the concerns, resulting in a lack of appropriate recording and subsequent decision making.

Elsewhere SARs noted the absence of other multidisciplinary team meetings that should have ensured a coordinated approach, for example before or after hospital discharge, in response to service refusal, or in the face of concerns about care quality. Agencies were said to be unaware that meetings could be convened even when safeguarding referrals were not made. In one case the absence of multiagency planning meetings prior to the hospital discharge of a homeless man was described as “an absence of a cohesive, coordinated and collaborative approach at these points of significant transition.” In another case the absence of a multidisciplinary meeting to discuss best interests was noted as an omission:

> “There were various attempts at assessing X’s mental capacity but there was no multi-disciplinary team meeting to agree his best interests or adjustments to be made in his best interests.”

Where multidisciplinary meetings took place, they did not always convene the whole system, and even if they did some agencies and practitioners showed a lack of engagement. One SAR calls this “a major and significant omission”. In another case, both the fire and rescue service and the police were missing despite their involvement with the individual. As a result, the fire and rescue service was unaware that the individual had a pendant alarm that could have been linked to third party monitoring, or that they had a hearing impairment that required a visible smoke alarm. A further SAR notes delays in setting up multiagency meetings to consider sexual exploitation, due to practitioners being unsure whether a process used for children and young people could be used for young adults.

Even where a risk management forum was used, the result was not always positive. One SAR comments that the outcome of a complex case meeting was unclear as there were no minutes; links between the meeting and safeguarding processes were unclear. In other cases, decisions reached were not always implemented or monitored. One SAR notes that decision making in the MARAC was over-optimistic and superficial. It did not identify multiple risks or take a whole family approach and failed to consider the impact of mental health and alcohol abuse on the individual's ability to protect her children.

7.2.4. Information-sharing

A major failing noted in many SARs was the absence of information-sharing. This was notable where agencies were working in silos, but it also featured in cases where some degree of coordination had been established or was expected.

> “Interagency work is not helped by poor information flow, from district nurses to GP, from adult safeguarding decision makers to referrers, between frontline adult social care commissioned staff and decision makers in the commissioning local authority.”

Failure to share relevant information was noted during hospital discharge, and at points of service closure. One SAR, noting closure by mental health services, notes that failure to share information left an individual exposed:

> “There is no evidence of a formal discharge process involving the GP nor of a discharge letter being sent from the early Intervention Service to the GP. A discharge plan should have been agreed and shared with X and her GP at the time of (her) discharge from mental health services to identify the ongoing arrangements for support, relapse indicators and triggers, and crisis and contingency plans.”

Another comments on incomplete information following the hospital discharge of a woman who had almost died due to a twisted bowel; while prescriptions for laxatives and recommendations for enemas were given, the particular risks of constipation were not explained to non-specialist colleagues caring for her.

Other examples included: police failure to make notifications to other agencies after noting on a home visit an individual’s poor mental health presentation and aggression to his family; failure to share information from police adult-at-risk notifications beyond adult social care; an ambulance service failing to inform an emergency department that they had assessed the individual as lacking mental capacity to decide on conveyance to hospital; an absence of shared information about an individual’s Learning Disability Health Action, which was not available or known about by all the practitioners who worked with him; failure to share information with housing providers; absence of information about health and care needs in a care home placement; poor communication between a GP and community matron about recommended doses of medication; information about mental health and self-care ability not shared between a consultant psychiatrist and a GP; failure to notify community services about a violent partner’s release from prison; incomplete information provided to a mental health review tribunal, which released an individual from hospital detention without fully understanding the level of risk he posed in the accommodation to which he was returned; to a hospital’s failure to inform a care home and community healthcare staff that an individual required end of life care; care providers’ failures to notify the local authority that commissioned care was either not being accepted or had been cancelled by the individual; a care home’s failure to tell an individual’s speech and language therapist about his nocturnal eating habits, with the result that a full assessment of the risks of choking was not completed and the preventive action plan was incomplete.

One SAR notes that there was no mechanism for the police to routinely share information about an offender with the Community Rehabilitation Company. When officers became increasingly concerned about the risks an individual posed to the public, they did not initiate communications with the CRC, despite knowledge that he was on probation, nor did they refer him to the MAPPA process:

> “The information they had was not known to Probation services and was largely understood by non-specialist police officers who were not familiar with the MAPPA processes and the rationale for referral. As a multiagency process, MAPPA could have provided the opportunity for risks to be understood and interpreted and supported agencies to work together to prepare a detailed and robust multi agency risk management plan.”

In a case of self-neglect, the full adult social care assessment was not shared with the care agency, who were there unaware of the severity of the individual's physical health problems or of concerns regarding self-management of medication or risk of self-neglect, so the agency did not escalate concerns about the state of his accommodation. One SAR notes that two individual receiving mental health services in a shared supported living context, had separate support workers who did not share risk information with each other, resulting in the absence of any strategy to manage the tensions between the two residents and eventually a murder. Another notes that two men living together where one had disclosed domestic abuse, each had their own adult social care case worker but finds little evidence of joint working or communication. A further SAR notes that district nurses, recognising the risks of surgery-based treatment for someone who was reluctant to engage, requested that they be informed of any failures to attend for clinic appointments, but were not so advised and were therefore unable to provide follow-up at home.

Even within agencies information-sharing was sometimes compromised: a police control room did not share information with officers dealing with the individual effectively; teams within a hospital did not communicate together about discharge plans. One SAR, where health and social care were integrated within one organisation, raises questions about whether such integration has assisted the flow of information between secondary and community healthcare teams, between adult social care intake and community teams, and between community-based health and social care teams.

In further interagency examples there was evidence of assessments being undertaken and decisions made based on incomplete and sometimes incorrect or inaccurate information. Handovers from one agency to another sometimes omitted key facts. Patients with complex and or serious physical health needs who attend different hospitals were noted to be at risk of not having their full histories understood by each individual hospital, as full histories remained within the medical notes retained by each hospital.

In one case, where a woman with multiple care and support needs was attacked and murdered in her home by two teenage girls, there had been over a 3-year period 472 incidents involving her reported to the police, almost half of which she made herself, with the remainder made by others either concerned for her or about her behaviour.

> "Neither this nor other information, including her high level of agency contacts and problems she had with adults and young people being at home and causing damage, informed the targeted work that the Community Safety Partnership … was doing in this area. This was despite X being identified by the police as a repeat caller and designated a priority through the Problem Orientated Policing process."

One SAR provides a 'communication ecomap' showing how information was held by a number of different sources but not equally shared across the partnership. It demonstrates "clear enclaves of multiagency or multi-care communication" and a "scattergun approach to communication". No one agency could see the whole picture. Another notes that staff beyond the local authority did not know how to share information about providers' care quality concerns, were not encouraged to do so and were unaware of what mechanisms were used to improve quality and how they could contribute to these.

A further challenge was how information shared was interpreted by the receiving agencies:

> "This case has highlighted not only how important gathering and information sharing is, but also how important it is to clarify that the information shared has been understood fully. There were many occasions where there was confusion … The recording and interpretation of

the same conversations and communications differed."

This is illustrated also in a case in which a private hospital was caring for a young woman with complex mental and physical health needs, including stoma care. The hospital stated they have offered the bed because they felt they could meet her mental health needs, but that the extent of her physical care needs was not known to them before admission. However, both the previous hospital and the commissioning body felt they had appropriately shared information on her physical needs.

addition to failures to share information, agencies sometimes failed to seek information from others through consultation to aid decision making. On a hospital discharge, health practitioners were not consulted when adult social care revised the care plan to reduce the requirement for staff to assist with moving and handling. In another, agencies closed down their individual involvements with a homeless individual without any multiagency consultation to consider the impact of their decision. In a further case, assistance was not sought to contact an individual who was reluctant to engage:

> "There were on three separate occasions proposals to close X's case following a lack of contact and an assumption made that everything must be in order owing to no response and subsequently no support was required. On no occasion did Adult Social Care contact (the NHS Trust) or the GP surgery to identify contact details of family or friends who may be able to assist with contact or gain a better understanding of his routine habits, so contact may be established."

There were examples of a refusal to provide requested information. In one case an environmental health department would only share information if a freedom of information request was submitted; the SAR noted their absence of understanding of their role in safeguarding arrangements. In other cases, SARs noted that attempts to observe principles of making safeguarding personal or article 8 of the European Convention on Human Rights the right to respect for private and family life), or to respect an individual's unwise decisions, meant that important information was not shared in circumstances when it would be lawful to do so. There were sometimes also misunderstandings of legal rules on data protection.

> "Participants at the learning event were clear that there remains uncertainty about information-sharing besides lack of access to the information systems used by different agencies and practitioners, which inhibits working together."

In one case there was evidence of differential value being attached to information from different sources; clinicians were seen to prioritise family opinion over that of paid carers, which the SAR considered diminished the value of knowledge carers held and meant that treatment decisions may not be based on best evidence.

Recording and IT systems could sometimes impede information-sharing.

> "Different recording systems compounded the issues with communication across multi-agencies."

Examples were given of communications between different services in primary care using different data management systems; an absence of shared portal to advise of hospital discharge; a police system that was described as not fit for purpose in terms of sharing information with other agencies. One SAR notes that athough information may be recorded by practitioners within their own agencies, there is often no method for linking information

across the differing systems. Thus systems restrict rather than facilitate access to information, making it difficult for practitioners to be informed of the full history of the case and current concerns. In one case different practitioners had different forms of access to aspects of the individual's medical history. The care home had a multiagency visit book where visiting professionals made an entry. However, the Learning Disability Healthcare Plan held by the GP practice nurse was not shared with the care home. The SAR comments that what was also missing was any central location where it was documented, for the relevant practitioners to see, that the condition of the individual's skin was deteriorating.

One SAR reports testimony from practitioners at a SAR learning event describing how an adult with a severe and enduring mental illness may be supported by a community mental health nurse as their CPA care coordinator and also by a mental health support worker employed by the local authority. These two practitioners would record their contacts on separate health and social care electronic systems. At the time of the incident under review, social workers were working within community mental health teams and recording information on health systems only, not those operated by the local authority.

One SAR noted practitioners' concerns about the impact of IT and record systems on their practice:

> "The representatives at the SAR Learning Event expressed concerns about the different electronic record management systems currently in use by the key agencies involved in the care and treatment of X. These IT systems, which include RIO, AIS, Medway and Symphony, do not facilitate the sharing of information and joint working across agencies and clinical teams. Staff from jointly commissioned teams have to duplicate entries into more than one system. Consequently, there is the potential for important information to be missed by staff, as they are not able to access and view all the relevant assessment plans of colleagues involved in the care and treatment of patients."

7.2.5. Interagency referrals

Some SARs noted problems associated with referrals between agencies. In some cases, the system for making referrals was flawed – this was an observation made about links between district nursing and an incontinence advisory service, and between district nursing and equipment supply services, the latter being described as unsafe and unnecessarily complicated, resulting in a referral not being actioned, equipment not delivered and therefore no provision for wound and nursing care. In one case there was no protocol to support agencies in making referrals to the fire and rescue service for home fire safety visits, leaving agencies to operate in an ad hoc fashion. In another case the SAR noted the need to clarify pathways for transition, especially for victims of child sexual exploitation, where there was a lack of access to mental health therapeutic support. In several further examples, there were difficulties contacting out of hours services.

A number of SARs noted missed opportunities to make interagency referrals. Examples included an absence of referral to mental health and medical assessment when an individual's mental health and physical health were deteriorating; absence of referral to a pain clinic; failure to refer to an intermediate treatment team for specialist advice and support about falls; lack of referral to an eating disorder service for specialist advice; absence of referral to secondary mental health services; failure by district nurses to escalate the worsening condition of ulcers to the GP or tissue viability nurse; failure to address housing disrepair issues with a private landlord; lack of awareness about an end of life referral process, leaving a family to make their own referral; and several instances in which referrals were not made to fire and rescue services for fire safety assessment and advice.

In one case, access to adult social care was noted to be difficult:

> "The ambulance service does not have a direct referral pathway to adult social care and there is no guarantee that adult safeguarding will pass on a referral to adult social care when a section 42 enquiry (Care Act 2014) is not indicated … (Other) participants at the learning event suggested that there was a need to improve access to adult social care …"

In other examples, a referral made was considered inappropriate. Despite the known factors causing one individual's severely deteriorating condition, they were referred to a reablement team, who was neither equipped nor available to provide an appropriate level of support. One SAR notes that it was not clear what the purpose of the referral to another agency, commenting that agencies needed to be clearer about what is being expected when a referral is made.

There were also instances in which referrals made were rejected by the receiving agency. Several SARs noted the perception that it was not unusual for mental health services to reject referrals. Other examples included requests from one agency to another for assistance or co-working: a consultant involved in discharge planning requested the involvement of a consultant specialist in autism, but this was refused; adult social care rejected a referral about self-neglect from the ambulance service; a mental health social worker asked the learning disability team to conduct a joint assessment of a homeless man, but this service declined to conduct an assessment at the individual's sleep site, a response the SAR describes as:

> "Unhelpful and lacking in the flexibility required to engage with someone with the level of need and complexity attached to X's case."

One SAR issues a caveat about interagency referrals, noting that they could become a substitute for effective interagency collaboration and a shared approach. Another refers to referrals of increasing concern being circulated between community mental health services, community learning disability services, adult social care and acute mental health, with no one service leading on addressing the concerns and risks. Another notes that practitioners responded to their own increasing concerns about an individual's health and wellbeing by referring him on to others rather than by communicating with others to share concerns and develop a shared plan of support and intervention. Here the referral can become what in another case is described as a discharge of responsibility from one agency to another. One SAR makes a related point about safeguarding referrals, observing in a case where multiple referrals were made:

> "The review questions whether the volume of safeguarding alerts in this case is an indication of professional uncertainty regarding the best way to respond to risks and vulnerabilities, and that making safeguarding referrals may have given professionals a false sense of security."

In another case the referrals between agencies to some degree reflected differences of opinion about which team should take the lead role for an individual who, in addition to his homelessness and substance use, had both mental health problems and a learning disability:

> "The pattern that had developed of referring cases back and across agencies was not good practice and led to delay and a lack of leadership and coordination by statutory services. These issues remained unresolved at the time of X's death."

A further SAR describes disputes between a number of unitary authorities in close proximity to each other as to which of them should take responsibility for a homeless man with multiple needs who transitioned between several locations. The SAR notes a lack of confidence in applying sections 6 and 7 of the Care Act 2014 to secure cooperation between specialisms and across organisational and geographical boundaries; equally

there were disputes about whether his needs should be addressed using the Housing Act 1996 or the Care Act 2014. The SAR concludes that the responses he received, which included being driven between authorities in the search for one that would conduct an assessment, constituted organisational abuse, violating his dignity and human rights:

> "Practitioners involved in X's case did not act with deliberate intent to cause him harm. It is recognised that X's conditions and resulting behaviours … coupled (with) the complexity of the legal framework, impact of austerity and lack of organisational … would undoubtedly impede their ability to carry out their functions. However, his legal rights to be appropriately assessed for support to meet his housing and social care needs were … repeated ignored by a number of statutory agencies and as a consequence his health and wellbeing deteriorated … He suffered serious harm, such that the failings would likely have given rise to an action for a breach of his human rights."

A further SAR comments that in circumstances such as this there could be too much focus placed on whether an individual fits the criteria for one or other specific service:

> "There needs to be a joint approach and pathway for cases that do not fit any particular team but where it is evident that person is vulnerable and has complex needs."

7.2.6. Interagency safeguarding processes

There were particular challenges in relation to interagency working in safeguarding. As explored in the section on direct practice, SARs noted many instances in which safeguarding referrals could have been made but were not, including from ambulance services, police, GPs, district nurses. SARs note:

> "Fundamental lack of understanding of section 42 across agencies."

> "Substantial doubt about the awareness within and across agencies of the threshold criteria for a section 42 enquiry."

Some agencies, although concerned about risk, did not turn to safeguarding where it would have been warranted to do so:

> "Although there were concerns about X's vulnerability and self-care no formal steps were taken by housing staff involved with X to seek to address these under Multiagency Procedures to Support People who Self Neglect or the Multiagency Policy and Procedures for Safeguarding Adults at Risk. These were two potential routes open to them address X's health and wellbeing. The scope of the self –neglect procedures includes those not engaging with a network of support and where there is a perceived and actual risk of harm, suggesting that X fell within their scope."

In this section the focus is on the overtly interagency elements of safeguarding – those relating to communication, information-sharing and multiagency collaboration. One thematic review notes poor communication between agencies and the local authority safeguarding service. The full facts were not always shared. In one case although an ambulance crew made a safeguarding referral when an individual declined hospital admission, but communication of the concern was not robust – it was made as routine rather than via the out of hours service, so no weekend safeguards were

put in place. In some cases, incomplete information shared resulted in referrals not proceeding to section 42 enquiries, often without consultation with the referrer by the local authority. In one case safeguarding records did not collate a chronology of concerns to build a wider picture and patterns were not identified until years of exploitation had happened.

In some cases, referrals to adult safeguarding were made, but when rejected staff did not escalate their concerns. Regardless of whether a referral was accepted or not, several SARs commented on the lack of feedback to referrers and some on the lack of escalation or persistence from referrers. One SAR comments that in a case of domestic abuse, the safeguarding response that a woman referred by an acute health trust did not meet the criteria resulted in the health practitioners no longer seeing her as vulnerable or at risk.

Where safeguarding did proceed, there were omissions and failures in the interagency process, including a lack of robust application of procedures and information-sharing. In some cases, there was limited use of multiagency safeguarding meetings and in others multiagency meetings were not well organised or productive:

> "The notice given to agencies to attend safeguarding strategy, case conference and planning meetings was inconsistent. Important partners were not invited and relevant information was initially missed."

> "At the … safeguarding meeting, it does not appear that any agency was appointed as the lead agency, or any practitioner as the lead or key worker, responsible for coordinating information-sharing and monitoring implementation of the plan. This too is a significant omission."

In one case, where two alerts about the same incident were received resulting in only the first being pursued, the information from the second was not merged, resulting in crucial details from a hospital A&E department not being available at a first strategy meeting, at which the hospital trust was not present. In the same case, a member of staff in relation to whose actions police were still conducting criminal enquiries attended the meeting, with the police also present but feeling unable to challenge the attendance due to the presence of the individual's son. Such a procedural irregularity would have compromised criminal proceedings had they been taken forward.

In a further example, two men who were living in circumstances of extreme self-neglect, hoarding and squalor died in a house fire. Despite a regular sequence of safeguarding strategy meetings to determine and monitor the progress of intervention, the absence of two key agencies compromised the effectiveness of the plan – the fire and rescue service had not been invited to participate so no fire risk assessment had been carried out, and despite concerns that one of the men was exercising coercive control over the other, police involvement was not sought either.

A further SAR, reviewing injuries sustained by two men in their care home, notes a series of deficiencies in the safeguarding enquiry: the lack of focus, consistency of evidence-gathering and a failure to consider and evidence hypotheses other than manual handling, leading to conclusions that were not clearly evidenced and were based on assumptions rather than fact. In addition, it notes poor coordination between safeguarding and the police:

> "The major lesson that comes from this Safeguarding Adults Review is the impact that failure to undertake a coordinated, evidence-led safeguarding and/or criminal enquiry, has on the adults who suffered the injuries, their families and in the long term to the reputation of

agencies."

Another SAR observes that safeguarding strategy meetings, while providing a forum for information sharing, did not resolve disagreements, illustrating the governance challenge within a multiagency process in which each individual agency has nonetheless its own autonomy of decision making:

> "While the series of safeguarding strategy meetings that took place … became a generally positively viewed forum for communication and information-sharing about the actions each agency was taking, it was not in a position to establish a consensus on a shared strategy or to require agencies to operate in a specific way. Nor did it act as a dispute resolution route in relation to the fundamental differences of opinion about intervention."

7.2.7. Poor understanding of roles

In some cases, agencies working with each other or attempting to do so had poor understanding of each other's roles, customs and practices. In one case, a hospital and a GP did not understand what supported living was or the nature of his support from non-qualified staff. In another there was misunderstanding about what was covered by fire safety visits to supported living premises, which were not intended to provide person centred risk assessments or plans. Lack of understanding of the role of the fire and rescue service featured in a further case also. In another example all agencies lacked clarity about who was responsible for commissioning care and support services, what the rationale was for different types of post discharge service (rehabilitation or long term) and how to arrange such services. One SAR comments on a lack of understanding across agencies about the purpose and scope of a police 'welfare check'. In this case, where a young man with physical and learning disabilities lived with his mother in severely neglected home conditions, the social worker and continuing healthcare nurse had requested a police check following the mother's denial of access. They allowed themselves to be reassured by the police feedback and lessened their sense of urgency about access to the young man, who was later found in a life-threatening condition. The SAR notes that their reliance on the check:

> "Was not helpful or appropriate given that the officers had no knowledge of the case, no safeguarding experience or health and social care background."

Poor understanding of roles was demonstrated further in a SAR involving harm to residents in a care home. A decision had been made that the police had investigative primacy but this was not communicated to all partners, resulting in some confusion; the provider started internal investigation and disciplinary processes and partner agencies had poor understanding of why this was problematic.

In a case in which there were significant delays in convening the Mental Health Act assessment, then further delays due to sourcing a bed and obtaining a warrant to gain readmission to the individual's property, the SAR found that those involved had poor understanding of each other's roles and of the legal parameters within which different practitioners worked. There was substantial miscommunication about whether a bed was being found out of hours, resulting in delay; in addition, ineffective out of hours bed management meant that information available was inaccurate.

Sometimes roles were disputed between agencies. In a case in which the Medicines and Healthcare Products Regulatory Agency had issued an alert, there were differing opinions about whose responsibility it was to disseminate information about the alert – the supplier of the equipment or the

agency that had purchased it. Role discussions sometimes became disputes about funding. In one case housing and adult social care could not agree on who would fund a deep clean to which the individual had agreed:

> "Before housing would agree to pay, they required a care plan which clearly set out how a one-off clean would be of benefit in the long term and improvements would be sustained. This was not specified in the care plan and the housing department did not commission the clean."

In another a dispute about funding caused difficulties between agencies. The NHS Trust asked adult social care to fund reablement services for the individual on discharge from hospital in line with a protocol stating that they would fund provision arising from physical conditions. He was, however, deemed not eligible, a decision that impacted on the relationship between agencies, with information not being shared and meetings not attended.

While not specifically an issue related to understanding of roles, one SAR does illustrate how legitimate implementation of agencies' roles can create challenges. Here a care home was left without active care plans when police seized case notes for evidence. No copies of the case notes were made before removal; while the care home made temporary plans, in some cases these lacked essential detail, and documents required in the original (those authorising non-resuscitation, signed by the authorising doctor) were no longer held by the home.

7.2.8. Out of area placements

Out of area placements, of which there were a number among the SARs reviewed, brought their own challenges to interagency collaboration. In one case, the host local authority did not know who was placed in its area, or which local agencies were involved in the care of people with complex needs so placed. In another geographical distance created barriers. One authority had experienced difficulty securing information from the home area:

> "It was unacceptable practice that reports from X's home local authority, especially from the social work, mental health, learning disability service and respite care facility, were either not provided or were insufficient to be helpful … "

In a further case there was poor case management by the clinical commissioning group for an out of area nursing home placement that was unsuitable to meet the individual's needs. Little support was provided to the nursing home in managing persistent and aggressive refusal of nursing care that resulted in extreme health deterioration and ultimately death. Although he had been assessed as lacking capacity in respect of care and treatment, no best interests strategy was devised to ensure that he received treatment. The SAR notes that the CCG's invisibility was in breach of national guidance on out of area placements:

> "The unsuitable nature of the placement was compounded by a lack of proactive follow up by [the CCG] and a resultant failure of case coordination. Challenges of working across borders and therefore at a distance may have also played a part … Without strong leadership of the inter-professional and interagency network, the efforts that individual agencies made to secure care and treatment for X were undertaken in isolation. As one learning event participant observed: 'accountability was invisible and silent'."

Out of area placements also brought additional communication challenges in safeguarding enquiries, which were the responsibility of the area in which the placement was located. In one case communication with the placing authority and with the individual's family was not timely and resulted in

some confusion about the status of the investigation. In another the local team coordinating an enquiry into an incident in a locked rehabilitation hospital found poor support from commissioning authorities:

> "Attendance at safeguarding meetings by placing commissioners was variable (some of whom were geographically distant) which was not good practice, but is a common difficulty when adults are placed at some distance from their originating place of residence. [This] made the task of coordinating the enquiry more challenging for the host authority. Local authority practitioners … were conscious of their statutory role to coordinate the safeguarding enquiry but felt increasingly unsupported."

The challenges of geographical boundaries are well illustrated in one SAR. Here an individual, about whom community support agencies had had serious concerns regarding mental health and self-neglect, required emergency acute hospital admission for treatment of serious physical deterioration. The acute hospital to which he was admitted lay outside his county authority, so his recent mental health history and self-neglect were not known to the psychiatric liaison team in that hospital who assessed him before discharge home. The information-sharing deficits were further compounded when the hospital omitted to share the discharge summary with his GP and other agencies. The SAR notes that when those agencies were then making decisions about their own interventions, some were unaware that he had been in hospital at all, or that a Mental Health Act assessment requested prior to his admission had been cancelled. He died a week later after cancelling or avoiding ten care calls by his care agency.

> "The lack of contemporaneous information available to the psychiatric liaison team at the acute hospital, the lack of evidence of coordination of different specialities within the hospital, combined with the poor communication outside of the hospital highlights a risk in the multiagency system when individuals in crisis are admitted to hospitals outside the coverage of their specialist health care provider."

7.2.9. Disconnect between separate organisations providing linked services

In one case the SAR notes considerable challenges that arose in the supervision by the Community Rehabilitation Company of a man whose profile, offending history and behaviour placed him in a high-risk category. The split between the CRC and the National Probably Service, particularly after the former entered private ownership, had an extreme impact on how the case unfolded:

> "The two organisations could not share all information and, as now separate identities, did not have access to each other's work. There was no escalation pathway at that time between CRC and NPS. CRC staff report anecdotally that there seemed little point in attempting to return a case to NPS as these were usually refused and there was no provision to discuss cases jointly to resolve concerns. Relationships between the two organisations are reported to have been acrimonious as both tried to cope with the new ways of working."

7.2.10. Looking back and forward planning

The concerns about inter-agency adult safeguarding performance have echoes in previous thematic reviews[105]. The concerns are not new. Once again, then, SABs should reflect individually, regionally and nationally on what makes adult safeguarding inter-agency practice so challenging and change so apparently difficult to achieve. Strategic business plans should be informed by the outcomes of this reflection.

Improvement priority twenty four
In light of the reporting by SARs of poor interagency practice, SABs should review (in local, regional and national discussion) how they seek assurance on standards of interagency practice and contribute to improvement across their partnership. Based on SAR findings, priorities for attention include: case coordination, leadership, use of complex case management frameworks, information-sharing, interagency referrals, safeguarding processes, understanding of roles, out of area placement and organisational disconnect.

7.3. Domain C: The Agencies around the Team – Organisational Behaviour

There were many features of the agencies involved that were found to constitute poor organisational behaviour and which in some cases had contributed to the poor practice observed in both direct work with the individual and in interagency working. The themes that emerge here relate to workload pressures, staffing, supervision and support, management oversight, resource absence or shortfall, commissioning, and organisational structure, culture and systems.

7.3.1. Workload pressures

Many SARs drew attention to pressures on services across the sector, illustrating the challenging context in which the practice observed had taken place. In many cases, stretched resources – in finances, staffing and services – were seen to have a negative impact on frontline decision making, with services overwhelmed and the workforce fatigued.

> "The team report that they were under increased pressure. The risk of poor decision making and inability to focus on agreed actions is high in such circumstances. Required processes were not followed, for example the completion of a threshold tool that enables appropriate decision making by the (safeguarding) team."

Such pressures were particularly noted in safeguarding teams, district nursing services, an emergency duty team, emergency services such as ambulance and police, Community Rehabilitation Company and National Probation Service teams, mental health services, a MARAC system,

[105] For example, see 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.

continuing healthcare commissioning, drug and alcohol services, occupational therapy and community health. 7.3.1.3. They impacted upon response times, with delays noted from NHS 111, ambulance services, police, adult social care, occupational therapy, mental health services and Mental Health Act assessment, including instances of delay in responding to mounting risk and some that breached agency standards.

> "A 6-hour delay in ambulance attendance has been subject to an internal investigation by the ambulance service and was due to the high levels of calls, sickness and a shortage of qualified paramedics. Ambulance response times are a national issue."

In one case there was a delay of 7 months in convening a safeguarding allocation meeting, at which the case was closed due to the time elapsed. In another the waiting time for an adult social care response to referrals had increased by 500 per cent from 5 to 25 days. Delays in continuing healthcare funding resulted in one man spending time in a hospital environment in which his will to live deteriorated significantly.

More broadly the pressures impacted on other aspects of service quality: the ability to engage in preventive rather than reactive interventions; timely commissioning of care and support; time to read case histories; quality of reports and analysis; communications with other agencies; attendance at multiagency meetings; time available to reflect; time to build relationships through which to explore an individual's life story for triggers to present lifestyle; the quality of personal care; the timeliness of reviews and the provision of therapeutic intervention. In one case a safeguarding plan was compromised when staffing and funding pressures meant the withdrawal of a day centre service to provide showers and laundry to a man with severe self-neglect. In another an individual waiting for psychological therapy with waiting lists of almost a year died before she could be seen. In another a GP surgery was closed to new registrations, leaving a nursing home patient with significant physical health needs at greater risk.

Pressures to ensure that interventions were short-term meant that where individuals were reluctant to engage persistence was short-lived and professional curiosity curtailed:

> "Workload pressures, when combined with individuals who appear to have capacity to refuse treatment and/or care and support, may result in insufficient (time for) professional curiosity and an emphasis on respecting a person's autonomy rather than persistence in raising concerns about risks of significant harm."

> "In the practitioner learning events, practitioners broadly indicated that the absence of professional curiosity about X's origins was because of limited time they had available to work with clients."

SARs noted the impact on staff also, with examples of staffing feeling overwhelmed and demoralised, losing a sense of urgency. In one case they were frustrated at an apparent lack of organisational strategic vision on how to deal with complex cases.

7.3.2. Staffing

Staff shortages contributed to overload for some practitioners who were carrying big caseloads. One social worker had raised an unsafe caseload as a formal grievance. There were instances in which workforce turnover was high and others in which agencies struggled to provide consistency of staffing. High turnover of staff also resulted in loss of organisational memory about cases and their history and compromised the building of relationships of trust with individuals using services, thus contributing to their reluctance to engage. One young woman had six social workers during

the two-year period before she died. One individual who had difficulty engaging with staff in mental health services had thirteen CPNs over ten years, which the SAR terms unacceptable. In a further case fourteen different adult social care practitioners from three different teams were involved over 2½ years, the longest involvement being three months.

Some SARs were critical of workforce management practices in agencies, with what one SAR called chronic understaffing. A district nursing service faced severe staff shortage and sickness, resulting in one nurse being responsible for over 500 patients. There were failures on hospital wards and in care homes to ensure required 1:1 staffing ratios or waking night staff. One provider had taken on contracts that they were unable to fulfil. A care agency could not fulfil its responsibility to make two-handed visits. Lack of nursing mentors meant that nursing home staff could not be verified as competent to take blood samples. An IMCA service had no staff available to act as Relevant Person's Representatives in cases of deprivation of liberty. Staffing in a safeguarding team was insufficient to enable urgent responses to be made where warranted, a situation termed 'dysfunctional' by the SAR. A health trust's safeguarding team had a poor level of staffing. The removal of the post of mental health liaison officer by the police had a significant impact on the sharing of relevant intelligence. Some SARs noted that no arrangements were made to cover a staff member's work during sickness absence.

Staff were sometimes unqualified or inexperienced. A police force had only a small number of specialist officers resulting in inexperienced officers carrying out investigations. In another case no qualified social worker was available to work with a complex case. In two cases there was no learning disability nurse in an acute trust. An emergency alarm service had staff on duty that were untrained and unsupported by protocol, who took action based on bias and assumption. There were problems too with staffing shift changes in the police that compromised the responsiveness of the service. And in other cases, there was poor handover of information during staff changes.

In some cases, staff were noted not to be suitably qualified or trained for the work they were doing. Examples of training gaps in care and nursing homes included skills to support eating in people with dementia or learning disability (particularly where swallowing difficulty was experienced), bowel management, pressure relief, diabetes, stoma care and first aid. In one home inadequate training was seen as the root cause of the failure to monitor an individual's skin viability, with similar problems noted in domiciliary care also and in one case in a hospital context:

> "Towards the end of her life the extent of the wound care required was beyond the general expertise of both mental health and general health nurses. Whilst there were clearly individuals who worked hard to care for X, they often did not have the skills, knowledge or support from their organisations to provide the level of specialist physical care she required."

More broadly across the sector staff had not received training in mental capacity (in particular assessment, best interests decisions, lasting power of attorney and the role of the Court of Protection), safeguarding, self-neglect, mate crime, disability hate crime, intergenerational abuse, conflict resolution and assertiveness. Several SARs noted a common lack of understanding across agencies about legal options available in high-risk situations when engagement is poor or access is being denied by a carer, one noting that more knowledge was also needed about legal routes such as the inherent jurisdiction of the High Court. Some practitioners lacked knowledge about Care Act advocacy; staff in a mental health trust lacked knowledge about the provisions of the Care Act 2014; district nurses' training had been ad hoc with poor attendance; an unqualified social care practitioner was managing complex risk without any professional training; staff in an emergency alarm service managed by the council were untrained and in addition had no protocols to guide their decision making; a nurse had returned from extended leave during which significant changes had been introduced but had received no re-induction and was unaware of mandatory reporting. Elsewhere a provider had not trained their staff in managing

sexual offending risk and moreover did not ensure their staff could attend specialist training commissioned by the local authority or follow advice from specialist services. One SAR had doubts about staff skills in getting beyond presenting problems when assessing complex family dynamics. Another noted that staff who were not specialists needed further skills in communication in order better to understand individuals with autism or mental health problems and engage with their needs. A further SAR is critical of the local authority responsible for placing a young man with complex needs in supported living, where there had ensued significant disagreements between the provider and the family:

> "The staff member … who took lead responsibility for arranging the placement had, in the panel's view, insufficient training and proactive support to manage a case of this increasing complexity. She did not really see that her role and responsibility extended beyond the arrangement and review of the placement. She did not have an understanding of the keyworker role. The panel's view is that placing the staff member in this position represents a significant organisational oversight."

Some SARs noted agencies' responsibility to monitor staff competence, one noting that a system of checks and balances to do so in a community nursing team had not been followed. Another noted that personal assistants recruited through direct payments in fact have no framework for skill and suitability checks, training or quality assurance and monitoring in line with the changing needs of individuals, the reliance being on the person managing the direct payment to ensure safe and effective delivery of care.

7.3.3. Supervision and support

Closely allied to questions of staff qualification, training and competence are those relating to the supervision and support provided to staff by their employing agencies. One SAR makes the point that competence is not just about training; organisations had broader responsibility to ensure that knowledge and skills are embedded in practice through measures such as reflective supervision. SARs noted deficits, identifying that the high-risk and complex cases under review had sometimes not been discussed in supervision between practitioners and supervisors, raising question marks about organisational practice. Examples include a failure to discuss an individual's refusal of support prior to discharge home, failure to identify that practitioners had not formed a workable relationship with a family, several in which supervision did not pick up the need for review of the approach being taken and failure to discuss and review mental capacity assessments.

Care coordinators in several mental health trusts lacked robust supervision and support, including one in which the coordinator's absence of contact with the individual was not noted. Staff in care homes lacked supervision of bowel management by clinicians and supervision of their care of complex health needs. A safeguarding adults manager new to her role received neither training nor supervision. One care home could not supply any supervision records at all. Equally there were no records of formal supervisions being given to a probation service officer by his manager, where the expectation would have been of a formal supervision session every six to eight weeks. In another, the manager struggled with some elements of the home's operation in the absence of involvement or support from the owner during a period of close safeguarding and CQC scrutiny of matters to which the owner's failure of financial investment had contributed. Concerns were expressed about the availability and quality of supervision for newly qualified social workers and for tissue viability nurses. One SAR noted a misuse of supervision to engage in defensive practice that served to maintain a sustained failure to address the taunting, mistreatment and humiliation of residents:

> "It beggars belief that staff were asked to sign a declaration each time they had a formal supervision session to confirm they had not witnessed any abuse."

SARs sometimes noted circumstances in which support for staff dealing with difficult situations had been lacking. Those in community health setting lacked support to respond to challenging family members. GPs and other primary care staff struggled to work with complexity without access to legal or specialist support. Home care workers did not feel adequately supported by managers when working in high-risk situations.

In some cases, supervision was noted to focus solely on the practical elements of a case or the level of service response without bringing insight or understanding to the complex array of factors that could be affecting the individual's behaviour and motivation or the dynamics of complex relationships. Just as professional curiosity was absent, so too was supervisory curiosity, with lack of challenge and a failure to consider patterns of thinking such as cognitive or confirmation bias, leading to practitioner misinterpretations of circumstances going unnoticed. One SAR commented that materials to support reflective supervision in adult safeguarding are limited.

In some circumstances, staff had not been supported to manage the personal experience of their work. In one case staff were described as traumatised; in another they struggled to deal with the emotional impact of two deaths. In a further case of severe hoarding and squalor, risks to staff had not been assessed or met, including the need for protective equipment. Another SAR found insufficient attention had been paid to the wellbeing of practitioners and a further example the lack of recognition of the emotional impact of the work.

> "In the face of his mother's relentlessly aggressive and racist behaviour towards care workers and professionals, a number of staff described feelings of burn-out and powerlessness which they found difficult to cope with. Senior managers praised the efforts of staff to engage with hostile service users whilst giving little consideration of the emotional impact of managing aggression and violence."

7.3.4. Management oversight and leadership

SARs often questioned the role that managers had played in the cases under review. One key theme was an absence of management oversight of key decisions, or a failure to record that oversight. A range of examples were given: no evidence of oversight of a decision made by a non-warranted practitioner performing triage to screen out a referral for AMHP assessment; failure to provide suitably experienced management to AMHPs working singly out of hours; no oversight of complex safeguarding enquiries; failure to identify the cancellation of a care package by an individual at high-risk; lack of oversight of recording practices in a home care agency and a hospital social work team; lack of management presence and oversight in a district nursing team, a home care agency and unqualified adult social care duty officers. A poor response from an adult social care duty system was found to be "Inadequate, unsafe, unfocused and lacking in sound practice, supervision and management." A care home that had been rated as having poor management still required improvement at the focused CQC inspection that took place after the resident's death. In some cases, managers did not identify significant delays in response to safeguarding concerns or failed to recognise failing risk management. In one case manager failed to recognise that an outsourced adult social care and community health service did not understand how to use self-neglect procedures. The SAR comments:

> "Only by using an approach of active leadership, supported by evidence from internal audit and responsive escalation routes, can an organisation ensure that the needs of adults at risk can be responded to with timely approaches consistent with agreed policies and procedures."

Poor management decisions and practices were noted in some cases. A Community Rehabilitation Company manager did not check the accuracy of a probation service officer's report before signing it off, and gave advice about work priorities and non-escalation of risk that was out of line with agreed guidance of the time: "As such the manager's decisions were not defensible and the oversight provided did not support the PSO to maintain the expected standards of practice." A manager's decision not to open a safeguarding enquiry was considered not to be robust in the light of the circumstances. On escalation of a case of anti-social behaviour, a housing association manager did not take appropriate action in line with the agency's policy. In one case practitioners received inconsistent and sometimes conflicting advice from different managers.

In several cases poor management was found to have contributed to the deterioration of care quality, in some cases amounting to systemic abuse and neglect. One care home did not recognise its own limitations and was prone to accept unsuitable placements, with significant impact for staff and residents. In one case key factors in one case were noted to be deficiencies in leadership, oversight and supervision of staff, an over reliance on agency staff and the unsatisfactory handling of complaints. In another case the registered manager failed to address what was termed the unprofessional behaviour of a gang of male employees and to increase their oversight in the light of the high turnover of employees onsite.

> "It did not question the adequacy of its specialism. It did not question its single-site model of sourcing residents with diverse support needs. It did not adequately supervise or increase the oversight of those employees whose behaviour towards residents was devoid of merit or promise. There was poor oversight of staff and a sustained failure to address the taunting, mistreatment and humiliation of residents."

In a further case the care home provider had routinely conducted internal investigations into the poor or abusive conduct of their own staff members in isolation and without reporting outcomes to either the council or CQC.

> "Often a whistle-blower would themselves resign, while the alleged perpetrators were given warnings following disciplinaries and retained or recycled within the service. The former is an astonishing practice which arguably played a key part in the duration of abuses at (the home) … The latter may constitute wilful neglect."

In some SARs there was evidence of poor communication between strategic and operational levels of management. A senior level interagency protocol covering accommodation needs for people requiring detoxification or support with alcohol was not known to operational staff managing cases. In one case there were blurred boundaries between senior and operational decision making, with managers over-riding staff. In another, senior staff were seen to have created a culture of fear and frustration.

In some cases, senior managers were not sighted on the levels of risk being managed by staff; this was in part due to an absence of escalation when a case was not recognised as complex or risky but there were other factors at work too. In one care home staff lacked confidence to escalate their concerns to management but relied on advice from each other. Even where managers were aware of a high-risk case, they did not always respond. One SAR referred to a poor and unsupportive management culture in a care agency. Another noted that when practitioners placed an individual on a high-risk register, the purpose of which was to notify senior management of cases requiring oversight, management follow through was missing:

> "It is not clear from any of the documentation how such managerial oversight was operationalised and what decisions were made by the senior management in X's case."

Poor levels of management responsiveness had a negative impact for staff:

> "District nurses, who were probably the people with the most direct contact with X, raised the fact that they felt they had clearly and repeatedly escalated concerns within their organisation, and made their managers aware, but they had not felt as if their concerns were listened to. They felt unsupported by management and 'powerless'."

Clinical case management was a further issue noted in at least one SAR. A dual-diagnosis pathway was described as having insufficient appropriate senior clinical oversight, leaving frontline practitioners without well-led, specialist, senior clinical leadership in a complex case.

7.3.5. Lack or shortage of services

A further key feature of the organisational context for practice was the absence of suitable resources to meet needs identified. Particular areas of shortfall mentioned were accommodation for young people approaching adulthood and needing tier 3/4 psychiatric care; accommodation for vulnerable young people leaving care; adults with autistic spectrum conditions and Asperger's Syndrome; emergency overnight accommodation and move on facilities; specialist older people's mental health services; facilities for integrated treatment of mental health problems and alcohol dependency; services for people who were homeless and at risk of suicide; pathways for palliative care of terminally-ill people with a history of self-neglect and addictions; resources for homeless people with multiple and complex support needs that include risk to others:

> "[The council] told the review that in their experience it is generally the case that those individuals with such needs and who are the most vulnerable either fall outside the remit of the statutory bodies and commissioned services or there is a gap in suitable accommodation options."

In one SAR, a case in which a young man murdered a vulnerable young woman living in the same unit, both places commissioned by authorities at some distance, was critical of the use of accommodation known to be unsuitable. The SAR notes:

> "The extent to which (the care home) was not a suitable placement for both X and Y raises the question of whether there is sufficient provision for adults with ASC and Asperger syndrome and whether enough priority is being afforded to the development of local services."

In another, staff were frustrated by the mismatch between assessment of the individual's needs and thresholds for services. His needs no longer seemed suited to low secure settings, but at the same time he was also being turned down by more secure rehabilitation settings. Wet hostel facilities were described as underdeveloped in one case, as were in several cases outreach capacity for work with people whose engagement is erratic, emergency accommodation for people with substance misuse and continence needs, rehabilitation and detoxification facilities and pathways to prevent homelessness among frequent users of hospital emergency departments. One SAR noted the challenges of developing such services:

> "In relation to supported accommodation for vulnerable individuals there are issues of planning permission for such establishments, qualifications and experience of providers, commissioning expectations and analysis of risks associated with multiple occupancy by those with competing needs."

Facilities for people with no recourse to public funds were also in short supply, in particular specialist immigration advice and stable accommodation to support the immigration process. Resources that did exist were noted to be underfunded and overstretched. In some cases it was basic equipment that was missing: a hospital did not have a scanner available for someone of the individual's size and weight; a GP surgery did not have a ceiling hoist that would enable examination to take place; a working wheelchair could not be sourced; a care home had two suction machines, neither of which had been tested or was working. In another care home where a woman died with hypothermia as a contributory factor the SAR notes that her care was likely to have been significantly compromised by the absence of a working boiler to supply hot water and heating

> "The care home did not make timely and adequate arrangements for her and other residents' comfort and safety during that period, and the temporary arrangements in place in themselves posed risks to health and safety. The deteriorated state of the care home environment, which only fully came to light in inspections after X's death, showed evidence of chronic under-investment in the fabric of the building."

In some cases, existing services were insufficient to meet demand, resulting in delays. Notable here were facilities suitable for people detained under section 136 of the Mental Health Act 1983, the availability of AMHPs and of doctors approved under section 12 of the Act. In one case delay in securing a Mental Health Act assessment was compounded by a subsequent lack of hospital beds; despite the urgency of the need, admission had still not been achieved by the time the individual, who had been thought unlikely to leave his house, did so and died from injuries sustained in a car crash. Inflexible appointments and limited outreach compounded difficulties of access to mental health services. In two cases, pressure on local beds, in particular psychiatric intensive care, resulted in admission to private hospitals far from home, causing delay and making liaison with local services difficult:

> "The lack of mental health beds to respond to X's needs also caused avoidable delay. Firstly, the postponement of the mental health assessment was because all the suitable resources were full, and the decision was taken not to assess X until his needs could be met. Secondly, the transfer from the mental health trust's hospital to [the private] hospital caused communication problems eventually leading to the failure to plan X's discharge … unlikely to have happened if he had remained solely in the care of [the trust]."

Placement outside of home area across the sector was noted to bring additional challenges for existing services:

> "There can be no confidence that there is sufficient capacity in speech and language, psychology, behaviour support, learning disability nursing and psychiatry services to meet the needs of unknown numbers of adults who are placed outside their own localities. Thus far, there has been no conversation concerning the funding and capacity implications for local services."

7.3.6. Commissioning

Gaps and shortfalls in facilities are clearly related to commissioning, and many SARs had points to make about how agencies commissioned services. Several SARs placed commissioning difficulties within a national context, one commenting on the impact of the Transforming Care programme of change and the complete overhaul of health and social care commissioning practice that it engendered:

> "The scale of change required to achieve the national targets in the desired timeframe was enormous and could not realistically be achieved."

The resultant absence of 'requisite variety' in the local commissioning marketplace was seen to limit the options available, resulting in this case in the individual being placed in a setting that was not able to support him safely. Commissioners in one SAR were frustrated at not being able purchase what was needed – the problem was a shortage of supply, not a shortage of funding. A further SAR notes the national context also:

> "A systemic weakness is apparent in the commissioning of care placements and poor quality of notifications/feedback from those selected. This is compounded by the availability of suitable placements for those with complex needs – this is a national challenge."

These factors impacted on the cases reviewed, one SAR noting that local health commissioners had struggled to find good quality local providers for clients with complex needs and challenging behaviours, particularly in relation to some groups:

> "The combination of learning disability and personality disorder diagnosis is not one that many current providers feel suitably experienced or skilled to accept. This difficulty can often still result in adults with learning disabilities having to be placed far away from their home area."

In one case a local authority did not ensure that an independent provider had established the necessary conditions to support an individual, the SAR calling for greater attention to be paid to identifying and monitoring the tasks being commissioned. In another, commissioning placed insufficient weight on the views of a provider who had identified that an individual they knew well had escalating needs, with an undercurrent of suspicion about the provider's motives in raising the need. One SAR found it unclear how some young people had been placed in a home not registered for young people and where there was a resident whom the Court of Protection had ruled should not have contact with children and young people. Another notes that a young person's home authority played an insufficiently prominent role in ensuring that a care home could safely manage a young man who posed high-risk of sexual violence to others, leaving his residential school to lead on facilitating his transition. In other cases too there was insufficient attention paid to the mix of residents.

Other examples of poor commissioning included: failure to factor in a plan for the interface between two providers, leading to opposition from one to the other; care commissioned from a provider about whom there were already concerns and failure to monitor implementation of the contract; commissioning of carers' assessments without inclusion of reviews in the contract; time-limited funding of a specialist immigration advice service; failure to ensure availability of agencies with specialist knowledge, such as of stroke and of amputation; challenges in identifying safe accommodation and other gaps such as support for PTSD and other mental health therapeutic supports. In one case a drug and alcohol service was switched to a new provider, but the outreach service, a flexible service that had enabled an individual to be reached despite his reluctance, was not part of the contract for the newly commissioned service. In another, the SAR comments that the current separate commissioning of mental health and physical health did not support the provision of a holistic service. In a further example the SAR notes that commissioners failed to recognise and learn from the repeated failure of placements and therefore missed the need to create a bespoke package of care.

Commissioning of advocacy services drew comment in several SARs. In one case, this compromised the local authority's compliance with legal duties:

> "Proper services have not yet been commissioned for Care Act advocacy, creating difficulties in accessing timely advocacy and fulfilling statutory duties under the Care Act 2014."

Another notes that the advocacy contract in place before the Act was not updated in line with the principles and intent of the Act. It was care group specific and did not include those with physical disabilities, brain injuries or substance mis-use problems, leading the provider to refuse referrals for adults in those care groups. Nor was the contract structured to ensure that statutory advocacy could be prioritised. Conversely a further SAR found that advocacy was commissioned against specific legislative functions and did not reflect a wider, citizenship-based model. Quality assurance was problematic also:

> "There is currently no national governing body for advocates which could amongst other functions monitor practice and competencies of individuals via a registration requirement."

There were quality assurance issues noted within commissioning and contract compliance arrangements also. Commissioners had insufficient time to monitor contracts and contracts were sometimes too imprecise about staffing arrangements to facilitate detailed monitoring. Quality assurance systems in one commissioner were not well-developed enough to pick up that a care provider was struggling. One SAR questions how effectively commissioners pursued active oversight of out of area placements, particularly without local intelligence; another noted that a clinical commissioning group did not undertake quality assurance measures in relation to out of area placements. Another notes that neither the local authority nor the CQC gave regular oversight to a provider. In a further example, a care provider had received mixed messages from commissioners and the CQC about improvements needed. One SAR concludes:

> "Compliance with contracts is over-reliant on trust and good practice, leading to risks for service users of provider failure, challenges in intelligence gathering about service changes, and lack of understanding of host and placing authority responsibilities."

In one case there had been a failure to ask searching questions about the benefits of a particular residential placement and to request detailed accounts of how fees were being spent on their behalf; the SAR terms this a lack of rigor and failure of judgement in commissioning, with an absence of essential monitoring and review. Another notes that practitioners' concerns about an individual's engagement with services were not escalated to Commissioning for them to apply relevant quality assurance processes to the agencies supporting him. Another notes that commissioners made assumptions about the reliability of a service because it was CQC registered. Here there was no monitoring by the clinical commissioning group; assumptions were made and found to be inaccurate when CQC found significant gaps in risk and incident management, training, policies and procedures after a whistle-blower raised concerns. In another case also the SAR suggests that quality monitoring of placements was insufficient and warns again relying on CQC registration. Indeed a further SAR points to a disconnect between quality assurance mechanisms such as care home inspections and assessments or safeguarding actions relating to individual residents. The information from these sources was not joined up, meaning that a holistic view of the quality of care and level of risk could not be easily ascertained.

Several other SARs in fact are critical of the CQC's approach: a delay of almost a year in publishing an inspection report for a hospital issued with an enforcement notice and five improvement notices was seen as poor practice. In another case follow-up inspection of a care home that required improvement did not take place and when further problems came to light inspectors did not escalate the matter for management review in a timely way. A further SAR expresses concern about the timeliness of CQC enforcement action.

Problems could arise if services decommissioned by one authority were also providing services for other commissioners. In one case no notification was sent to other local authorities. Commissioners in one area seeking to place a patient with high-risk and complex needs within a private hospital at

some distance were not aware of concerns known locally at the time, or that the CQC had issued an improvement notice. Had this been known, the SAR comments, the contracting process could have had additional safeguards built in.

A number of SARs make the point that supported lodgings and semi-independent accommodation is not regulated by any of the regulatory bodies, meaning that accommodation for some of the most vulnerable is not overseen to ensure standards:

> "In the context of extremely limited choice it is hard to ensure that places are selected and commissioned in good quality provision; the absence of inspection of such establishments makes quality hard to assess."

7.3.7. Organisational structure

The structures of the organisations involved in some cases posed challenges. Several SARs noted a disconnect and failure of collaboration between adult social care and children's services in the local authority:

> "Adults and children's social care are so institutionally and culturally separate that taking a "think family" approach is not standard, even in cases where there is a parent-carer of and adult-child living with other younger children."

In another case the same disconnect was noted between adolescent and adult mental health provision. In a further example, it was unclear within a local authority's structure which team had responsibility for providing urgent comprehensive reassessment and increased services. A further SAR notes that a move away from specialist teams impacted on case management. Another notes a lack of clarity between the adult safeguarding operational team and other social care assessment teams, who believed that no action could be taken in a safeguarding case until the safeguarding team had completed screening.

> "These assumptions around practice have developed over time in the absence of clear protocols to support robust practice, accountability and responsibility. Naturally this leads to more drift and delay that can subsequently contribute to on-going risks."

Challenges were also noted in the interface between commissioning authorities and outsourced provision, for example of adult social care and community health services. In one case the local authority had outsourced all adult social care apart from the responsibility of determining what response should be given to safeguarding referrals, which were sent from the outsourced service to a local authority safeguarding management team. If safeguarding did not proceed the team gave guidance and recommendations for further actions by the outsourced service but could not, however, be certain that these were acted upon as it was not accountable for the work of that service. In the case under review its poor service went unchecked. In another case, outsourcing of drug and alcohol services meant that current provision "does not have the capacity of appetite or capability for high-risk cases". Another SAR notes problems with the governance structure between short-term and long-term local authority teams, where the latter was outsourced. Transfer of cases between the two was problematic, responsibility for carers' assessment was unclear, and there was a lack of clear differentiation between safeguarding investigation and assessment for services.

> "This split of responsibilities between assessment, safeguarding and long-term functions is still causing some inconsistency and tension between teams around eligibility threshold, eg is the issue safeguarding or assessment and tensions around the double sign-off."

Periods of organisational structure change were also seen to disrupt practice One SAR notes the adverse impact of the national Transforming Rehabilitation Programme, through which probation trusts were dissolved and the service split into a National Probation Service and 21 Community Rehabilitation Companies, which transitioned from public to private ownership. Thus there was considerable organisational unrest at a crucial time for work carried out with a high-risk individual who subsequently murdered a man he had befriended.

> "There was uncertainty about jobs, roles, locations and how the CRC new owners were going to operate and behave. This is reported to have had a negative effect on staff and the quality of supervision provided. The two organisations could not share all information and, as now separate identities, did not have access to each other's work. There was no escalation pathway at that time ... CRC staff report … that there seemed little point in attempting to return a case to NPS as these were usually refused and there was no provision to discuss cases jointly to resolve concerns. Relationships between the two organisations are reported to have acrimonious as both tried to cope with the new ways of working."

Other SARs commented adversely on the impact of service re-organisation or re-design on both staff and people using services. In one case, outsourced contracts for key functions such as adult social care and community health were in the process of renegotiation with a change of provider, adding what the SAR calls an 'additional layer of anxiety' within the teams. In another, service redesign in one of the agencies involved adversely impacted on other agencies' understanding of referral pathways. The reorganisation of mental health services impacted adversely on care homes' access to a liaison service providing valued advice and organisational change in mental health services, including a shift from paper to electronic recording, affected staff of computer systems. Re-structuring was noted to erode organisational memory and to create risks for people using services; in one case an individual "fell into a void" during a mental health service re-design. They also damaged fragile engagement, as for example in a case where changes to how housing support services were delivered impacted upon continuity and frequency of contact with the individual. One SAR notes that the impacts of such changes were underestimated.

> "The impact of service redesign, recommissioning and pressure on budgets on staff stress levels and ability to work effectively was not taken into account by their respective organisations."

7.3.8. Organisational culture

Organisational culture was in some instances observed to militate against good practice in the cases under review. The features noted were diverse. One related to embedded shared attitudes and values about the organisation's clients. A thematic review casts light on a range of factors that influenced low referrals to safeguarding. An ethos of empowerment and self-determination was emphasised, leading to a failure to evaluate mental capacity, degrees of coercion and control and public interest. Decision making was over-focused on the capacity of the person – the phrase 'has capacity and the right to make unwise choices' occurred throughout the local authority chronologies submitted to the SAR. In consequence, the SAR finds, organisational culture had become blunted to high-risk situations. Here and elsewhere too there were perceptions that people who misused substances brought harm on themselves; abuse was seen as part of their 'chosen lifestyle'. Some agencies attributed poor value to multiagency safeguarding work; mental health services in particular could not see any added value from making a safeguarding referral.

Another SAR noted similar attitudes towards people who abused alcohol and were homeless, a culture that affected perceptions of tenant-ability, risk and eligibility. This SAR argues that a more robust, humane and flexible approach to housing was needed to support the individual to stabilise and recover. Similar attitudes to people who self-neglect were noted in other SARs, with common assumptions that their behaviour was lifestyle choice.

A few SARs noted a culture of professional optimism, which resulted in an absence of professional curiosity and challenge, including via supervision and line management, and across professional boundaries. A further feature observed was the expectation that work would move quickly, with a high turnover of cases, which was noted in several cases:

> "Analysis suggests that this case demonstrated a problematic culture within adult social care, rather than just the poor actions of a few individuals. Staff from a number of teams failed to listen to or provide a personalised service to X. Through-put was more important in the culture of the organisation than quality of safeguarding or personalisation."

An additional feature of organisational culture was an observed management culture of praising the persistence of practitioners' efforts when experiencing hostile engagements with individuals, which normalised such behaviour and left staff tolerating unacceptable levels of abuse. Both practitioners and managers confirmed there was a cultural expectation that engagement was a priority, even when sustained hostility was being demonstrated. The SAR observes that the organisational duty of care to employees was not fulfilled here.

Finally, some SARs referred to a 'negative' culture. In one care home some staff were said to be threatening and created fear; in another the environment was described as 'scary and chaotic' – a culture of fear. In a further example, the home's culture discouraged complaint or objection, leaving residents unable to speak out about the conditions they were living in. Lack of escalation by staff was elsewhere also seen as a cultural feature.

7.3.9. Organisational policies, procedures and guidance

A significant element of the systematisation of practice within agencies – the internal processes that enable an organisation to do its work - resides in agencies' policies, procedures and guidance to staff. SARs noted a number of deficits in this respect.

Some policies were seen as unhelpful in the safeguarding context. Examples included a GP surgery's policy on failures to attend appointments – three non-attendances would result in the individual's case being closed, with no further contact initiated – and an adult social care policy of sending letters to warn of automatic case closure if no response was received within 14 days. Rigid service delivery rules militated against necessary flexibility; several district nursing teams had a policy that if patients were mobile, they were to attend the surgery for treatment, despite knowledge that some at-risk individuals were unlikely to do so due to poor engagement. There were clashes between health and safety policies and service delivery, as for example when squalid home conditions meant that a team dedicated to preventing hospital admission could not work with the individual. The purpose of a GP surgery safeguarding list lacked clarity:

> "Although X is said to have been on the surgery safeguarding list, it is unclear what this actually achieved in terms of reviewing the approach to his presenting problems."

A rigid focus on assessment processes, thresholds and eligibility was seen as unhelpful where it stopped practitioners and agencies from taking a person-centred approach when assessing and seeking to meet needs and to mitigate risks. There was reference to mental services declining to provide support for emotional distress until an individual had addressed their drinking. Another SAR comments:

> "X had complex support needs that were not being addressed. These included his self-neglect, alcohol and drug use, mental health concerns, physical health needs, anxiety and depression, criminal behaviour/anti-social behaviour. This is the significant issue and highlights the need for agencies to be pragmatic in relation to thresholds and criteria to enable people with complex needs to receive the support they need."

A protocol setting out a pathway to a risk management meeting set a threshold of several months of non-engagement and two practitioner meetings before a risk panel could be held, so was not activated as no practitioner meetings had been held. In one case practitioners believed that referrals to an Anti-Social Behaviour Risk Assessment Conference had to relate to a single individual so did not make a referral given it was the group dynamic within a friendship group that was the key feature of the behaviour.

In other cases, policies that would have been helpful were absent. There were multiple mentions of non-existent or poor escalation routes and guidance for staff to use them. A GP surgery had no safeguarding policy. Some agencies did not have their own procedure for self-neglect or an overarching multiagency policy to refer to. An adult social care department had no policy on supervisory oversight of case closure. Several SARs mentioned a lack of guidance/procedures relating to reluctance to engage. Assessment tools contained no mention of the need to observe potential fire risk. Guidance on direct payments was insufficiently clear on responsibility for ensuring that the arrangement was appropriate, the need for DBS checks on carers and support for those managing the payments on behalf of an individual. The terminology used in moving and handling procedures was noted to be confusing for care home staff and in another home staff had no guidance on the extent of their power to regulate an individual's food intake. A residential college did not have a formal admissions policy; management oversight of the admissions and safeguarding procedures was insufficient, resulting in a flawed admission. In several cases there were deficits in diabetes management due to an absence of guidance. In one case adult social care staff had no guidance on implementing section 117 aftercare under the Mental Health Act 1983 and the mental health trust's care programme approach policy omitted guidance on reviews of section 117 services. Several SARs note that practitioners experienced challenges identifying and managing risks owing to a deficit in local policy, guidance and toolkits. One SAR noted the absence of accessible operational guidance derived from strategy:

> "A key finding was the absence of a self-harm and suicide prevention strategy, translated into a framework for frontline staff to use when assessing these risks and deciding how to respond."

A hospital discharge policy failed to highlight consideration of the need for safeguarding measures or prompt staff to consider voluntary sector support for individuals; another had poor transitional arrangements and was described as 'inefficient and ineffectual'; yet another contained insufficient guidance on the resumption of care packages and responsibilities for ensuring that changed circumstances lead to reassessment of needs. A safeguarding policy within a mental health trust needed urgent review as it did not embed the principles of the Care Act or guarantee that staff were clear where they could access safeguarding support within the trust.

In some cases, staff were not aware of policies that did exist. Audits in an adult social care department had found deficits in organisational awareness of multiagency policies on self-neglect, management oversight, joint working with other agencies and analysing non-engagement. Staff in some agencies were noted to have gaps in their understanding of the roles and responsibilities involved in a safeguarding enquiry.

7.3.10. Other organisational practices

Other practices in agencies drew comment in some SARs because of features that impacted negatively in the case. One SAR notes that a housing agency's auto system over-rode notifications about adults at risk who should not be housed in a particular area, resulting in a vacancy being allocated in an area that posed a high level of risk for an individual. A hospital system failed to send letters inviting an individual to follow-up appointments, and there was no failsafe procedure to identify the absence of follow up. GP practices drew comment in a series of cases: one had no process through which to ensure that a newly registered patient who had not been registered anywhere for some years saw a doctor to ascertain medical history. In another case frequent changes of address for the individual meant that some GPs were unsighted on her history due to delays in the transfer of medical records. A further GP practice relied on conducting virtual founds of a care home; the individual declined to take part and without visits to the home the GP lost the opportunity to observe and have a conversation with them. Other examples included a GP practice that did not make home visits in the area in which the individual lived; one in which there was no mechanism for identifying patients over 90 whose cases had not been reviewed; another where the practice's governance processes did not pick up the need to review a bespoke diabetes care plan.

Several SARs commented on the adult social care practice of closing cases between reviews, so that no coordinating worker had oversight of individuals receiving care and support and levels of risk were not monitored. The practice of case holding only when there were active interventions meant that risks were not mitigated.

> "The process of annual reviews by (the council), whereby a proportion of cases with existing care packages are unallocated, makes it less likely that coordinated multiagency responses will be initiated in all cases of self-neglect, impacting especially in the more complex cases where an adult is reluctant to receive services."

One SAR notes that there was no clear process for authorising additional funding when needed for people receiving continuing healthcare so that needs could be met in a timely way. Another notes that the homelessness registration process was set up in a way that made it extremely difficult for an adult with autism to negotiate. Another notes inconsistent reporting of the deaths of people who are street homeless, noting the absence of a single point of contact for this.

One SAR noted how a pattern of deficits in how multiple processes were followed created a systemic failure in a care home. Admission processes had resulted in a mix of residents whose mental and physical health needs were "mismatched and irreconcilable". Care planning and risk assessment were not detailed or person-centred enough to guide staff on how to meet peoples' needs or interests. Health needs were not well met. Daily recording was inadequate and there was failure to properly apply or record restraint. Incidents were not analysed to inform care planning and risk assessment. Safeguarding alerts were not made. Staffing was incompatible with care plans and commissioned service support. Service users and relatives were not involved in changes to plans, resulting in heightened anxiety. In this as in other SARs it was possible to see a 'perfect storm' of organisational system deficits, each of which individually could have been mitigated but which together resulted in an unsafe service.

Many SARs commented on agency IT and record systems across a range of agencies. Poor standards of recording noted in direct practice were sometimes traced to features within the organisational system. Templates for recording intervention were found lacking:

> "The paperwork to document the assessments and reviews of X's social care and support needs and how they are being met does not encourage or require staff to seek and bring together information from the range of services and agencies involved with the service user. For example, there are no questions requiring contact to be made by the assessor with the service user's GP to gather and share relevant medical information."

Record systems in some agencies, including adult social care, did not have warning markers or flags available to identify levels of risk or a history of concerns. A residential college had an inadequate system for recording safeguarding concerns. Ambulance service recording system prompted the need for officers to consider property and pets but did not mention potential dependents of the individual being treated. A systems change from one record system to another resulted in it being difficult to find a clear record of the pathway of care for an individual or to understand his needs and wishes. MAPPA records were not visible to staff in the Community Rehabilitation Company so the details of an individual risk profile would not have been accessible to the CRC staff supervising him thereafter. A recording system did not systematically capture, record or describe a perpetrator's behaviour, the absence of an easily accessible, cumulative record obscuring the cumulative risk and potentially compromising protection of future victims. In one case communication was principally via electronic case notifications (system messages), which were not always picked up or prioritised, and there was no consistent practice of sending back-up emails or making back-up phone calls to the workers concerned. In another, the care home's system produced care plans for each area of an individual's life (mobility, health, eating, independence and social activities), the different records the making it difficult to form a whole picture of his care needs. One SAR expressed concerns about how easily a failure to collect repeat prescriptions could be identified:

> "The information available to any doctor will depend on the IT system used by each practice and the personal configuration used by each doctor. It may have been necessary for the duty doctor or X's GP to have actively interrogated the system to discover X not having requested repeat prescriptions. This situation is further complicated by the number of different routes by which repeat prescriptions can be requested."

Finally, in other cases, separate IT systems impeded practice. One SAR noted that separate record systems within a local authority for children's and adult services made it difficult for information known to the one to be accessible to the other. A further disconnect was noted in mental health services, the SAR noting:

> "The challenges posed when using differing electronic recording systems. An adult with a severe and enduring mental illness may be supported by a CPN as their care coordinator and also a mental health support worker employed by the local authority. These two practitioners currently record their contacts on separate health and social care electronic systems. SAR panel discussions identified that, at the time of the incident, social workers were working within CMHTs and recording information on health systems only and not on local authority systems."

Improvement priority twenty five
In light of the reporting by SARs of concerns about how organisations support safeguarding practice, SABs should review (in local, regional and national discussion) how they seek assurance about organisational systems, culture and resources, and contribute to improvement across their partnership. Based on SAR findings, priorities for attention include: workload pressures, staffing, supervision and support, management oversight and leadership, resource shortfall, commissioning, organisational structure, culture and systems.

Domain D: SAB Governance

There were relatively few comments in SARs on the ways in which SABs exercised their interagency governance responsibilities in the cases in question.

7.4.1. SAB policies and procedures

Gaps in policy and procedure

In some cases the SAB had provided no or insufficient policy or guidance in relation to specific issues; examples of policy gaps included self-neglect (including guidance on when it should become a safeguarding issue), hoarding, information-sharing, multiagency work with complex risk, high-risk policy, escalation pathways, working with non-engagement and mate crime. In one case the launch of guidance and toolkits had been delayed. In other cases, key issues such as fire risk were missing from existing policies, a safeguarding policy did not provide a procedure for addressing care home management concerns and whole home investigations, and there were no multiagency risk forums that could be used outside of safeguarding.

> "In the absence of the safeguarding process there was not a formal system for partners to share intelligence and information and to jointly assess and respond to risk. Any professional could have initiated a multiagency team meeting but without a clear protocol nobody took the lead for arranging a meeting."

One SAR noted deficits in relation to forms used under the safeguarding policy:

> "Across the partnership there were varying views in terms of safeguarding definitions and when safeguarding duties apply in terms Care Act criteria. Practitioners felt that safeguarding templates compounded this difficulty; templates were deemed to not be intuitive, did not offer prompts to practitioners and in particular the wording around consent and capacity was felt to be confusing."

Implementation of policy and procedures

A number of SARs note that the practice that took place was not in line with actions that would be expected under SAB policies and procedures and raise questions about the extent to which SABs' guidance is embedded within local agencies. In particular, a number of SARs note poor observance of self-neglect policies. Several found that actions taken were not consistent with the SAB's self-neglect policy or found no evidence of when and how awareness of the policy had influenced what took place. Participants at the learning event for one SAR wondered whether policies and procedures would achieve greater traction if they were simplified or shortened. At a similar event for another SAR, participants indicated that the self-neglect was neither well-known nor well used; they found it hard to understand. The SAR emphasises the need for proactive follow up by a Board in relation to implementation of its procedures:

> "The existence of a policy does not ensure its use. When policy and procedures are implemented, attention must be paid to how they will be disseminated, and their use supported. Practitioners need to gain experience of using procedures and have supervision and forums to check their understanding and develop their practice. Agencies who are lead agencies within self-neglect procedures need to undertake audits to ensure that the policy and procedure is used appropriately and to identify the challenges practitioners are experiencing together with good practices being locally developed."

A further SAR comments on poor use of safeguarding procedures generally in the absence of collaborative working between agencies and the absence of action under section 42, Care Act 2014 in a case of self-neglect:

> "Safeguarding procedures were not utilised in a sustained attempt to prevent and protect X from abuse and neglect, including self-neglect."

The SAR notes that the findings reflect themes found in other SARs on self-neglect in the same locality and concludes that it therefore provides a window on systemic issues that need the SAB's attention.

One SAR notes that the SAB did not seem to be aware that its policy was not embedded in practice. As observed in other cases too, no audits had been undertaken to assure Boards of implementation. One SAR, noting the relative recent inclusion of self-neglect within safeguarding and that the SAB's self-neglect policy dated only from 2017, nonetheless expresses concern:

> "Whilst acknowledging that these procedures are still relatively new, and therefore perhaps not fully integrated into single and multiagency practice, nevertheless understanding of this policy change and of good practice in response to self-neglect varies amongst staff groups and (the) SAB's recommended procedures appear insufficiently embedded across agencies in operational practice."

Other SAB policies found not to be used by practitioners included guidance on a range of matters: criteria for safeguarding enquiries, information-sharing, risk assessment indicator tools, risk management forums, responding to non-attendance and non-engagement, and safeguarding escalation. One review found a lack of common understanding across agencies of the criteria for safeguarding enquiries under section 42 and the circumstances in which referrals should be made. Again SARs commented on a lack of audit to inform SABs' on how well their policies were used. One draws particular attention to the failure to follow escalation policies, encouraging the SAB to consider the complex processes that may need to be addressed in order to ensure escalation takes place:

> "Failure to use escalation procedures is a common finding of serious case reviews and the reason for their lack of use should be explored further. It may be due to a simple lack of awareness of the procedure, but it is often more complex than this; status differential between workers can play a part, (or) workers recognise that overworked and under resourced colleagues are doing their best and resist adding to their burden. On occasion, provider agencies can be reluctant to raise issues with services who refer to them."

7.4.2. Gaps in governance

In one case the SAR concludes that the SAB's governance role in relation to domestic abuse was underdeveloped. The SAB collected no data on domestic abuse and had conducted no audits or inspections concerning the application of the Mental Capacity Act, either within safeguarding in general or in relation to domestic abuse in particular. Links between the SAB and the Domestic Abuse Board were not strong. Another SAR raised concerns about the quality of safeguarding training being delivered in agencies, finding that e-learning delivery was not effective and that training did not promote themes such as human rights, equality or the impact of discrimination. Another suggests that the SAB should place a greater focus on community awareness. One SAR questions how well-sighted the SAB was on the issues that arise when care providers struggle to provide safe care, and another expresses surprise that the oversight of care homes had not been high on the SAB's agenda following publication of a SAR on provision made by a local residential and nursing care home provider.

The governance of safeguarding in sexual exploitation was found to be complex in the context of overlap and transition between children's and adult services. One SAR notes that transition was a shared agenda between 4 boards, including the SAB, but the leadership lay with the Local Children's Safeguarding Board's child sexual abuse steering group. As a result, it proved difficult for adult service representatives to influence the work plan, which remained child-focused. The SAR notes that a cross-age strategic group that could direct activity for both children and adults was planned and emphasises the importance of establishing a shared vision and clarity about its purpose, terms of reference, membership and responsibilities.

7.4.3. Governance of the SAR process

One SAR draws attention to poor SAB governance in relation to the commissioning of the SAR, in which a family challenged the original decision not to commission a review. This decision had been signed off by the Director of Adult Social Services, not by the SAB independent chair, which the review suggests is contrary to statutory guidance.

7.4.4. The SAB's role in improving practice

One final aspect of governance is the question of how SABs shape and monitor actions going forward following a SAR. In one case, the SAR methodology included review of actions taken by the SAB and agencies after previous SARs. It finds that previous learning had not been embedded into practice and makes some observations about how post-SAR actions are framed and pursued.

- SMART actions plans were too often focused on 'one off', quantifiable actions that could be easily RAG rated. It is critical of a focus on standalone, 'bite-sized' training, making the point that training will not get to the 'nub' of complex issues or change practice in isolation. It requires

follow-on actions such as supervision and team meeting discussion to change culture and practice, commenting that this multi-pronged approach is more difficult to RAG rate but is likely to be more effective.

- RAG rating had been done on the basis of flimsy evidence. It notes that only one organisation was able to provide supervision audits from action in response to previous SAR recommendation. The audits were not sufficient to prove or disprove change in practice, yet the action was RAG rated Green.
- Documents were developed and subsequently also RAG rated as green. However, there were no actions to check whether the pathway was being used or how practitioners valued the guidance.
- There was no consistent evidence of any other form of quality assurance to identify any change in practice, for example peer reviews, audits or other feedback loops developed to assess how successful actions were.

The SAR concludes:

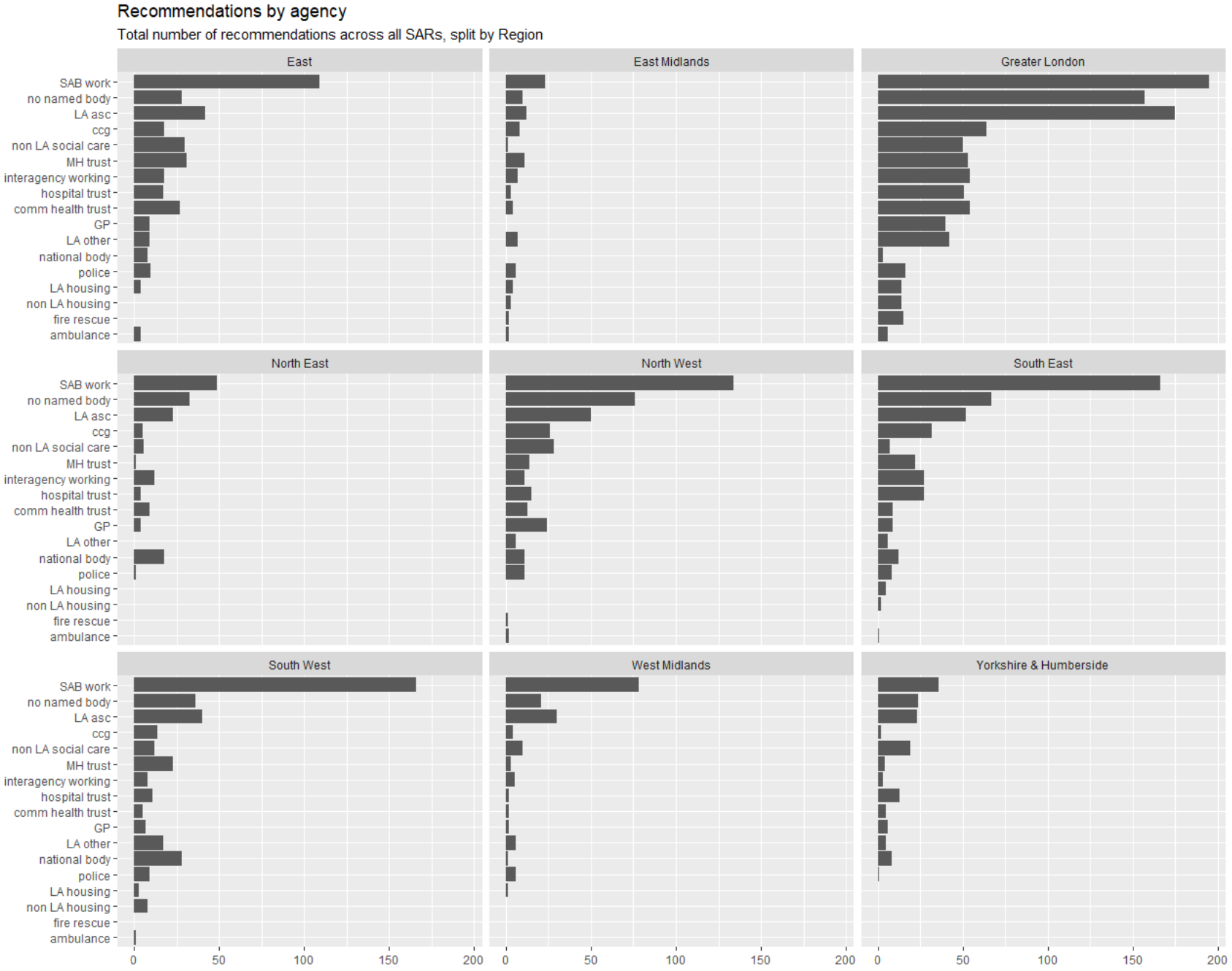
> "The Board has long recognised the need for systemic learning. Where the Board has not been quite as successful is in influencing the responses to those gaps and weaknesses within organisations. Whilst priorities were clearly identified, actions plans tend to default to one-off actions that can easily be measured and the Board was probably too quick to sign these actions off. The Board has not held agencies to account in the longer term to ensure that there has been systemic learning."

8. Recommendations

8.1. Recommendations by agency

The table below presents data on the number of recommendations and the agencies to which they were addressed. Recommendations were categorised by the agency (or agencies) to which they referred. The table and chart below show these split by agency and region. The majority of recommendations were for the SAB itself, unnamed bodies and adult social care. There were also high numbers of recommendations for CCGs, non-local authority care providers, and mental health trusts. Conversely, there were relatively few recommendations for emergency response services.

Number of recommendations by agency and region										
Recommendations	**East**	**East Midlands**	**Greater London**	**North East**	**North West**	**South East**	**South West**	**West Midlands**	**Yorkshire & Humber**	**Total**
Ambulance service	4	2	6	0	2	1	1	0	0	**16**
CCG	18	8	64	5	26	32	14	4	2	**173**
Community health trust	27	4	54	9	13	9	5	2	5	**128**
Fire and rescue service	0	2	15	0	1	0	0	0	0	**18**
GPs	9	0	40	4	24	9	7	2	6	**101**
Hospital trust	17	3	51	4	15	27	11	2	13	**143**
Interagency working	18	7	54	12	11	27	8	5	3	**145**
LA Adult Social Care	42	12	175	23	50	52	40	30	23	**447**
LA housing	4	4	14	0	0	5	3	1	0	**31**
LA other	9	7	42	0	6	6	17	6	5	**98**
Mental health trust	31	11	53	1	14	22	23	3	4	**162**
Non-LA housing provider	0	3	14	0	0	2	8	0	0	**27**
Non-LA social care provider	30	1	50	6	28	7	12	10	19	**163**
Police	10	6	16	1	11	8	9	6	1	**68**
Work of national body	8	0	3	18	11	12	28	1	8	**89**
Work of SAB	109	23	195	49	134	166	166	78	36	**956**
No named body	28	10	157	33	76	67	36	21	24	**452**
Total	**364**	**103**	**1003**	**165**	**422**	**452**	**388**	**171**	**149**	**3217**


Recommendations by agency
Total number of recommendations across all SARs, split by Region
East
East Midlands
Greater London
North East
North West
South East
South West
West Midlands
Yorkshire & Humberside
SAB work
no named body
LA asc
ccg
non LA social care
MH trust
interagency working
hospital trust
comm health trust
GP
LA other
national body
police
LA housing
non LA housing
fire rescue
ambulance
0
50
100
150
200

Across the sample of SARs where this information was made available, the number of recommendations ranged between 0 and 71. The mean average was 10.17 recommendations per review. The mode, the most frequently occurring number of recommendations, was 7; the median, the middle value when all the numbers were ranked, was 8.5.

As the quantitative data table illustrates, there is a trend towards all recommendations being addressed to the SAB, giving it the responsibility for determining which (combination of) agencies should lead on implementing particular findings.

The theme of imprecision is noticeable here. There were 10 SARs where recommendations were directed to "partner agencies" without specificity as to which services were included in this phrase. There were also occasions when recommendations were directed to "health". It is more helpful for SABs when report authors are clear about which agencies they believe should lead on implementing particular recommendations.

On three occasions SARs contain no recommendations specifically because of the conclusion that agencies had taken action already. Thus, one SAR noted that "there are now dementia champions and training in each care home. Admissions procedures have been strengthened to include assessment of the level of care required and whether the facility can meet a person's needs". Another observed that "a mental health triage assessment tool has now been introduced in line with Royal College guidance."

It was unusual for SARs to set a time limit by which recommendations should have been implemented. Similarly, only one report in the sample explicitly connected the SAR recommendations to the six adult safeguarding principles in the statutory guidance[106].

8.2. Recommendations on direct practice

Quantitative data[107] provides the frequency of themes observable in the recommendations. As other thematic reviews have found[108], mental capacity and risk assessment are especially prominent. However, not surprisingly in an analysis drawing on 231 SARs across a range of types of abuse and neglect, other components of direct practice are highlighted, particularly working with carers and meeting the range of a person's health, housing and social care needs.

is in the area of direct practice that the six adult safeguarding principles are especially relevant. Accordingly, the qualitative analysis of recommendations on direct practice begins with where these principles are reflected in SARs. This analysis is interpretive in the sense that reviews themselves do not utilise the framework of the six principles when making recommendations.

[106] Section 14.13.
[107] Section 5.7.2.
[108] Braye, S. and Preston-Shoot, M. (2017) *Learning From SARs: A Report for the London Safeguarding Adults Board*. London: ADASS. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

8.2.1. Empowerment

In a rare acknowledgement of diversity, one SAR recommends that good practice requires specific statements in records that the requirements of the Equality Act 2010 have been met. More generally, recommendations focus on ensuring the entitlement to advocacy support[109] and a person-centred approach that draws on appreciative inquiry and a strengths-based focus. Practitioners and managers are reminded that making safeguarding personal (MSP) is "not optional", that the person's voice must be heard, and that support must be available to enable individuals to achieve their desired outcomes and to promote their wellbeing.

> "The Board should consider how gender, ethnicity, religion and culture, as well as any other factors that are particular to [the area], show themselves in domestic abuse cases involving adults at risk - and what the implications are."

> "SAB to ensure that advocacy services are sufficient and fit for purpose, and staff are knowledgeable and supportive of it."

> "Agencies should promote a personalised approach, which includes recording and acknowledging who the person is, their history, their abilities, wishes, behaviours, and approach to risk in order to understand how to support them."

> "Promote a holistic approach to patient assessment and care planning against best practice and ensure it is personalised to the individual; for example, speech and language therapy (SALT) plans should be adapted to personal wishes and needs. It is also important that care plans are personalised to reflect decisions of the patient with mental capacity including when this is contrary to medical advice."

8.2.2. Partnership

Closely allied to the principle of empowerment is that of partnership. Here recommendations focus on two overlapping areas. The first is partnership with the adult with care and support needs, demonstrated for example in recommendations that service users should have copies of their care and support plans, and the continuity of a key worker who focuses on building a relationship of trust.

> "A review of the relevant policies and procedures should take place to ensure that the patient's agreement and consent as to whom they want to be involved and informed is regularly reviewed and documented."

> "Multiagency audit to establish extent and quality of professionals' understanding and practice of hearing the client's voice, how well they know the adult, and embed their wishes and feelings in assessment and planning."

The second partnership is with the person's family and wider network of potential support. The focus here is on a whole network or "think family" approach. This may involve the provision of information about how to raise concerns and feeding back how complaints and safeguarding alerts have been addressed. Recommendations highlight family involvement where appropriate and carer assessments but also exploration of family

[109] Section 67 Care Act 2014.

relationships and challenge when it seems that relatives may not be acting in a person's best interests. Recommendations focus also on information-sharing and highlight the importance of communication. Examples include:

> "Health and social care to consider a whole family approach and relationship-based practice, including use of genograms/ecograms, ensuring individual voices are heard and robust support when individuals and families with significant risk are identified."
>
> "SAB and LSCB to ensure that CSC and ASC systems align into a whole family framework and life course approach to address risk."
>
> "SAB to seek assurance that carer needs are identified and offered assessment, including dependence between carer and cared-for person, and contingency arrangements."
>
> "CCG to ensure system for residents and family members to raise concerns with Healthwatch, CQC, local authority and providers as part of placement agreements, with clear information, a named contact and clarity on the role of the care coordinator."
>
> "[NHS Trust] to assure the Safeguarding Adults Board that the Care Programme Approach is effective; that service users, carers, family members and partner agencies are clear about the process and expectations of service delivery, together with ensuring where appropriate the change of care coordinators is communicated."

The overlap between these two components of partnership working are demonstrated in a number of recommendations:

> "Senior safeguarding practitioners should provide timely and accurate updates of progress to the adult, family and advocate."
>
> "Local authority to review guidance and procedures on care reviews to ensure reviews focus on lived experience of service users and facilitate and support service users and families to express concerns and worries."
>
> "Local authority and health and social care providers to ensure that staff are confident in working with relatives and family carers, are aware of the potential complexity, conflict and tensions that can arise between family members and have the practice tools to enable them to ensure that the service user's voice and wishes are at the centre of their practice."

A third area of partnership working is that between services. This is given greater attention in the section on inter-agency working but is worth highlighting here because the degree of partnership working has direct implications for service users and their families. One example illustrates this:

> "Work with both adult and child carers is an important area of work that would benefit from a joint approach both adult and children services. The two boards are asked to consider whether or not this is an area that remains one that could benefit from further work."

8.2.3. Prevention

This principle is implicit in recommendations that cover, for example, the use of pendant alarms, smoke detection systems and telecare with people with dementia or where there are fire risks, and of outreach teams to engage with adults at risk. Prevention is implicit too in recommendations that focus on discharge planning and responding to a person's health and mental health needs. Another example is the recommendation that body maps are used as part of preparation for a person's admission to hospital or care home.

> "Careful consideration should always be given to the gender and age mix in accommodation reserved for people with mental ill health, particularly when there is no onsite support … The continuing use of shared accommodation for individuals with no onsite support should be reconsidered, with particular consideration given to the compatibility of the residents, and any risk issues which could compromise the health and safety of the residents."

> "All those providing care (social care staff, providers, district nurses) should consider any fire risk to an individual during any contact and to take steps to mitigate foreseeable risk."

> "The Board should consider how a recovery-focused approach to mental health service treatment and support could be used to ensure that service users with long-term conditions who are discharged from services have a complete discharge plan including a summary of relapse indicators, a crisis and contingency plan, and information on re-referral pathways."

8.2.4. Protection

There are close connections between prevention and protection, with recommendations seldom highlighting the distinction. However, the focus on protection can be seen in recommendations that remind practitioners to consider the use of all available legal options, for example when working with people who are intoxicated and at risk, or with victims of domestic abuse, and advise agencies to check that community services have been reinstated after a person's hospital discharge.

> "SAB to request from the Council and Community Housing how the SAR findings and requirements of the Homelessness Reduction Act 2017 are being used to develop responses and service provision to meet the needs of adult victims of sexual exploitation."

> "SAB to review with partner agencies how hospital discharge care and support plans are arranged in complex cases with repeating patterns of risk."

There are recommendations that address explicitly the ethical dilemma of how to balance autonomy and risk, and that reinforce the importance of thorough assessments and investigations to mitigate risks, achieve best evidence and facilitate contingency planning.

> "SAB to raise awareness of the need to balance a person's ability to protect themselves from risk and harm with autonomy."

> "Police to ensure officers in cases of domestic abuse consider the proximity of any potential bail address to that of the complainant, especially when the perpetrator lives very close to the victim and the domestic history features a pattern of coercive, controlling behaviour. Police officers who visit a [well-known] domestic violence perpetrator and their supervisors are reminded of the need for thorough research on the perpetrator prior to doing so." Police to ensure that officers attending scenes of domestic abuse take into account all persons present and affected by the actions of a perpetrator. Those who are not victims but are affected should be recorded as a relevant party. Police to ensure that staff involved in risk assessing current [well-known] victims take careful consideration of the history of the parties and not deal with the one incident in isolation. This is particularly so when the further incidents are repeated regularly."

Consideration of how to safeguard a person also needs to take account of the implications of adverse childhood experiences, trauma and loss, as the following example highlights:

> "There needs to be a greater focus on loss and trauma. Adverse childhood and adult experiences, involving loss and other trauma, are known to lie behind many manifestations of self-neglect. They can impact on people's behaviour, such as disengagement, and on their physical and mental health, including diabetes and depression. Developing a trauma lens in health and adult social care practice is required."

8.2.5. Proportionality

This principle is harder to discern from recommendations about direct practice. Intervention that is compliant with a person's qualified right to private and family life is that which is sufficient to achieve a legitimate goal. The proportionality of any intervention must be capable of justification, for example when considering how to balance a person's autonomy against the likelihood of significant harm. Examples can also be found in recommendations that focus on MSP and on mental capacity assessment. Similarly, assessment must not be so narrowly focused on a presenting problem that important patterns within a person's history are overlooked.

> "Review whether a person's right to decline assessments under the Care Act 2014 and exercise their autonomy is weighed sufficiently, fully and carefully against professional standards in Health and Social Care."

> "Is the Board satisfied of the current legal safeguards in place to support staff in managing such complex cases reflect the principles of Making Safeguarding Personal in particular proportionality?"

> "When making a Best Interest decision, clinicians should consult those who know a patient best about a patient's needs and views. By failing to carry out a reasonable and proportionate consultation and recording the results, they may be failing in their duty under the MCA 2005 and also potentially their own duty of care."

8.2.6. Accountability

The focus here is unequivocally on practice standards. There are several components, the first of which focuses on the awareness and understanding that practitioners apply to their work. The spotlight inevitably falls on a range of situations, including awareness of the misuse of prescription drugs, and on the impact of bullying and of coercive and controlling behaviour, especially in terms of the barriers thereby created to accepting help, and of

high-risk factors in domestic abuse cases. Recommendations focus on awareness of the legal rules, for instance regarding advocacy, eligibility for care and support, options when access is denied to a person at risk, or the role of the Court of Protection. Recommendations focus too on understanding and responding to types of abuse and neglect, such as self-neglect or domestic abuse, and to people with particular disabilities, such as autism.

> "Safeguarding Adults Board may wish to reflect on the lack of a confident grasp of the implications of the Mental Capacity Act indicated by this case and consider whether any further action is necessary to increase practitioner knowledge in this area."

> "Council and CCG should undertake a stock take of the application of the Mental Capacity Act and how professionals are using it to support adults who may be in danger of self-neglect. This should include reference to the importance of assessing capacity early on in cases of self-neglect and review of the current policy as required. The results of the stock take should also be used to draw up training and development plans regarding self-neglect, use of the Mental Capacity Act and best interest assessments. This should be offered to relevant staff to strengthen awareness, joint working and confidence in working with complex risk situations."

> "The Board should obtain quantitative and qualitative data on needs assessments and carer assessments to ensure that professionals understand the duties placed on them by the Care Act 2014 and are meeting expected practice standards for holistic working."

Secondly, recommendations seek to improve and enhance the quality of practice. Following a sequence of practice tasks, some recommendations focus on issues of engagement, paying due regard to a person's gender and ethnicity, and improving the use of professional curiosity.

> "Agencies to review their risk templates to ensure they are designed in such a way as to assist with the recording of information, the layering effect of protected characteristics (race, gender, learning difficulties) and other relevant factors such as immigration status and harassment."

> "Developing staff skills and confidence to express concerned curiosity, to inquire into young people's lived experiences, to recognise and explore the impact of past experience on current engagement, and to assess the impact on on-going actual or hoped-for contact with family members."

Then come recommendations that highlight the importance of holistic assessments, including of risk and mental capacity, followed by detailed care planning that, for instance, gives parity of esteem to mental health and physical health needs. On assessment, SARs recommend not relying on individuals self-reporting and on telephone assessments but triangulating information and using observation.

> "Partner agencies assure the Safeguarding Adults Board that when dealing with a person who has suffered a relationship breakdown, rather than making assumptions or accepting things on face value, professionals in all agencies explore and understand the reason for that breakdown and whether it might be because of abuse including domestic abuse."

> "SAB to work with Adult Social Care to clarify the circumstances where home visits rather than telephone contact and assessments are appropriate with respect to persons with care and support needs, and a history of declining care and support, and safeguarding concerns."

> “Police to triangulate information and not take information given by individuals at face value.”

> “SAB to ensure social and health care assessments in cases of self-neglect address the issue of motivation as well as the ability to self-care, are holistic and address the social context and support systems or lack of them, of service users/patients.”

Then come recommendations that focus on review and recording, advising against premature case closures and emphasising the importance of clear summaries when case responsibility is transferred between practitioners, teams or services. Recommendations emphasise that reviews must take place and achieve their stated purpose, and that recording is one means of demonstrating understanding of, and compliance with legal rules, such as advocacy arrangements and working with relatives who hold Lasting Power of Attorney. Records should give a clear account of decision making, including consideration of legal options.

> “Council staff should understand the importance of avoiding subjective information in risk assessments. Council case records should be accurate and contemporaneous and fully updated with the progress of enquiries and decisions.”

> “ASC defensible documentation/record keeping [requires that] ASC case recording will meet the expected standards for professional recording (timely, complete, concise, factual, objective, professional) and will provide a clear rationale for professional decision making.”

> “The care agency should review their record keeping in order to ensure that the timesheets are signed by the service user or an explanation is noted as to why this is not possible. The Council’s commissioning team should consider the introduction of effective electronic monitoring which could provide improved tracking of care visit timeliness and compliance to both the provider and the commissioner.”

Finally, recommendations focus on quality standards with respect to specific issues, such as hospital discharge, admission into care settings and handovers between staff and services. For example, written discharge plans are advised, including confirmation that a community care package has recommenced.

> “Care Home must ensure risk assessment prior to hospital discharge, considering changes in the person's needs and suitability. It must ensure medication and directions are received on discharge and that correct moving and handling assessment is considered as conditions change. Community nursing must review community nursing admission and discharge of new patients after hospital discharge. It must ensure that moving and handling plans are utilised when patients are non-ambulant. It must review why there was no follow-up pain management. Community nursing must document pressure sores using grading systems. Hospital discharge summaries must communicate all relevant information about the patient's conditions.”

> “The provider organisation to assure itself that the pre-admission assessment process is fully completed; a full description of any issues raised to be completed in full with written text to enable a seamless handover for the resident when admitted.”

> “All assessments are to be completed upon admission for service users which must include full assessments of identified risks in a timely manner as outlined in the provider organisation’s policies, and that these lead to robust care plans to meet the service user’s needs.”

8.2.7. A window on practice

Not all recommendations compartmentalise direct practice according to health, housing and care needs, or specific tasks. Rather, they bring together awareness, understanding, knowledge and skills into a composite whole. In so doing, the complexity of practice is highlighted.

> "Encourage partner agencies to adopt systems and processes that enable a person-centred approach to practice, including a focus on the impact of adverse experiences and a recognition of responses to poverty and chronic conditions. Encourage partner agencies to 'think family' and to recognise the potential contribution of informal carers in understanding and working with individuals at risk of abuse and neglect, including self-neglect. Continue to promote an anti-poverty lens in risk assessments, healthcare interventions and assessments of care and support needs."

> "SAB to ensure supply of advocacy services is sufficient and fit for purpose, and that staff are knowledgeable and supportive of access to advocacy. SAB to seek assurance from partners that human rights and health and social care and support needs of adults at risk of abuse/neglect are understood by staff and discussed with family carers, especially at points of transition. GPs to focus on adults at risk and their best interests, to conduct annual health checks, including capacity assessments, use advocates and identify carer issues. GP templates for health checks and for epilepsy to be revised. Missed appointments to be followed up and to be seen as "was not brought". Issue and collection of (repeat) prescriptions to be monitored and omissions followed up. Acute Trust to use learning disability passports. Services should not close cases when risks have not been mitigated. Individuals at risk should be seen alone, with an advocate if necessary."

One SAR lists recommendations provided by a family, which also connect various components of direct practice, namely:

> "Involve family members in order to assist a person to engage with appointments and meetings; be aware of why people might fail to engage since this may be the result of ill-health and tiredness rather than lack of interest; consider the appointment of a key worker to whom the person can relate; work together rather than in isolation, ensuring that record keeping is comprehensive, accurate and up-to-date, and referrals and concerns followed-up; review how medication is monitored by GPs and other healthcare practitioners."

A few SARs in their recommendations remind agencies that practice should draw explicitly on research and on NICE and other guidance so that it is evidence-informed. Examples include:

> "Health and social care providers must review assessment and review processes to ensure they follow Valuing People guidance[110] and CA duties on wellbeing, ensuring inclusion of the service user and their advocate, informed by previous assessments and reviews, and holistic, timely and proportionate."

> "SAB and CSP to encourage use of Blue Light project approach[111]."

[110] Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: The Stationery Office.
[111] Ward, M. and Holmes, M. (2014) *The Blue Light project – Project Manual*. London: Alcohol Concern.

> "The Joint Review has highlighted the need for adult services (in common with the majority in England) to consider self-neglect in the context of research findings[112]. The review asks that the important learning set out in that research is considered by the SAB and where considered helpful disseminated to those working with adults and families. This should include consideration of the Mental Capacity Act (2005) requirements in relation to self-neglect."

One overarching question remains only partially answered, namely why it is that certain topics are consistently found in critiques of practice and recommendations for improvement. In relation to mental capacity, one SAR begins to explore an answer to that question.

> "MCA emphasis on presumption of capacity is inadvertently making it more likely that some practitioners may assume capacity rather than record their rationale for decision and this risks loss of evidence going forward' and 'The responsibility of making a best interest decision for a service user when they lack capacity weighs too heavily on some practitioners, which means they tend to avoid undertaking them."

8.3. Inter-agency recommendations

Recommendations here focus on improvements concerning how agencies work together. They recognise that all types of abuse and neglect require a multiagency response, which itself should draw on research on best practice to be evidence-informed:

> "If a complex case is not being managed using an existing multiagency process, no individual professional is responsible for drawing agencies together so there is a risk that an adult's changing needs and risks will not be responded to quickly."

> "SAB should ensure that agencies embed NICE guidance to establish effective pathways, leadership and information-sharing agreements to provide coordinated and shared care to people with learning disabilities and mental ill-health."

The focus is very much on workplace development, designed to strengthen how systems respond to adult safeguarding concerns:

> "SAB to explore whether changes in single agency pathways, policies and procedures promote or act as a barrier to multiagency work, collaboration and communication."

> "Review the learning from this case on where integration between community and secondary healthcare providers, and between health and adult social care is working well and where further work on embedding integration is necessary."

Quantitative data[113] illustrates the frequency with which SARs referenced different components of inter-agency adult safeguarding procedures and practice. How recommendations specifically sought to embed improvements follows.

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[112] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence.
[113] Section 5.8.1.

8.3.1. Coordination and communication

Some recommendations focus on coordination and collaboration in general. The breadth of adult safeguarding is highlighted in these recommendations, which address how different practitioners work together in primary care, how team members around the person agree roles and responsibilities, and how services collaborate to respond to the needs of people who are homeless, experience mental distress and/or residing in care settings. Examples include:

> "Communication between inpatient services and community teams in relation to discharge from hospital should enable planning to take place prior to discharge. Planning should follow CPA procedures."

> "The SAB needs to satisfy itself that Adult Social Care, Housing and other services who work most closely with the homeless population have developed a clearly understood and coordinated assessment, referral and interventions pathway for people with a diagnosed or suspected personality disorders based on best practice."

> "The SAB should support health and partner agencies in agreeing a protocol to ensure there is a coordinated and accountable process available to meet the care and safeguarding needs of adults where those needs are so complex, or their context so challenging, as to be vulnerable to significant harm or death within existing models of service delivery."

Some recommendations focus down on referral practice as a specific example of coordination. In particular, recommendations remind referrers to be very clear about risks and what is being requested. Feedback to referrers is also strongly emphasised. Thus:

> "A fire risk screening tool to include criteria for referral to the Fire Brigade for use by all agencies and accompanied by training to understand and use."

> "SAB to be assured that there are protocols to ensure differences in multiagency referral systems do not result in referrals being overlooked or missed and procedures to follow up referral actions."

> "SAB to request that the Council, Mental Health Trust and ASC provider circulate information about referral routes and responsibilities to all agencies."

Some recommendations focus on the importance and value of multiagency risk management meetings and/or high-risk panels, for protection planning and mitigation of risks. Examples include:

> "SAB to review guidance on multiagency arrangements to avoid agencies working in isolation with complex cases, including the use of network meetings, case conferences and risk management meetings."

> "SAB to undertake review and on-going audit of multiagency meetings used as part of initial case coordination for new referrals, and/or the self-neglect pathway and/or section 42 enquiries, including those convened by GPs, to ensure that practitioners and managers are clear about their roles and responsibilities, information is being shared appropriately, and lead agencies and keyworkers are being appointed."

One SAR asks and answers a "why?" question here, exploring why it remains the case that case conferences, panels and other meeting types appear underutilised in adult safeguarding. The SAR concluded that the reluctance to convene case conferences was due to the perceptions of others' workloads and capacity, and the fear of making a wrong call.

> "SAB to remind key practitioners as to the integrity required when conducting all safeguarding adult meetings that potential suspects or persons on police bail for the case under discussion, should not be allowed to participate and chairs of meetings must apply strict compliance."

Other SARs emphasise not just the value of multiagency meetings but also the importance of ensuring that the right practitioners and services are present.

> "Safeguarding Adult Board to revise the safeguarding adult procedures to make it explicit that there is a formal process for agencies concerned about safeguarding risks for an adult with needs for care and support to convene a multiagency meeting. This meeting should have representation from all partners involved who can share information and develop an action plan."

Leadership emerges as one core component of coordination and collaboration, in the form of a lead agency and keyworker. Thus:

> "Local authority and NHS Trusts to jointly review arrangements to identify people with complex needs and vulnerabilities and ensure that each has a named professional responsible for effective coordination and review of care arrangements."

> "Implement mechanisms for comprehensive and ongoing multiagency review of supported living tenants with complex needs including the allocation of a named case coordinator (to whom the case remains open) with lead responsibility for ensuring key information is shared, and for tracking and coordinating actions across all agencies."

> "Ensure that guidance addresses the requirement for lead agencies and key workers to be appointed in complex cases to ensure a coordinated response."

A core feature of safer organisational and multiagency systems is where there is a recognition of the value of challenge in order to avoid the risk of one view being formed of a case, thereby excluding other possibilities. Two recommendations clearly appreciated the importance of openness to alternative perspectives:

> "On the basis of this review, escalation, communication and challenge between agencies in relation to the health of adults with learning disabilities and complex needs should be tested out by the board with a view to supporting a culture locally where professional challenge is a strong part of the safeguarding culture in [the area]."

> “The Board and organisations must support practitioners to challenge more senior and/or qualified colleagues about decisions.”

A safer system is also one where there is constant reflection and learning to inform quality enhancement.

> “The Board should test out assertions about improved coordination and pathways between mental health, housing and adult social care - for example that the High-Risk Transitions Panel is 'very successful' and understand what these mean for adults at risk of suicide and self-harm.”

> “The Safeguarding Board should continue to promote the work of the Risk Assessment Management Panel process and should carry out an evaluation and efficacy review of the process.”

8.3.2. Information-sharing

The timely and proportionate sharing of information at every stage of the adult safeguarding process is one core aspect of coordination and communication. SARs recommend explicit agreements about information-sharing, for example how commissioners and host authorities of placement will share intelligence about, and take responsibility for ensuring, care home standards. “Systems in place” should be reviewed to ensure that they are sufficient robust to inform decision making about referrals, for instance into a MASH, assessments, changes in care and treatment and plans, discharge, and the prevention and prosecution of crimes. Examples include:

> “Ensure that all agencies’ staff recognise the need to report to police without delay, serious unexplained, potentially non-accidental injuries suffered by adults at risk. Ensure that policy, procedure, and training, highlights the need in potentially complex situations involving unexplained injuries to an adult at risk, that the police should be made aware as soon as possible.”

> “When a GP visits a patient and knows they are also being treated by other clinicians, that GP should consult with those clinicians to ensure he or she has the most complete recent history of the patient’s condition. The Community Trust must ensure that, when its staff are treating a patient who has just been discharged from an acute hospital and they do not receive a discharge letter, they must contact the hospital and obtain a copy of it.”

> “[NHS Trust] should review the procedures for information sharing and decision making when patients are transferred in either direction with all commissioned independent health care providers. The information provided for this review suggests that these crucial elements are dependent on individual practitioners who have knowledge of the requisite systems. However, it fails to consider the possibility of individual error and the need for contingency plans when a key professional is absent from work. Protocols for effective information sharing should be devised to overcome difficulties of sharing information where this is in the best interest of the service user.”

8.3.3. Recording and record-sharing

Recommendations focus on the importance of practitioners being able to access information recorded by other practitioners and services involved, especially out of hours and/or in crisis situations. Thus:

> "SAB to work with partner agencies to explore how to facilitate information-sharing through interlocking IT systems."
>
> "SAB should coordinate a review of the use of different IT systems with a view to reinforcing a system whereby different professionals can access important information to assist their efforts to meet a person's health, care and support needs."

Recommendations also focus on standards of recording adult safeguarding practice, ensuring that all actions and decisions taken in adult safeguarding investigations and enquiries are clearly documented. Thus:

> "Local authority to review safeguarding concern workflow to ensure rationale for decisions clear and feedback to the referrer."

The coordination of records and of information-sharing links to the principles of accountability (defensible decision making) and prevention. Thus:

> "SAB to consider, in conjunction with other local Community Partnerships such as the Community Safety Partnership, the Health and Wellbeing Board and the LSCB, developing local multiagency forums to share information on low-level concerns to coordinate preventative strategies and services."

8.3.4. Across boundaries

Information-sharing across different services continues to challenge practitioners. A further layer of complexity concerns communication and collaboration across local authority, CCG and other geographical and service boundaries. Examples follow of how recommendations have endeavoured to improve policy and practice in this respect.

> "SAB to ensure the protocol in place with neighbouring SABs to ensure appropriate cross-boundary referrals of safeguarding concerns are operating effectively."
>
> "There should be an established protocol between adjoining boroughs for referrals from EDT to the day and operational services."
>
> "Where commissioners have to place outside of their own local area, they should seek out the views that local services have of a provider especially in terms of the way this provider has handled safeguarding concerns … If a key responsibility cannot be clearly assigned either across commissioning agencies or across geographical boundaries, the matter should be escalated to a Pan London body and/or to NHS England so that a decision can be made without undue delay."

8.3.5. Adult safeguarding procedures

As elsewhere in this discussion of recommendations, an emphasis is placed on procedural clarity to prove a framework for practice. The development and/or review of adult safeguarding procedures is advised to strengthen multiagency cooperation, to provide guidance to support each stage of adult safeguarding, and to set out clear expectations about standards and roles. Thus:

> "That the Board review multi agency communications and pathways relating to complex needs and high-risk case management and that clear policy and procedures are developed to support agencies and frontline workers in their discharge of duties."
>
> "The Board should seek assurance that there are robust information sharing protocols which are reflective of balancing informed consent, mental capacity, public interest and vital interests and that agencies have mechanisms in place for disseminating changes in policy procedures and protocols. Assurance is required that referral pathways are streamlined and are outcome not process focused."

Multiagency protocols or procedures are also advised with respect to particular "client" groups, such as people experiencing homelessness with care and support needs, people who misuse alcohol, responses when adults at risk are missing, and people who self-neglect. Some examples are:

> "Robust multiagency policies and procedures to address self-neglect should be developed and instigated when to adults at risk in similar cases."
>
> "SAB to receive from Adult Social Care and Housing a joint multiagency protocol on assessment and service provision with respect to homeless people with care and support needs."
>
> "SAB to review multiagency hospital discharge procedures to ensure they are fit for purpose with regard to cases of possible self-neglect."

Sometimes recommendations are concerned with the use of thresholds guarding the entrance to adult safeguarding and advise review of the operation of safeguarding to ensure appropriate escalation of concerns to enquiries, for example with respect to self-neglect or domestic abuse. Thus:

> "Review the application of thresholds for Section 42 (Care Act 2014) enquiries involving concerns about neglect and self-neglect, the guidance given about making referrals, and the feedback given to referrers."
>
> "SAB should review the process by which the need for a section 9 Care Act assessment is raised through the safeguarding referral process. The SAB may wish to audit the extent to which this occurs currently to establish if this is in line with expected population need. If only a small proportion of safeguarding referrals lead to a section 9 assessment, the SAB should consider whether there is a need for increased resources or modifications to the safeguarding referral pathway to ensure this occurs.'"

8.3.6. Safeguarding literacy

Procedures alone are insufficient; practitioners and managers must be aware and see the relevance of the procedures to their work. Accordingly, recommendations sometimes focus on practitioners' adult safeguarding knowledge and responses to types of abuse and/or neglect.

> "Ensure staff within the agencies involved in this SAR are clear on the responsibilities and process for reporting and managing safeguarding concerns."

> "SAB to raise awareness of local guidance on when to raise safeguarding concerns."

> "Agencies should assure the SAB that staff understand that raising a safeguarding alert does not negate the need for any agency to take appropriate action to safeguard."

Sometimes the focus falls on the approach to different aspects of adult safeguarding, including raising concerns, responses to referrals, conduct of enquiries, achieving best evidence for criminal prosecutions and engaging other practitioners. Examples include:

> "SAB should arrange an audit of safeguarding alerts, referrals and responses to understand how the vulnerabilities of asylum seekers are explored and assessed."

> "Council adult social care should review practice on how the first point of contact operates to ensure that referrals about safeguarding concerns are appropriately received, screened and allocated, including feedback to referrers or agencies."

> "Construct processes and pathway to engage GPs in safeguarding activity."

8.3.7. Legal literacy

Effective adult safeguarding involves all agencies and staff involved having a clear understanding of when legal rules may have a contribution to make towards prevention of protection from abuse and neglect. Recommendations therefore focus on understanding and application of legal rules involving, for instance, mental capacity, information-sharing, care and support assessments, modern slavery, and provider concerns. Examples include:

> "SAB to seek assurance from LSCB regarding monitoring of staff knowledge of law and implementation of MCA. Seek assurance that legal services have reviewed and revised procedures for advice to CSC/ASC regarding MCA and transition. When services communicate, ensure appropriate systems in place to ensure effective implementation of MCA, especially when there are unwise decisions."

> "Remind Mental Health Trust of Care Act 2014 duty to assess when someone has a mental health condition and substance misuse."

> "Council should review its operation of the safeguarding adults pathway to ensure that its operation is in line with the Care Act and accompanying care and support statutory guidance, embraces the principles and practice of Making Safeguarding Personal, and promotes a multi- agency response in practice to self- neglect concerns."

8.3.8. A window on inter-agency adult safeguarding practice

Inevitably, given the findings that emerge in individual SARs, recommendations compartmentalise different aspects of how services work together to protect adults at risk. However, it is also possible to see an overview of collaboration and communication, as the following recommendation illustrates.

> "The Board will need assurance from key partner agencies that all agencies have made their staff aware of the expected standards around information sharing and recording practice and that these are enforced, and poor recording challenged. This is particularly important regarding decision making meetings, care and support plans and safeguarding plans. It would have been expected that an Enquiry Review Meeting would have been convened as part of the safeguarding enquiries. This is a formal meeting which brings together all relevant agencies and other key individuals to review the progress of the enquiry and consider further actions. The Board will need assurance from key partner agencies that they enable their staff time and space to work effectively in a multiagency way, that this is valued, and that the care and support needs of adults are addressed through multiagency processes and do not rely solely on email correspondence. There needs to be clarity regarding the role of a lead professional in the context of both assessments of care and support needs and care and support plans. The board will need to seek assurance that where adult safeguarding enquiries are conducted by a different authority from that which has responsibility for care and support needs, there is clarity about roles and responsibilities and that safeguarding enquiries are planned and coordinated in line with this."

8.4. Recommendations for organisations

8.4.1. Employer responsibilities

Professional regulatory bodies and case law have outlined what staff may reasonably expect from an employer. Good organisations will have transparent systems for managing workloads and will provide resources to enable staff to practise effectively. They will provide high quality training, supervision and support, to enable staff to make skilled judgements in complex, stressful, challenging and unclear situations. They will offer a safe place of work and have systems to develop and sustain a confident and competent workforce[114]. Recommendations addressed to organisations shine a spotlight on these standards.

The quantitative data identifies the frequency with which recommendations focused on these standards. As will be amplified by the qualitative commentary below, organisational responsibilities cover quality assurance, capacity building, strategic planning and the setting and codification of standards. There are largely unacknowledged but nonetheless clear links to how the investment made by organisations in adult safeguarding can contribute to realisation of the aforementioned adult safeguarding principles of prevention and effective protection from abuse and neglect, accountability, and empowerment of and partnerships with local communities and with statutory and third sector agencies.

For the purposes of qualitative commentary, the recommendations have been grouped into those primarily concerned with workforce development and those with a principal focus on workplace development. As research has found[115], workforce development in the form of training must be accompanied by a corresponding focus on changes necessary in the workplace if the knowledge and skills acquired are to be utilised effectively. This connection is not routinely found in how recommendations are framed.

[114] Preston-Shoot, M. (2019) *Making Good Decisions: Law for Social Work Practice* (2nd ed). London; Macmillan/Red Globe Press.
[115] Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect Work*. Leeds: Skills for Care.

8.4.2. Workplace development - training

The extensive breadth of adult safeguarding is illustrated by the range of topics on which training is recommended – for instance financial exploitation, sexual exploitation, mental capacity, substance misuse, mental health, domestic abuse, motivational interviewing, law, information-sharing, recording, moving and handling, pressure ulcer care and self-neglect. It is illustrated also by the different practitioners to whom staff development is targeted – GPs, police officers, gas engineers, commissioners, and care home staff for example. Sometimes the recommendations are detailed in terms of what training on specific topics should include. The first example also explicitly acknowledges that whole system change must run alongside workforce development for the benefits of the latter to be fully realised. Thus:

> "SAB to arrange multiagency training on self-neglect, involving practitioners, operational managers and strategic managers to ensure whole system change as well as workforce development; this training to include skills of expressing professional curiosity, the importance of ascertaining a person's history and a chronological account, and how staff should respond when there is a tension between a person's autonomy or self-determination and the likelihood or risks of significant harm as a result of their decision making and self-neglect."

> "Training in mental capacity: specific issues that may need to be addressed include the requirement that capacity is assessed specific to a particular decision; clarity about what the â€˜diagnostic test may mean for complex conditions where there is diagnostic uncertainty (and related to this, what it means to apply the MCA's tests on the balance of probabilities); emphasis on the individual responsibility of practitioners to carry out their own assessments of capacity before delivering or providing an intervention (ie ensuring that professionals do not misconstrue that specialist assessments are not by themselves determinative of capacity; they can only be used to inform judgements)."

> "Police to ensure patrol officers, supervisors and all staff involved in processing domestic violence incidents are fully conversant with the legislation relating to coercive and controlling behaviour as per section 76 of The Serious Crime Act 2015 … ASC training should include the requirements of the 2014 Care Act and Care Act Guidance (chapter 14) which references domestic violence and financial abuse as key areas of concern … and Data Protection Act 2018."

Sometimes SABs or their partner agencies are advised to review what is covered in training programmes generally or in workshops and seminars on specific topics. Sometimes they are encouraged to build programmes around the findings of quality assurance, with the objective of building a confident and competent workforce. Less often SABs are encouraged to monitor the outcomes of training, such as levels of understanding of drug and alcohol issues. Examples include:

> "SAB to seek assurance from all agencies that staff appropriately trained and supported to implement MCA2005, including recording assessments and decisions not to undertake assessments. SAB to seek reassurance of monitored implementation of staff development to ensure staff aware of indicators of abuse and neglect and their responsibilities to raise concerns internally and externally."

> "SAB to explore uptake and availability of training to ensure staff understand entitlements to assessment of eligible needs and that pathways promote this. SAB to seek assurance that training and supervision identify the correlated risk of poor mobility, incontinence and pressure damage, and therefore that risks are identified, assessed and responded to appropriately. SAB to seek assurance that training, supervision,

audit and governance within agencies (quality assurance) promote practice standards to ensure person-centred approaches and MSP in safeguarding interventions."

The purpose behind recommendations is not always explicit. The following example, mindful of the importance of securing criminal convictions following wilful neglect, is focusing on achieving best evidence although it is not explicitly framed as such:

> "Be assured that all Enquiry Officers and Enquiry Managers have received specific training for the role of /coordinating effective enquiries, taking into account the evidence gathering requirements of organisations such as the police and the CQC, also taking into account the Person-Centred approach of the Care Act."

One running theme through this national analysis has been the relative neglect within reviews of race and culture in adult safeguarding. This resurfaces here, with no recommendations that focus on unconscious bias and the attitudes, knowledge and skills necessary to counteract discrimination when raising or responding to adult safeguarding concerns. This is especially in cases of discriminatory abuse, involving hate crime.

8.4.3. Workforce development – supervision

As with training, recommendations cover supervision for groups of staff, including care home registered managers, care home staff, and newly qualified social workers. Similarly, supervision recommendations sometimes focus on specific issues, such as working with families who are hard to engage, ethical dilemmas surrounding autonomy, and accurate implementation of the requirements of mental capacity legislation. One SAR acknowledges the importance of supervision in focusing on reflection on the possibility of staff becoming desensitised to risk, for example in situations of self-neglect where there is no evidence of deterioration in a situation but where the risks of harm are already significant. Examples follow:

> "Supervision should routinely consider how to support frontline staff to maintain a person-centred approach in complex cases, where young people's engagement is ambivalent. Supporting frontline staff to manage the emotional impact of the work through debriefing after critical incidents, peer support and supervision."

> "Staff need support and supervision regarding when to intervene because someone's decisions place them at risk (the autonomy dilemma)."

SABs and partner agencies are also reminded of the importance of reviewing access to, and the quality of supervision. One SAR is explicit. Supervisors must have the knowledge and skills to challenge practitioners and to explore issues that arise in adult safeguarding, including assessment of decisional and executive capacity. Thus:

> "The panel felt that the supervision and support for the Care coordinator and Community Rehabilitation Manager should be revised to ensure that staff managing cases that are highly complex and demanding should receive frequent high-level supervision and the consideration of cases being rotated to avoid potential burnout."

> "[Local authority] and health and social care providers to ensure there is regular and sufficient supervision available to all social work staff at the right quality and level to enable all workers and managers to escalate and follow through agreed actions."

> "Seek reassurance from commissioning and provider organisations on supervision practice, with a particular focus on frequency and the degree to which oversight of cases is challenging as well as supportive."

Once again, the purpose behind recommendations is not always explicit. One recommendation reminded SAB partners that supervision records should be maintained that indicate when safeguarding was discussed and what was decided. This is an implicit acknowledgement of the importance of accurate and timely recording of all decisions, and the reasons behind them, in case of challenge[116].

8.4.4. Workforce development – staff support

Here the focus is on staff health and safety, and wellbeing. Some recommendations, for example, focus on offering space within which ethical dilemmas can be shared involving risk in the context of capacitated choice, or critical incidents reviewed. Others focus on mitigating risks to staff. Indeed, one SAR is explicit in recognising that training alone is insufficient; other mechanisms will also be needed to support staff to develop the confidence to tackle challenging situations, including ethical dilemmas. Examples include:

> "Staff wellbeing: how are the legal responsibilities of employers in terms of the duty of care and health and safety of staff, staff wellbeing, met and monitored? Is more messaging needed across agencies about the rights of staff not to be abused? What support systems are in place for staff who are being subject to hostility and aggression and are they being used?"

> "Remind home care managers of duty towards employees when work conditions pose serious risk of infection."

> "Supporting frontline staff to manage the emotional impact of the work through debriefing after critical incidents, peer support and supervision."

8.4.5. Workforce development – management oversight

Management oversight of practice is a core component of workforce development and of ensuring accountability for decision making. Recommendations here cover the whole spectrum of adult safeguarding practice, including the response to referrals, allocation of work, quality of assessments and enquiries, record-keeping and case closure. For example:

> "All agencies should provide assurance that there is management oversight of patients at high risk of developing pressure ulcers."

> "Serious self-neglect cases to be escalated to senior organisational levels so that senior managers are sighted on the risks involved."

[116] Preston-Shoot, M. (2019) *Making Good Decisions: Law for Social Work Practice* (2nd ed). London; Macmillan/Red Globe Press.

8.4.6. Workforce development – workload management

One component of management oversight comprises evaluation of individual and team capacity. Here recommendations focus on caseload management in both community healthcare and social care, and on staff capacity to complete high quality and timely assessments and reviews that comply with legal requirements, such as those embodied in the Care Act 2014 and Mental Capacity Act 2005. Recommendations are concerned with staff capacity and resilience including out of hours practitioners, within their workloads to build professional relationships and work effectively. Examples follow:

> "Police to review the crime management system so that supervisors can identify and scrutinise the adult safeguarding caseload."

> "SAB to ensure that partner agencies and those they commission allow practitioners the time to develop professional relationships with those at risk of self-neglect, to enable the causes rather than the symptoms of self-neglect to be addressed."

> "Team leader/deputy team leader for the community nursing teams should have over-arching responsibility for the caseloads."

8.4.7. Workplace development – access to specialist advice

Recommendations above regarding workloads and management oversight allude to the inter-connectedness of workforce and workplace development. One component of the latter is ensuring that staff have access to specialist advice, for example from lawyers and from specialists in mental capacity, mental health and substance misuse. SARs have concluded that it is not always clear how pathways to specialist advice operate and/or that organisational cultures do not encourage consultation with those who have particular expertise, recommending that provider agencies should review how specialist advice can be obtained. Examples include:

> "SAB, LSCB and CSP to consider what expertise can be commissioned to support frontline staff in managing longstanding high-risk complex domestic abuse cases with multiple risks."

> "Frontline professionals to seek support for complex cases from mental health and substance misuse services, and how to escalate concerns and be supported in difficult mental capacity assessments clinically and legally."

> "SAB to ensure that health and social care staff have access to legal advice regarding avoidance and denial of access, especially where the adult does not have executive capacity to choose contact."

8.4.8. Workplace development – quality assurance

As one SAR commented, system and organisational resilience should not be dependent on "heroic" practitioners. Accordingly, here, the focus is on audit specifically and quality assurance more generally. Again, demonstrating the breadth of adult safeguarding, the use of audits is recommended to ensure standards of mental capacity and risk assessments, responses to safeguarding alerts, the operation of MASH and MARAC systems, and supervision. Thus:

> “SAB to conduct a case file audit of section 42 enquiry threshold decisions and to agree proposals for service development based on the findings.”
>
> “CCG to audit and review quality of annual health checks. CCG to review strategies to ensure annual health checks are not just a tick box exercise but do involve multiagency working.”
>
> “Independent evaluation of MASH for its effectiveness on risk assessment and whole family approach. Audit MARAC management and quality regarding historic domestic violence information and use of Clare's law, and ensure correct professionals attend.”
>
> “Undertake an audit of out of county placements to identify the volume of such placements and to evaluate whether there are systemic patterns to be addressed.”

The focus on quality assurance generally includes oversight of placements to ensure that contractual standards are met, especially those “out of authority”, the effectiveness of the Care Programme Approach, and decisions to close down involvement. They reflect concern as to whether staff are aware and using relevant policies and procedures, and whether established systems for referrals, assessment and decision making are robust. Examples include:

> “Adult Social Care should review their professional oversight and management of safeguarding alerts to ensure that they are compliant with agreed standards. This should include assessment of risk, appropriate recording which captures professional judgment and collective agreement where a person’s wellbeing is influenced by multiple agencies.”
>
> “Review and strengthen current arrangements for the assessment and monitoring of the use and performance of semi-independent accommodation providers working with other London Authorities.”
>
> [NHS Trust] to assure the SAB that the Care Programme Approach is effective; that service users, carers, family members and partner agencies are clear about the process and expectations of service delivery, together with ensuring where appropriate the change of care coordinators is communicated.”

Occasionally SARs observe that quality assurance has the potential to contribute effectively to organisational culture. A culture of openness to learning from incidents and from self-assessments and peer reviews forms part of adherence to the principle of accountability. Examples are:

> “Care home operator should build a positive culture for staff to report incidents to management.”
>
> “NHS England to ensure there are regular fully documented contract monitoring meetings with the hospital, with priority given to learning the lessons from recent incidents and a review of performance with attention to incident and supervision levels.”

8.4.9. Commissioning

The focus of quality assurance on placements connects with commissioning and contract management, and with how commissioners work with providers to raise and consolidate standards, and to address concerns when they arise. There are several component parts to the focus on commissioning. The first highlights the importance of gap analysis and service development planning, based on surveys of assessed need. Thus:

> "Public Health as the commissioners of drug and alcohol services should review Health and Care Providers' access to drug and alcohol advice in the light of the findings of this Review."

> "Commissioners to address the needs of people who may present challenges due to self-neglect within their market development strategy, for example, through commissioning specialist domiciliary care provision."

> "Multiagency commissioners to map gaps in service development regarding sexual exploitation and address them, including a specific service for young people aged 16-25."

> "That the Board ensure a mechanism is established to inform future commissioning strategies given the local identified need of increasing complex needs and homeless individuals. The Board should seek assurance such strategies are reflective the principles of the Care Act 2014 in terms of safeguarding and commissioning accountabilities and Safeguarding Adults Policy and Procedures."

A second focus seeks to provide reassurance that service users receive timely support, for example through robust equipment supply chains. A third reminds both commissioners and providers of ensuring that proposed placements are appropriate both for existing and proposed residents, that staff have the required knowledge and skills to meet people's assessed needs, and that training and procedures are in place to ensure appropriate person-centred responses to emerging health and care concerns. Thus:

> "Seek reassurance that commissioning processes are robust in identifying the degree to which recommended placements have the capacity and resources to meet an individual's identified care and support needs."

> "Commissioners to assure that care homes can provide a safe environment and good record keeping, including preventive measures regarding pressure ulcers and techniques for dealing with residents resistant to intimate care routines and positional changes."

Recommendations also seek to ensure clarity regarding the interface between commissioners managing provider concerns and adult safeguarding.

> "Review the interface between commissioning and safeguarding to develop a governance framework for care quality concerns in line with CA2014."

Finally, there is a focus on contract management and subsequent recommissioning.

> "Local authority and CCG commissioners to gather information on whether roles and responsibilities are unclear regarding provision of nursing care to nursing homes. Local authority contract compliance should be through a targeted approach to visits based on risk and should ensure that care plans and medication records are fit for purpose for the needs of the individual. In settings not compliant with CQC regulations and/or contracts, care needs of all residents should be reviewed with a clear audit trail and with families provided with relevant information. Review the local authority home closure and provider failure protocol."

> "It is recommended that when planning to recommission health and adult social care services … the focus remains on the safety and wellbeing and welfare of the people in the home until this period concludes; and demonstrate that they have included the potential impacts on service users, patients and their families within their risk register and have contingency plans in place to protect service users."

8.4.10. Workplace development – resources

Recommendations sometimes address the commissioning of services to address gaps in provision identified in SARs. In mental health there are recommendations for the development of outreach teams and crisis response services, for a review of the availability of section 136 suites, for additional provision of hospital beds, and for commissioning of additional psychological therapy sessions to manage waiting lists. Other recommendations address gaps in domestic abuse services, for example with respect to individuals who are both victims and perpetrators, and long-term support for people who self-neglect.

> "SAB should seek to ask whether relevant housing providers have access to appropriate accommodation for supporting people with complex mental health needs, and specifically the needs of people who might require accommodation during/after admission for inpatient detoxification."

There are recommendations to address the availability of treatment for alcohol dependence and a shortfall in advocacy provision. Noticeable is the number of recommendations regarding the availability of provision out of hours. The following are examples:

> "Out of hours arrangements for placement in care settings: That providers who have staff who are in a role of assessing and placing people in appropriate care settings are aware of the process for weekends, evenings and bank holidays."

> "Scope of out of hours home treatment team to be reviewed to ensure focus on outcome and experience for patients, coordination of its services, recording systems and practices, and onward referral process."

8.4.11. Workplace development - records and recording

Continuing with the emphasis on quality assurance and enhancement, recommendations focus on the need to improve recording, for example when quality issues with care providers do not meet the criteria for adult safeguarding under section 42, or contractual breach. They emphasise the need for visible summaries of chronologies and risks, especially to assist with handover of case responsibility between staff and/or service providers. The emphasis is very much on standards, for instance of timeliness of record-keeping. Example include the following:

> “All non-health agencies should adopt good record-keeping standards and provide assurance to the SAB. All health agencies should provide assurance to the SAB of compliance with statutory and local record-keeping guidelines. Each agency to have a chronology of significant events to ensure timely recognition and sharing of important information to assist with safeguarding procedures.”
>
> “LA to ensure that client record system and record-keeping practice enable good intelligence to support decisions and judgements.”
>
> “That assessments, including financial and carer assessments, and advocacy arrangements are Care Act (2014) compliant and are robustly recorded and shared appropriately. Rationale for not undertaking full assessments should also be recorded.”

8.4.12. Policy development, review and dissemination

As the quantitative data highlights, recommendations addressed a perceived need for the development and/or refreshment of policies and procedures. This group of recommendations covered every type of abuse and neglect, different situations in which adults were at risk, and particular issues or challenges that arise in adult safeguarding.

On types of abuse and neglect, there were recommendations for policy development on financial exploitation, self-neglect, and discriminatory abuse (mate crime). For example:

> “Ensure that guidance on service refusal is embedded in relevant procedures, and that thresholds for pathways to safeguarding and self-neglect procedures are clearly identified (including the circumstances in which self-neglect procedures may be followed without client consent).”
>
> “All provider agencies are recommended to have a mate crime or exploitation strategy in place and to ensure all staff have an awareness of the exploitation of Adults at Risk.”
>
> “Organisations commissioning accommodation and care services to expect commissioned services to have a specific Mate Crime policy in place or have a specific Mate Crime section in their Safeguarding policy as part of the commissioning criteria.”

On practice, recommendations focused on assessment and reviews, risk assessment, and mental capacity, with an emphasis on ensuring that practice complies with the legal rules and with best practice as captured in guidance published by NICE and other professional and regulatory bodies. Also included in the focus on procedures for practice were hospital discharge and transition. Examples include:

> “ASC to review and revise its procedures to ensure all social care assessments are holistic and outcome-focused, incorporating the individual's own sought outcomes.”
>
> “Services dealing with the transition from childhood to adulthood need to be well versed in the two legal frameworks for decision making which apply before and after the age of 16.”

> "The Community Trust must produce an effective handover process, which will be applied when a patient is handed from one Trust to another. Local authority must ensure their care home managers have formal procedures for sharing information with clinical staff who are treating residents. Local authority must ensure that, when a resident is transferred from a care home managed by them to another care home, any current DoLS authorisation or application (with any associated documentation) is included in the handover."

On particular challenges, there were recommendations on information-sharing and on how interlocking IT systems can facilitate informed interventions. Information-sharing was also linked to handover between staff and services, achieving best evidence[117], and clear identification of individual at risk. Recommendations also addressed concerns about missed opportunities to use escalation of concerns. Examples include:

> "SAB to seek assurance from NHS Trust that IT system is robust in monitoring and responding to DNAs, with procedures to track and manage risk and vulnerable patients. SAB to seek assurance from CCG that all surgeries have robust systems to flag and address DNA and ensure that vulnerable patients are offered health care."

> "Develop a clear pathway for escalation of concerns to prevent unsafe discharges."

> "Local authority to provide assurance of robust monitoring of direct payments, with an escalation process for concerns, to ensure allocation is spent on implementing the person's support plan."

> "SAB ask Drug and Alcohol services to review its process for escalating safeguarding concerns, particularly in relation to self-neglect, and consider why a formal referral was not made in this case. This may involve further staff training or updating of policy guidance/processes."

On adults at risk, SARs made recommendations regarding support for victims, missing persons, people experiencing homelessness, patients transported home from hospital into unsafe situations, and patients who do not attend appointments.

> "SAB to seek assurance regarding multiagency protocols and guidance for shared understanding of how to respond to adults reported missing, including return interviews, information-sharing and joint work to minimise further episodes."

> "Leads for local homelessness strategy and four providers assess that the strategy addresses those at risk of chronic homelessness so that services are coordinated to address safeguarding concerns and prevent escalation of needs and harm, ensure timely and coordinated assessment, implement the duty to provide advocacy and commission on a citizen-based model, and embed staff understanding and acting on the advice of assertive outreach services."

> "Ensure that guidance on service refusal is embedded in relevant procedures, and that thresholds for pathways to safeguarding and self-neglect procedures are clearly identified (including the circumstances in which self-neglect procedures may be followed without client consent)."

[117] For example, to enable consideration of whether offences have been committed (section 44 Mental Capacity Act 2005).

The breadth of adult safeguarding is demonstrated by the range of topics covered in recommendations for policy and procedure development to provide a framework for best practice. For example, recommendations covered thresholds for home visiting by District Nurses, responses when access is denied to an adult at risk, end of life care decision making, and support for refugees and individuals with no recourse to public funds. The breadth is also illustrated by the range of care pathways and care planning that recommendations seek to ensure are in place. This range covers mental health, self-neglect, dual diagnosis, diabetes, domestic abuse, frailty and dementia. By way of example:

> "Mental health commissioning and mental health partners to support work on broadening the use of innovative models of mental health support … and to advise the SAB of progress."
>
> "Mental Health Trust to prepare a briefing paper for dissemination outlining when someone should be considered for CPA."
>
> "It is suggested that the Partnership adopts a self-neglect pathway. The pathway would specify a number of actions and interventions that must be completed (for example the nomination of a lead professional, assessments of mental capacity, and use of the toolkits, risk assessments, and clutter tool."

Efficient use of staff resources would suggest that a repository be developed of examples of policies and procedures that reflect best practice across the areas identified above.

8.5. SAB governance recommendations

8.5.1. SAB roles and functions

Research on the governance of adult safeguarding[118] has scoped SAB responsibilities in detail, identifying seven core functions:

- Strategic planning;
- Setting standards and issuing guidance;
- Quality assurance;
- Promoting participation;
- Awareness raising;
- Capacity building and training, and
- Relationship management.

[118] Braye, S., Orr, D. and Preston-Shoot, M. (2011) *The Governance of Adult Safeguarding: Findings from Research into Safeguarding Adults Boards. Final Report to the Department of Health*. London: Social Care Institute for Excellence.

The statutory guidance[119] mirrors to some degree the aforementioned research. It refers to prevention of abuse and neglect; development of policies, guidance and strategies, and promotion of multiagency training. SABs are encouraged to develop effective links with other key local partnerships. SABs are also responsible for overseeing and holding partners to account for the quality, responsiveness and effectiveness of adult safeguarding services. This might be done through analysis and interrogation of data, and the use of self-audits and peer review. Integral to this oversight and improvement agenda is the development of collaboration, monitoring progress against stated intentions through annual reports. The statutory guidance requires SABs to identify mechanisms for monitoring and reviewing the implementation and impact of policies and training, with a particular emphasis given to self-neglect. Crucially, what is meant by impact is left undefined.

A key question to answer, therefore, is the degree to which recommendations align with these statutory responsibilities. As reflected in the quantitative table below, recommendations do explicitly align with key SAB functions, most especially the development of policies and guidance, provision of multiagency training, holding partners to account through the use of quality audits, and establishing links with other partnerships. The responsibility to contribute to the prevention of abuse and neglect is implicit in the focus of the recommendations rather than explicitly named. As will be seen below, SAB roles are framed in terms of engagement and relationship-building, ensuring and seeking assurance, contributing to sector development and acting as a conduit for promotion of best practice.

8.5.2. Commissioning and managing reviews

The SAB's accountability function emerges through recommendations that respond to difficulties experienced in engaging particular practitioners or services in SAR processes. Thus:

> "[The Board should] review the measures available to it for seeking compliance with section 45, Care Act 2014, where an individual or organisation fails to fulfil their statutory duty to provide information, and to consider requesting that the Department of Health strengthen national guidance on this matter."

Accountability is also explicit in the number of recommendations that SABs should ensure that agencies have implemented the improvements noted as being required in their IMRs, with outcomes impact assessed. Accountability is explicit too in ensuring that agencies implement SAR recommendations and in exploring the degree to which services have responded to the findings of earlier reviews. Thus:

> "As a result of this review, all agencies have provided action plans to address both identified practice and systems issues within this case. It is recommended that the Board ensure they have a robust mechanism to monitor the implementation of Individual Agency Action Plans and to evaluate the subsequent impact as result of this learning."

Holding agencies to account is explicit in the recommendation that NHS Trusts share the findings of serious incident investigations, and that SABs themselves should revisit action plans after a period of time to ensure that learning has been embedded fully. The function of making connections and building relationships is also present. Thus:

[119] DHSC (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (sections 14.135 and 14.139 – 14.141).

> "Reconvene a learning event after one year to evaluate with managers and practitioners across the agencies involved what has changed as a result of learning from this SAR."

An enabling or developmental function emerges through recommendations that the SAB refreshes and relaunches its SAR policy, having reviewed its referral pathway and the guidance it provides to agencies on identifying potential cases for review. Recommendations on SAR process also included advice on collecting and scrutinising information before making final decisions on whether or not to commission a review. Examples follow:

> "Safeguarding Adults Board to ensure partner agencies review their SAR referral processes to make sure they are timely and effective and understand that the SAR panel should be used for advice and consultation when considering whether the criteria for a SAR referral is met."

> "Safeguarding Adults Board should within 6 months review their decision making pathway regarding the identification of a Section 44 Review in order to ensure timely decision making in the context of the date of when an incident actually occurs."

This enabling and developmental function is also seen in recommendations regarding guidance for those involved in the SAR process, including training for IMR writers, standards for agency reports to ensure appropriate sign-off by managers, support for agencies to facilitate their participation and the provision of pre-IMR briefings. Examples follow:

> "Consideration should be given to the level of support offered to smaller agencies to enable them to engage more effectively with future Safeguarding Adult Reviews."

> "SAB to ensure individuals signing off IMRs are given a checklist of what a good IMR looks like, including SMART recommendations."

> "The Board should consider, in future reviews, a pre-IMR briefing so that IMR Authors are aware of the methodology being proposed by the independent author and can be reminded of what is expected of organisational involvement and IMR analysis."

Making connections as a function, establishing links and relationship-building, can be seen in recommendations that focus on clarifying the interface between the duty to enquire[120] and SARs, monitoring by agencies of cases where a SAR, or another review process such as a DHR, has been commissioned, and expectations of commissioners and providers with respect to retention of records and information-sharing, even when particular services have been decommissioned. Thus:

> "SAB to work with commissioners and providers of health and social care to ensure that records and information are returned and made available to SARs even after contracts have ended."

> "Commissioning services should agree how information will be kept and made available as evidence to complete a SAR and incorporate this into contracts."

[120] Section 42 Care Act 2014.

8.5.3. Dissemination

Development/enabling and provider functions can be traced in recommendations on dissemination of SAR findings, for example to other SABs regionally and nationally. However, accountability is also present, for example in auditing the circulation and impact of 7-minute briefings and ensuring that findings and actions are implemented. This is dissemination with a purpose, to inform practice standards, prompt revision of agency procedures and stimulate training provision. Dissemination sometimes extends beyond local boundaries to agencies with regional or national remits and central government departments. Examples follow:

> "SAB to disseminate learning across the [region] to ensure further guidance on the Mental Capacity Act 2005, self-neglect and alcohol dependence. SAB to raise awareness through workshops for all agencies. SAB to ensure that the neighbouring SAB is fully informed of the learning and recommendations from the review."

> "The chair should raise the issues of national concern[121] with the Department of Education and Department of Health and make other London chairs aware of the report and the issues raised."

> "The Safeguarding Adults Board will produce a learning brief, which will be widely disseminated in partner agencies, and address key points including identification/ recognition of carers who do not self-identify as such, and the involvement of family in decision making."

8.5.4. Training

Recommendations here focus on the SAB as a provider and/or enabler of multiagency training, for example on mental capacity assessments, self-neglect and risk assessment. Closely linked, however, are functions of accountability, in reassessing the training staff have received and how its effectiveness has been tested, and developmental, in promoting a focus on particular topics or issues, such as cultural competence and hate crime. Thus:

> "Training should help to develop cultural confidence for staff working with clients who did not share their cultural background."

> "The SAB should implement multiagency training to raise the awareness of hate crime in all its forms (disability, race, religion, sexual orientation and gender identity), including support for victims when reporting hate crime and in identifying appropriate social and therapeutic support."

> "SAB learning and development sub-group to review current training programmes to identify how the following are included - professional curiosity and work with evasive and dangerous individuals and families; coercive and controlling behaviour, assertiveness and conflict resolution; whole family systems approach to assessment and review."

[121] Unregulated placements to accommodate young people in the process of leaving care transition, and the provision of tier3/4 mental health resources.

8.5.5. Quality assurance

Holding agencies to account is the prominent focus here, enabled through single and multi-audits of such practice areas as risk assessment, work with people experiencing homelessness, hospital discharge, the impact of self-neglect policies and procedures, and the use of multiagency risk management meetings. There were recommendations also to audit the practice of making safeguarding personal, responses to the needs of carers, and commissioning and contract management, for example with respect to out of authority placements and whole home investigations. The focus here is on oversight and the seeking of assurance that safeguarding systems and practices are robust, thorough and effective. Examples include:

> "Where the team makes a decision on a safeguarding referral, its decision should be conveyed to the referrer within a specified time period. Regular case file audit and/or other quality assurance tools should be used to confirm compliance with this expectation that feedback is good practice … Conduct a multiagency audit and/or other quality assurance mechanism to evaluate how far Making Safeguarding Personal has been understood and embedded in practice."

> "Follow the launch of the revised self-neglect policy with explicit review and audit of its implementation across all partner agencies."

SABs themselves are occasionally placed in the frame in terms of their approach to audit and quality assurance. Thus:

> "It is recommended that the Board should consider how it can become more adept at not only identifying systemic issues but in articulating them to practitioners and how it may hold agencies to account by showing subsequent changing practice."

8.5.6. Governance

Functions of accountability and of making connections are prominent in recommendations that SABs should engage in governance conversations to ensure strategic oversight of safeguarding across the life course. Thus, SABs are encouraged to engage with Community Safety Partnerships to map our respective roles and functions and agree how they will work together to avoid duplication. With Local Safeguarding Children Boards SABs are encouraged to agree joint procedures, for example about safeguarding work with families or responding to self-harm and suicidal ideation, and to develop shared strategic priorities, for instance regarding transition or domestic abuse. One example of working closely with a Health and Wellbeing Board focuses on action plans to improve health outcomes for people with learning disabilities.

Examples of recommendations focusing on links with other partnership bodies include:

> "SAB, LSCB and CSP to agree a joint strategic group reporting to all three Boards to develop strategic priorities, coordinate actions and oversee delivery regarding child and adult victims of sexual exploitation. SAB, with LSCB and CSP to address the findings of the LGA peer review and this SAR."

> "Concerns about missed opportunities to initiate safeguarding actions while X was still a child are serious. It is important that some assurance is given that if the same situations arose, they would be responded to differently. It may initially be appropriate for the SAB to liaise with the

relevant LSCB, which may be able to give a better view as to whether changes in legislation and practice are likely to have resolved these issues."

Another aspect of governance relates to SAB membership, specifically whether additional agencies should be represented on the Board, review of how it conducts its business through sub-groups and reinforcing the importance of partner agencies engaging fully in meetings and learning events. Thus:

> "The SAB and LSCB should consider which community services are not routinely involved with local safeguarding arrangements and consider how best to engage them."

> "It is recommended that a review of sub-group roles, activities and actions be undertaken as part of the refresh of the Strategic Plan."

8.5.7. Policies and procedures

Recommendations place considerable faith in policies and procedures, with SABs given a prominent developmental role. As the quantitative data reveals, this developmental role spans the development, review and revision, and dissemination of policies and procedures across the entire spectrum of adult safeguarding, with particular emphasis on self-neglect, use of escalation, and assessment and risk assessment. Some recommendations clearly link the development of procedures with an emphasis too on training and evaluation of implementation and impact. Examples include:

> "SAB to ensure that escalation processes are in place and that staff performing a supervisorial role are able to demonstrate that their staff understand how to use them within their organisations and how to constructively challenge partners when required … An [already developed] internal audit can be [used] to ensure effectiveness."

> "SAB to review and revise self-neglect guidance and ensure all Board members disseminate the policy appropriately. SAB to review and revise risk management guidance and ensure all Board members disseminate appropriately. SAB to produce an escalation policy, including convening professionals' meeting when there are concerns and several agencies involved."

> "SAB to develop and share across the partnership a shared risk assessment and risk management protocol."

There is a corresponding emphasis on the development or revision and dissemination of policies and procedures relating to mental capacity assessments, commissioning of services, referral pathways, transition, and recording and information-sharing. Several objectives can be discerned from this developmental work, namely to improve people's access to services through the establishment of clear pathways, to clarify how agencies are expected to work together, and to raise practice standards. Once again, some recommendations clearly link the development of procedures with an emphasis too on training and evaluation of implementation and impact, and on working alongside other partnership bodies with responsibility for safeguarding. Thus:

> “That the Board ensure a mechanism is established to inform future commissioning strategies given the local identified need of increasing complex needs and homeless individuals. The Board should seek assurance such strategies are reflective the principles of the Care Act 2014 in terms of safeguarding and commissioning accountabilities and Safeguarding Adults Policy and Procedures. That the Board ensure the pathways around complex needs and high-risk case management are applied in safeguarding training.”

> “Review guidance across agencies on the importance of documenting the reasons for mental capacity decisions (whether based on the presumption of capacity or explicit Mental Capacity Act assessment); request agencies to use regular case file audit to check compliance. Consider the development of guidance on multiagency and multi-professional capacity assessment in specific cases, such as those involving self-neglect, in which impairment of executive capacity may be a feature.”

> “Develop and promote practice guidance on best practice regarding transition into and subsequent support of disabled people in supported living, using the learning from this case.”

> “Develop information sharing agreements with all agencies and the technological solutions to make information-sharing practicable for practitioners.”

Other recommendations focus on the development of procedures regarding specific adult safeguarding concerns, such as approaches to preventing and mitigating fire risks, counteracting mate crime, responding to financial exploitation and also when high-risk patients do not attend appointments, and managing whole home investigations. Thus:

> “SAB to produce and promote a multiagency fire risk strategy. This should incorporate training to agencies (including pharmacies) on awareness of fire risk factors; the provision of awareness raising material to service users and carers; incorporation of fire risk and checking smoke alarms in assessment and care planning tools; referring service users for home fire safety checks, with prioritisation and tracking of people who are non-ambulant and smoke in bed; and consideration of a range of support options, including advice, supervision, alternatives to emollient creams, laundry provision, and equipment (including smoke alarms, fire extinguishers, fire retardant aprons and bedding, and sprinklers).”

> “The SAB to update the regional Joint Safeguarding Adults Policy to include Mate Crime.”

> “Consider what guidance and support is available across partners to support adults at risk of significant debt, financial abuse and exploitation.”

Other specific adult safeguarding concerns on which recommendations focus include the coordination of adult safeguarding enquiries with provider concerns procedures, support for practitioners managing complex cases, the adequacy of local services, the management of ethical dilemmas and the response to concerns about people in positions of public trust. Examples follow:

> “SAB to support partners to understand legal implications which apply to supported accommodation and how to balance any conflicting desires with their duty to promote wellbeing.”

> "SAB to seek reassurance from Acute and Mental Health Trusts regarding the suitability of local provision for the assessment of suicidal patients and also to review arrangements for out of hours mental health support including the availability of the triage car."

> "Safeguarding Adults Board to develop best practice guidance on how care and accommodation providers should balance an adult's right to independence with effective family engagement."

Perhaps harking back to the absence of reference to race, culture and religion in SARs, there are few recommendations that address the importance of anti-discriminatory practice. One example, however, follows:

> "The Board should consider how gender, ethnicity, religion and culture, as well as any other factors that are particular to [the local authority area], show themselves in domestic abuse cases involving adults at risk - and what the implications are."

Recommendations also evidence concern that not all practitioners and agencies might understand the value and remit of adult safeguarding policies and procedures, for example in respect of homelessness. Alternatively, there are recommendations that adult safeguarding policies and procedures be revised, with particular emphasis on the value of multiagency meetings to agree responses to complex and challenging cases. Examples include:

> "SAB should issue a multiagency pathway and associated guidance to stipulate the responsibility of agencies for making safeguarding referrals."

> "SAB to review guidance on multiagency arrangements to avoid agencies working in isolation with complex cases, including the use of network meetings, case conferences and risk management meetings. And ensure that guidance addresses the requirement for lead agencies and key workers to be appointed in complex cases to ensure a coordinated response."

Recommendations also focus on another SAB function, making connections through awareness-raising with local communities and services. The former involves development and dissemination of information about how to report concerns regarding financial exploitation, mate and hate crime, modern slavery and sexual exploitation. The latter focuses on engaging with local services, including trading standards, train and taxi operators, financial institutions, faith groups, supermarkets and third sector organisations working with people who are homeless or suicidal. There is an implicit recognition here of contextual safeguarding[122], namely the importance of extending the focus on where abuse and neglect may be taking place and on those services that might be well-placed to identify it. Thus:

> "An information sheet is developed for families to be provided when their relative moves into a care or supported accommodation setting about risk indicators and who to contact if they have a concern about abuse or neglect, including Mate Crime."

> "The positive awareness demonstrated by concerned members of the community and elected representatives in this situation should be used to inform wider awareness raising strategies on safeguarding adults who may be experiencing or at risk of abuse or neglect, and how to support people in their local communities."

[122] Firmin, C. (2017) *Contextual Safeguarding: An Overview of the Operational, Strategic and Conceptual Framework*. Luton: University of Bedfordshire.

> "The Safeguarding Adult Board to run an awareness campaign surrounding adult safeguarding specifically targeting supermarket workers and other retailers."

Policies and procedures provide a framework to guide best practice, especially when accompanied by an emphasis on training (workforce development) and on quality assurance (ensuring workplace development in line with procedural and practice expectations), as the following examples demonstrate:

> "Ensure that staff understand that many circumstances are both safeguarding situations and domestic abuse, and that they have a range of social work and legal options with which to work with people. Ensure that organisational policies, protocols and procedures about safeguarding explain the links with domestic abuse and, similarly, policies, protocols and procedures about domestic abuse refer to safeguarding. Consider integrated training that covers both safeguarding and domestic abuse rather than treating them as separate issues."

However, a word of caution is necessary. Research[123] has found that the range of extensive policy documents can overload busy practitioners, having to manage time and workload pressures. SABs should pay attention, therefore, not just to content but also to accessibility when procedures are being developed or revised, and to evaluating what is facilitating or impeding their use. One recommendation implicitly acknowledges this point:

> "Due to the level of detail in the policy, and the reference nature of its format and function, it may take time for practitioners to become accustomed to its layout, the location of the information they require, and to use the policy to its greatest potential."

Improvement priority twenty six

In light of the consistency of recommendations in SARs across all four domains of analysis, which often appear to replicate those made in reviews that predate the time period under review in this national analysis, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and how they contribute to service and policy improvement and enhancement across their partnerships. Priorities for attention include:

- how to maximise learning from previous reviews to ensure that future reviews use the available evidence-base to explore where good practice has been facilitated and where barriers to good practice need to be confronted
- how to share learning between SABs to develop proportionate approaches to future reviews that build on the evidence-base rather than starting afresh.

[123] 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.

9. National Legal and Policy Context

The Quality Markers[124] advise SABs to consider which SAR findings would be better addressed in national, regional or other forums. However, concern has been expressed that SARs have given insufficient attention to this domain, even though practice and policy locally are profoundly shaped and influenced by the national legal, policy and financial context within which they are situated[125]. As the quantitative data shows, just under one quarter of SARs in this sample direct comments towards this national context. Within the commentary here there are few consistent or repetitive messages, perhaps reinforcing the critique that SARs themselves are insufficiently systemic, in that they fail to consider a key domain of the system.

There are four references to the impact of financial austerity on the public sector, and specifically on agency resources, on demand for mental health services, on staffing and on availability of advocacy. There are single criticisms of available legal rules, directed to the central government departments with responsibility for these areas of social policy, namely the absence in England of an adult safeguarding power of entry when there is insufficient evidence to justify use of the Mental Health Act 1983 or the Police and Criminal Evidence Act 1984. The Mental Capacity Act 2005 is observed in one review to be complex; in another the interface between the legal rules relating to homelessness and social care is similarly described as complex; in a third the law relating to home educated children is challenged for paying insufficient regard to safeguarding. One SAR recommends that the Department of Health and Social Care reviews current limitations on when mental health legislation can be used with respect to individuals with a diagnosis of alcohol dependence syndrome. Another SAR suggests that the Ministry of Justice should review criminal law provisions to ensure that the range of available offences has kept pace with growing understanding of sexual exploitation, and that the available provisions to protect and facilitate victims to give evidence are adequate.

> "The difficulties in the current legislative provisions arise because there is a significant number of individuals who do not lack capacity for the purposes of the Mental Capacity Act 2005 but are in some way vulnerable to coercion or duress by others and are outside the scope of domestic violence legislation. Local authorities have statutory duties to inquire into the circumstances, but it is unclear what steps can be taken thereafter to secure protection."

Adequacy of support for victims, specifically those who have experienced domestic abuse, is a question directed by one SAR to the Crown Prosecution Service, with a suggestion that staff must understand the impact of coercive and controlling behaviour, especially on an individual's engagement with the criminal justice system. SABs are also encouraged to seek the involvement of the CPS in adult safeguarding locally and/or regionally. One review also encourages SABs, locally and nationally, to consider which community services are not routinely engaged in adult safeguarding practice and governance, and to seek their involvement, supported by guidance from central government.

Single criticisms of statutory guidance and practice guidance also feature. These include lack of guidance with respect to missing adults, adults at risk of sexual exploitation, and expectations regarding information-sharing by sexual health clinics regarding suspected exploitation and/or trafficking and modern slavery, or by independent schools regarding serious crimes committed by young people with challenging behaviour. One SAR recommends that guidance on the Mental Capacity Act 2005 should clarify which body should apply to the Court of Protection when it is a CCG that is funding a

[124] Social Care Institute for Excellence and Research in Practice for Adults (2018) *Safeguarding Adult Review Quality Markers Checklist*. London: SCIE.
[125] Preston-Shoot, M. (2017) 'On self-neglect and safeguarding adult reviews: diminishing returns or adding value?' *Journal of Adult Protection*, 19(2), 53-66.

person's care. The absence of regulation of some providers of accommodation for young people and adults at risk is also a focus for several reviews[126]. One SAR questions the absence of a national governing body for advocates, to monitor practice and the competence of individual advocates via registration requirements. Finally, one SAR picks up a theme discussed earlier in section 3, namely the interface between different review processes and that this is a national issue deserving of attention.

> "There is no coherent process for coordinating the management of social care led safeguarding enquiries and health led provider quality concerns in health settings when one triggers the other or they occur simultaneously. The absence of guidance results in different practice norms which affects the quality of response to incidents. This is not just a local issue."

Other researchers have also commented on parallel review processes, observing that separate processes may not be the most efficient and productive way to promote multiagency and multi-authority learning. Parallel processes reinforce sector divides and duplicate evidence gathering[127]. Within the sample for this national analysis were examples where SABs had combined with LSCBs and/or CSPs to avoid this pitfall.

The Department of Health and Social Care is encouraged to review care pathway guidance in order to classify alcohol dependence and depression as a dual diagnosis, and to clarify that nominated individuals[128] are personally responsible for a registered care provider's contribution to SAR proceedings. The Department is also urged to review statutory regulations, and specifically Regulation 18, to ensure the inclusion of specific mention of supervision and support for care home managers. Also in relation to care homes, the CQC, Health and Safety Executive and the Local Government Association (LGA) are recommended to review memoranda of understanding to ensure that they provide a clear pathway for collaboration where both care standards and health and safety concerns are involved.

Given the number of SARs in the sample that focus on neglect/omissions and/or organisational abuse in care homes, it is perhaps unsurprising that commentary and recommendations are directed towards the CQC and the Department of Health and Social Care. In separate reviews the CQC is encouraged to review how it monitors compliance by regulated providers with regulations and responses to required improvements, when and how it uses its enforcement powers, and how it shares information with commissioners about the outcome of inspections. The frequency of inspections of providers where there are concerns is criticised, as is the absence of timely information-sharing and publication of inspection reports when there are known areas of risk and need for improvement.

The CQC alongside the Care Provider Alliance and Skills for Care are recommended by one SAR to issue guidance on the responsibility of the nominated individual for supervising the management of regulated activity, with particular focus on quality assurance and adult safeguarding. One SAR, with reference to reported data in this national analysis on the involvement of the CQC in SARs and adult safeguarding locally, recommends that the regulator reviews guidance for inspectors when determining whether to attend safeguarding strategy meetings; another, on similar lines, focuses on CQC involvement in safeguarding enquiries and provider concerns meetings.

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[126] See section 4.9.2 in this report.

[127] Robinson, A., Rees, A. and Dehaghani, R. (2019) 'Making connections: a multi-disciplinary analysis of domestic homicide, mental health homicide and adult practice reviews.' *Journal of Adult Protection*, 21 (1), 16-26. Manthorpe, J. and Martineau, S. (2019) 'Mental health law under review: messages from English safeguarding adults reviews.' *Journal of Adult Protection*, 21 (1), 46-64.

[128] Regulation 6, Health and Social Care Act 2008 (regulated Activity) Regulations 2014.

Focus turns to the Department of Health and Social Care with respect to concerns about standards of commissioning and contract management, including staff training and capacity in the system. Thus, one SAR refers to the national shortage of placements for people with complex needs; another is highly critical of what it regards as outdated campus models of provision for people with learning disabilities and autism, and recommends that no such provision should be approved in future. Other reviews focus on the regulation of commissioning, coordination when there are multiple commissioners of a single service, and coordination of reviews of individual residents. Cross-boundary issues, notification of a host authority by a placing authority, and formal consultation with CCGs and local authorities when residential care services that require CQC registration are being planned, are directed not just to the Department but also NHS England and Improvement, and the LGA[129]. It has been recommended that the remit, powers and enforcement resources of all agencies should be set out in guidance with respect to regulated services as a safeguard for people with particular care and support needs, such as autism.

Two reviews recommend that the Department of Health and Social Care establish a functioning national SAR repository so that learning from review could be widely available. One also recommends that there should be a periodic national analysis of SARs, with specific reference to identifying issues requiring national attention. Development of the national SAR library has stalled because of the absence of funding, whilst the Department of Education historically has been much more proactive in ensuring learning is disseminated from thematic reviews of Serious Case Reviews (SCRs) involving children, young people and their families. This specific concern is the subject of the first improvement priority recorded in this report.

The Department of Health and Social Care comes under scrutiny also with respect to mental health provision. Two SARs comment on the lack of availability of section 136 Mental Health Act 1983 beds; two others on the impact on individuals with complex needs of the shortage of tier 3/4 mental health provision and the lack of specialist mental health medium secure facilities. In the latter case lack of provision resulted in an individual spending six months in a prison facility where their mental health deteriorated significantly. Two reports also note that Coroners had expressed concerns about the lack of resources available for people with dementia and learning disability.

NHS England and Improvement is also referenced with respect to lack of suitable provision and the need to develop local and regional services, in one instance for adults with autism and in another for patients with both mental health and complex physical health needs. Cross-boundary placements come into focus again, with recommendations to ensure information-sharing between providers and between commissioners and providers. SARs also express concern about the failure by health providers to share information, even when this is permitted to safeguard adults under the Data Protection Act 2018, whether by sexual health clinics in response to concerns about sexual exploitation or by mental health services when high-risk patients are discharged or transferred.

Several reviews seek the involvement of NHS England and Improvement with respect to GPs and primary care more widely, for example to disseminate SAR learning. Individual SARs highlight the challenges of engaging GPs and other primary care staff in reviews and suggest that

[129] Guidance has been issued regarding partnership working with respect to out of authority placements (ADASS (2016) *Out of Area safeguarding Adults Arrangements: Guidance for Inter-Authority Safeguarding Adults Enquiry and Protection Arrangements*; NHS England (2012) *National Protocol for Notification of NHS Out of Area Placements for Individual Packages of Care (including Continuing Health Care)*. Reviews in this sample and in other analyses have found a lack of awareness and implementation of this guidance (Preston-Shoot, M. (2017) *What Difference Does Legislation Make? Adult Safeguarding Through the Lens of Serious Case Reviews and Safeguarding Adult Reviews*. Bristol: South West ADASS.)

national guidance is required. Others focus on practice, for example the importance of timely transfer of GP records between surgeries and access to records across primary care practitioners, including out of hours, and of including pharmacists in adult safeguarding. The need for clear, effective and proportionate expectations regarding GP follow-up of adults at risk who miss medication reviews, out-patient appointments or health screening is mentioned in several SARs. One review also recommends amendment of a national hospital discharge notification form to ensure completion of sections that record details of health and social care inputs required in the community. Another suggests review of when a person should be seen by a doctor to reassess previously agreed DNACPR decisions.

Individual SARs also focus on the Department of Work and Pensions to highlight the need for an adult safeguarding and anti-poverty lens when dealing with adults at risk and/or with care and support needs, and on the Ministry of Justice to stress the importance of collaboration between the Prison Service and the National Probation Service with respect to discharge, guidance regarding adults at risk of exploitation, and information-sharing with other services regarding individuals with a history of serious violent and/or sexual offences.

The Home Office is criticised in one review for lack of compassionate and person-centred practice regarding individuals who are trafficked, seeking asylum and/or with no recourse to public funds, highlighting how difficult it is for people to obtain identification papers and how time consuming and expensive appeals processes prove. Attitudes and social policy are implicated in driving people into homelessness and exposing them to abuse and exploitation. The Home Office has also been encouraged to work with other government departments to align definitions and raise awareness of domestic abuse, to conduct research on perpetrators of domestic abuse and sexual exploitation as part of attempts to reduce offending, and to clarify the adult safeguarding requirements that must be met when licensing transport providers.

> “Challenging immigration status is very difficult for people with acute or disabling mental health issues. Mental Health staff have limited knowledge of this aspects of the law despite a significant number of people in the local area having mental health and contested immigration status. The Home Office does not factor in the difficulties this group of people will have in challenging decisions about their status.”

Notwithstanding the above commentary, SARs show missed opportunities to highlight where other reviews have focused on similar concerns, such as abuse in closed institutions, and where revisions to the legal rules and/or national policy could strengthen adult safeguarding provision. The response to Covid-19 has demonstrated, for example with respect to adults who are experiencing multiple exclusion homelessness, what can be achieved when resources are made available. On missed opportunities, with respect to fire risk for example, there has been no critique in this sample of whether the powers available to Fire and Rescue Services are sufficient. Several reviews focus on annual gas safety checks in social housing but overlook that wiring can be a source of risk and yet electricity checks are only required every five years. There is only limited reference to whether formative training and continuing professional development pay sufficient attention to adult safeguarding knowledge and skills, including competence in assessing mental capacity. Only one review questions the Department of Health and Social Care, mindful of the six adult safeguarding principles, about the need for guidance on a SAB’s responsibilities towards an adult who has survived abuse and neglect and whose case has been the focus of a SAR, where they remain in need of protection from abuse and neglect going forward.

What SARs also cannot report, and what SAB annual reports do not convey, is the response by central government departments and national regulatory and professional bodies to the learning on the national legal and policy context that emerges from SARs and to the recommendations that are addressed to those bodies. The adult safeguarding principle of accountability[130] applies here too.

Improvement priority twenty seven
SABs, regionally and nationally, should discuss how SAR learning and recommendations requiring a response beyond the scope of local SABs are shared with central government departments and national regulatory bodies, and how those bodies are held to account.

[130] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (section 14.13).

10. Conclusions and Reflections

This project represents the most in-depth quantitative analysis of Safeguarding Adult Reviews (SARs) to date. It has involved a laborious process of locating and curating reviews from Safeguarding Adults Boards (SABs) across England in the absence of a complete national dataset; the development of a bespoke data entry tool to enable the collection of metadata for each review; an additional data cleaning process in order to allow for this depth of analysis; and the development of a subsequent thematic analysis approach to generate meaningful findings for practice.

It is to be hoped that the findings from this work support improvements across the sector, and a wider view of areas for national attention and prioritisation, learning from some of the most serious cases in safeguarding.

The process itself has also provided some learning that may support subsequent research, analysis, and sustainability of this work:

This project has started the important process of a developing a structured national SAR dataset, akin to national datasets held by national departments in social care and health. Given the severity, importance, and potential for learning from SARs, there is an argument for a systematic approach to recording key information about every SAR conducted in England, and a routine process of analysing this data for the benefit of the sector. Continuity in the data entry tool used will result in a structured dataset, enabling subsequent years' analyses to be more easily completed.

These analyses relied on an intensive data entry process. This report and the analyses it contains are only possible due to the high quality of the data entry. This is a resource intensive process which required additional project management and subject expertise. Whilst there is a great benefit of adding all future SARs to this database, the means for doing this need to be considered in the context of resources and funding.

- One option could be to give responsibility to the SABs or reviewers to complete the data entry by making a link to the tool available online. This might add structure to the reviewing process by encouraging reviewers to capture certain information about the review and the individual(s) it focuses upon.

- A second option might be an annual submission process, whereby SABs submit all reports and publications on a given date to a research team, who review the documents and complete the date entry.

- A third option would be for a repeat of the process followed in this project annually, where a research team make contact with all SABs to request any new reviews.

This project has utilised a statistical programming language[131] to undertake the majority of analyses. This approach involves writing scripts of code which can be executed repeatedly as new data is added. As well as enabling powerful analyses with limited resource in this first report, it also means that, should additional SARs be added to the dataset in the future, the resource required to repeat the process will be significantly lower.

[131] https://www.r-project.org/

On the data entry tool itself, a great deal of complexity was introduced to the dataset due to the complexity, variety, and sheer volume of information contained in SARs. Such complex documents are not conducive to quantitative analysis and therefore much of this report focuses on simplifying and adding some structure to unstructured data. The resulting data was necessarily 'messy'[132] and required a multi-stage process to allow for analyses. However, this was considered preferable to creating a simple data entry tool and enabled a greater level of analysis. For instance, abuse itself is complex and can happen in many locations, to many people, and have many perpetrators. The recommendations SARs make can be complex and refer to good and poor practice in many different agencies. The data entry tool allowed researchers to capture all of these elements quantitatively without losing too much detail. It did, however, require a level of data cleaning:

- The primary challenge was in the distinction between reviews and the people they featured. One form of analysis treats the individual as the unit of analysis (for example, average age). The second treats the review as the unit of analysis (for instance, average length of review). To get around this, the tool allowed for multiple people to be entered per SAR, with an individual details section for each. A more advanced, and managed approach would be to split data in this way from the point of data entry – akin to case management systems in social care, where a unique ID for individuals is linked to a unique ID for SARs. However, without a centralised system, this is not feasible and the process in this project worked around this in the most efficient way possible.

- Other data fields also lent themselves to complicated analyses – such as the themes and recommendations arising from SARs. This was complicated by the fact that SARs could make multiple comments on good and bad practice, in the same or different areas, to multiple agencies, and then make recommendations to completely different agencies. Subsequently each of these fields was then converted into individual tables for analyses. This is not the most efficient approach to analysis but has allowed for a more structured narrative in understanding the dataset.

On exploratory analyses and statistical tests, a limited number of tests have been used in this report, partly due to resource and available time, and partly due to the fact that data did not meet the assumption for many tests. There are potentially many further areas to explore statistically in this dataset, particularly related to clustering across multiple variable (for example, developing typologies of serious cases) and in looking for more complex relationships between variables (for instance, whether certain types of abuse correlate to particular recommendations). One exploratory analysis included here was that of pairwise correlations between types of abuse, which showed how certain types of abuse often occurred together. This approach lends itself to a wider analysis of section 42 data as well as SAR data; however, this would require access to individual level data on a large scale. Nonetheless, this would provide an even richer comparison of section 42 and SAR abuse profiles.

Regarding national data, only a limited selection of national section 42 data has been included in these analyses. However, now that the dataset has been created there is the potential for many further comparisons with national and population level data. That said, there are some limitations in the SAR dataset, which relate to the information available in the reviews themselves rather than the data entry approach. Because SARs do not have a structured means of recording information, there is an absence of diversity information in the reviews and inconsistency in the data related to the individuals concerned. Although in the context of a single SAR this may not be relative to the learning, diversity information across the entire dataset would help understand whether serious abuse was happening disproportionately to a specific group, in the same way that these analyses have highlighted disproportionality of SARs to general population and section 42 enquiries by region.

[132] https://www.jstatsoft.org/article/view/v059i10

Finally, representing this level of complexity quantitatively is not simple, and these analyses have only attempted to lead the reader towards where qualitative analyses will support further understanding. Ultimately, learning from SARs should come from the reports themselves. This approach only serves to highlight areas which may be of importance for further exploration when considered across the larger scale.

The statutory guidance is clear about the purpose of SARs[133]. Reviews should be designed to determine what agencies and individuals might have done differently that could have prevented harm or death. Their completion and dissemination are so that lessons can be learned and applied to future cases to prevent similar harm occurring again. To what degree are SARs achieving this purpose?

In the years before the timeframe for this national analysis, particular reviews have horrified, prompted scandalous outrage and spawned efforts at system transformation. Prominent amongst these reviews are reports on hate crime (discriminatory abuse)[134], organisational abuse[135], and neglect and omissions regarding the health and wellbeing of adults with learning disabilities[136]. There have been significant reports on cases involving self-neglect[137], fire deaths[138], the importance of professional curiosity and of relationships between commissioners and providers[139], and substance misuse[140]. Some of these SCRs and SARs remain in the adult safeguarding memory; learning from others fade with the passage of time.

Each of the types of abuse and neglect, on which the "seminal" reviews just referenced made recommendations to prevent similar harm happening again, reappear in the sample of 231 SARs included in this national analysis. The outcome is, at least to some degree, similar and/or repetitious recommendations for practice development and service improvement or enhancement. However, it should be remembered that individual SARs tend to see lessons to be learned in relation to particular issues and localities[141]. The advantage afforded by thematic reviews is that they offer a regional and/or national overview, with layered complexity, new and wider insights, and clear messages for system reform.

When discussing the different choices of methodology open to SABs, including consideration of proportionality, reference was made to the fact that some SABs have found themselves in the position of commissioning more than one review on the same type of abuse and neglect.

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[133] Department of Health and Social Care (2020) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office (sections 14.168 and 14.169).
[134] Flynn, M. (2007) *The Murder of Steven Hoskin. A Serious Case Review*. Truro: Cornwall Adult Protection Committee. Leicester, Leicestershire and Rutland SAB (2008) *Executive Summary of SCR in relation to A and B.* Warwickshire SAB (2010) *Gemma Hayter – SCR.*
[135] Flynn, M. and Citarella, V. (2012) Winterbourne View Hospital: A Serious Case Review. Bristol: South Gloucestershire Safeguarding Adults Board. West Sussex SAB (2013) *Orchid View SCR*.
[136] Flynn, M. and Eley, R. (2015) *A Serious Case Review: James.* Suffolk SAB.
[137] Flynn, M. (2010) *Ann*. Sheffield SAB. Lawson, J. (2011) *Mr BB: Serious Case Review*. Westminster SAB.
[138] Gloucestershire SAB (2012) *Adult X.* Tower Hamlets SAB (2015) *Safeguarding Adult Review Executive Summary: Mr K*.
[139] Lawson, J. (2015) *Serious Case Review in respect of ZZ*. Camden SAB.
[140] Torbay SAB (2009) *SCR – Ms Y*. Sutton SAB (2015) *Adult Serious Case Review of 7 Deaths related to the Use of Alcohol and Other Drugs*.
[141] Robinson, A., Rees, A. and Dehaghani, R. (2019) 'Making connections: a multi-disciplinary analysis of domestic homicide, mental health homicide and adult practice reviews.' *Journal of Adult Protection*, 21 (1), 16-26.

In the period after the timeframe for this national analysis, there have been other SARs published on types of abuse and neglect, and on specific social issues from which lessons can be learned regionally and nationally. One example is a thematic review on modern slavery[142]; another is people experiencing multiple exclusion homelessness[143].

For some types of abuse and neglect, for example self-neglect[144] and domestic abuse[145], and some examples of care and support needs, including alcohol dependence[146] and homelessness[147], an evidence-base has been built from SCR and SAR findings and from research. As this national analysis has found, explicit reference to that evidence-base is patchy. For other types of abuse and neglect, an explicit evidence-base has yet to be codified but could be assembled from a detailed reading of specific reviews and published research. A proportionate approach to future SARs, aimed specifically at policy and practice enhancement, would be to analyse what happened in particular cases through the lens of the components of the evidence-base, to answer the question of where the enablers were that facilitated good practice and where the barriers were.

Improvement priority twenty eight

Projects should be commissioned to develop the evidence-base for good practice with respect to preventing and protecting people from particular types of abuse and neglect. This is especially important with respect to those types of abuse and neglect that are prominent amongst the cases in the sample, such as self-neglect, but also those that were added to adult safeguarding by the Care Act 2014, such as domestic abuse and modern slavery, and those that were the focus of what have become "seminal" reviews prior to the time focus of this national analysis but where findings and recommendations have been repeated in SARs in this sample.

It is also important to counter some myths that circulate about SARs and their predecessor SCRs. The first relates to people experiencing homelessness. SABs have historically completed SCRs and SARs where an individual with care and support needs has been homeless and there has been concern about how agencies worked together[148]. There are 25 SARs in the sample for this national analysis where homelessness was a feature of the person's lived experience. As noted just above, there have been other reviews published after the timeframe for this national analysis where multiple exclusion homelessness has featured.

The second relates to impact and outcomes of review activity. Although there is clearly more that SABs can do to capture the difference that reviews have made, as identified in this report SABs were able to point to a variety of outcomes that had enhanced procedures and practice.

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[142] Manson, S. (2019) *Safeguarding Adult Review: Learning from the Experience of Large-Scale Modern Slavery in Lincolnshire*. Lincolnshire SAB.
[143] Preston-Shoot, M. (2020) *Ms H and Ms I: A Thematic Review.* Tower Hamlets SAB. Preston-Shoot, M. (2020) *Homeless Thematic Review*. Manchester SAB
[144] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234
[145] Thiara, R. and Harrison, C. (2019) *Summary Report: Domestic Abuse and Adults at Risk*. Enfield SAB.
[146] Alcohol Change UK (2019) *Learning from Tragedies: An Analysis of Alcohol-Related Safeguarding Adult Reviews Published in 2017.* London: Alcohol Change UK.
[147] Preston-Shoot, M. (2020) Adult Safeguarding and Homelessness: A Briefing on Positive Practice. London: LGA and ADASS.
[148] For example, see North Yorkshire SAB (2012) *Serious Case Review: Robert.* Harrison, S. (2012) *Serious Case Review: Mr A*. Lambeth SAB.

The instances of poor practice recorded by the SARs raise searching questions about the "health" of organisations, in terms of the resources available compared to the volume and increasing complexity of demand. Findings about the accessibility of mental health provision are just one instance. Other thematic reviews have highlighted shortcomings in CPA practice and concerns about the lack of help available to people with forms of mental distress[149]. Moreover, whether the focus is on supporting practitioners to complete assessments where an individual's mental capacity fluctuates, or to explore complex family dynamics, or on challenging practitioners in terms of the lens through which they are viewing and approaching a case, or how they are working with other services, the importance of reflective spaces in which supervision and support can foster learning and enhance practice cannot be over-estimated.

The SARs should also prompt searching questions about the still fragmented nature of services, including those meeting health and social care needs, with the result that expectations of partnership working and collaboration are superimposed upon the policy imperatives and targets required of individual agencies.

There are questions to be asked also on whether a sufficient profile is given to the knowledge and skills required for adult safeguarding practice in initial professional formation or training and in subsequent continuing professional and practitioner development. Adult safeguarding practice is challenging, as evidenced by these SARs when they focus on the balance to be struck between an individual's autonomy and a duty of care, on protecting individuals from abuse when their decision making is impacted by another person's coercive and controlling behaviour, and on responding to risk when a person is disinclined to engage.

There are questions also to be asked on whether the legal, policy and financial context within which adult safeguarding is situated facilitates or acts as a barrier to the realisation of the six adult safeguarding principles to which reference has been made throughout this report.

Improvement priority twenty nine
SABs locally, regionally and nationally should be leading a continuing conversation that seeks to address the questions that arise out of the poor practice reported by SARs.

However, it is important to remember that SARs do also comment on good practice and that, inevitably because of the phraseology of the mandate that underpins reviews, the balance of any focus is on what can be learned. It is important to recognise that much adult safeguarding practice is unheralded, person-centred and committed to empowerment, prevention and protection. This report has been written in the midst of the Covid-19 pandemic which, in many respects, has shown the very best of health and social care staff, emergency services and many other practitioners on whom people at risk of abuse, neglect and significant harm rely.

[149] Manthorpe, J. and Martineau, S. (2019) 'Mental health law under review: messages from English safeguarding adults reviews.' *Journal of Adult Protection*, 21 (1), 46-64.

11. Sector-Led Improvement Priorities

The findings of this analysis give rise to priorities for sector-led improvement, which have been listed throughout the report as they have arisen. Here they are clustered within five key categories, while remaining numbered in the order in which they arise in the main report, with the paragraph at which they are located listed for ease of cross reference. Some are priorities that should already be standard good practice and therefore require reinforcement. For others, additional resources will be required[150].

SAB practice on the commissioning and conduct of SARs (priorities 2, 4, 5, 6, 7, 8, 10, 14, 18, 20)

2 (para 2.1.7): SABs should review their record-keeping to ensure that completed SARs remain in the collective memory and available as a baseline against which to measure subsequent policy and practice change.
4 (para 2.3.5): The SAR quality markers should be reviewed and completed, informed by the findings of this national analysis. After dissemination of the revised quality markers, SABs should be asked to report on how they have been used to enhance the SAR process.
5 (para 3.1.4.1): SABs should be asked to provide reassurance that partner agencies understand the relevant legislation regarding referral and commissioning of SARs.
6 (para 3.1.9): Regional and national SAB networks to be used to review approaches to the interpretation and application of section 44 Care Act 2014 in decision making about SAR referrals.
7 (para 3.2.8): SABs should review their governance procedures for SARs and ensure that referrals and decision making are timely, with meeting minutes and reviews clearly noting the reasons for positive or negative delay.
8 (para 3.3.5): SABs must ensure that SARs identify the types of abuse and neglect within cases being reviewed.
10 (para 3.4.7): SARs should give a full account and offer a reflective analysis of the methodology used. The quality markers should be revised to emphasise the importance of methodological rigour.
15 (para 3.8.5): SAB should review their reporting of SARs in annual reports to ensure compliance with the requirements of statutory guidance and the imperatives that learning is embedded, and the impact and outcomes of reviews evaluated.
18 (para 3.11.6): SABs should review their approach to ensuring the quality of reports.
20 (para 4.4.4): This research highlights the need for better recording of ethnicity in SARs. Terms of reference for all SARs must include consideration of how race, culture, ethnicity and other protected characteristics as codified by the Equality Act 2010 may have impacted on case management.

Supporting sector-wide learning from SARs (priorities 1, 3, 11, 13, 19, 29)

1 (para 1.4): The future of the national library of SARs should be secured, with SABs committed to depositing completed reviews therein, and technology developed to enable searching by types of abuse and neglect.
3 (para 2.2.6): SABs locally and regionally adopt the data collection tool as the basis for learning from SARs.

[150] The report's authors believe that improvement priorities that are new resource-dependent are: 1, 4, 12, 17, 19, 21, 22 and 28.

11 (para 3.4.7)**:** Regional and national networks provide a space where SABs can discuss learning regarding a proportional and change-oriented approach to cases involving types of abuse and neglect that have previously been the subject of local reviews.
13 (para 3.5.11): Regional and national networks provide a space where SABs can discuss and disseminate learning from experiences involving the individual and/or their family in SARs.
19 (para 3.13.8): Sector-led improvement to engage with SABs to capture the impact of review activity.
29 (para 10.4.11): SABs locally, regionally and nationally should be leading a continuing conversation that seeks to address the questions that arise out of the poor practice reported by SARs.

Support for adult safeguarding practice improvement[151] (priorities 16, 17, 21, 22, 23, 24, 25, 26)

16 (para 3.10.5): The national SAB network should engage with DHSC, ADASS, NHS England and Improvement and other national bodies responsible for services whose roles include adult safeguarding to reinforce agency and service compliance with their duties to cooperate and share information.
17 (para 3.10.8): Sector-led improvement to explore further work on the interface between section 42 and section 44 Care Act 2014: (a) to inform understanding of routes that provide best learning in cases involving people who have survived abuse and neglect, and (b) to inform initiatives to strengthen practice in the category of abuse and neglect most over-represented in section 44 statistics (ie self-neglect).
21 (para 7.1.1.5): Consideration should be given to the dissemination of briefings on good practice regarding all forms of abuse and neglect but especially those newly highlighted by the Care Act 2014 within adult safeguarding, such as domestic abuse, modern slavery and discriminatory abuse (hate and mate crime).
22 (para 7.1.2.1): Briefings should be published for practitioners and managers on the implications for best practice in adult safeguarding of the requirements of the Equality Act 2010.
23 (para 7.1.5): In light of the reporting by SARs of poor practice in direct work with adults at risk, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and contribute to improvement across their partnerships. Based on SAR findings, priorities for attention include:

- How needs and risks are assessed and met (addressing specific forms of abuse and neglect; responding to gender, race, sexuality, learning disability; assessing, planning and reviewing intervention; risk and safeguarding; factors such as finances, housing, health, mental health, mental capacity; key processes such as hospital discharge and transition; working with families and significant others; recording);
- Making safeguarding personal (securing engagement; relationship-based practice; knowledge and understanding of history; promoting participation and voice; personalising intervention);
- Practitioner attributes: Improving knowledge, skills, confidence, legal literacy and professional curiosity.

[151] Drawing also on the roles of designated named professionals in healthcare and safeguarding leads such as Principal Social Workers in local authorities, as set out chapter 14 of the statutory guidance.

24 (para 7.2.10): In light of the reporting by SARs of poor interagency working, SABs should review (in local, regional and national discussion) how they seek assurance on standards of interagency practice and contribute to improvement across their partnership. Based on SAR findings, priorities for attention include: case coordination, leadership, use of complex case management frameworks, information-sharing, interagency referrals, safeguarding processes, understanding of roles, out of area placement and organisational disconnect.
25 (para 7.3.10.7): In light of the reporting by SARs of concerns about how organisations support safeguarding practice, SABs should review (in local, regional and national discussion) how they seek assurance on organisational systems, culture and resources, and contribute to improvement across their partnership, working to the priorities set out in the main report. Based on SAR findings, priorities for attention include: workload pressures, staffing, supervision and support, management oversight and leadership, lack or shortage of services, commissioning, organisational structure, culture and systems.
26 (para 8.5.7.9): In light of the consistency of recommendations in SARs across all four domains of analysis, which often appear to replicate those made in reviews that predate the time period under review in this national analysis, SABs should review (in local, regional and national discussion) how they seek assurance on practice standards and how they contribute to service and policy improvement and enhancement across their partnerships. Priorities for attention include:

- how to maximise learning from previous reviews to ensure that future reviews use the available evidence-base to explore where good practice has been facilitated and where barriers to good practice need to be confronted
- how to share learning between SABs to develop proportionate approaches to future reviews that build on the evidence-base rather than starting afresh.

Revision to national policy/guidance (priorities 9, 14, 27)

9 (para 3.3.8): In light of the findings from this national analysis, the statutory definitions of types of abuse and neglect should be revisited and, if necessary, revised to ensure that they fully capture the developing understanding of the contexts in which adult safeguarding concerns and risks emerge.
14 (para 3.7.1): Statutory guidance should be revised to indicate when the time period for a SAR commences.
27 (para 9.16): SABs, regionally and nationally should discuss the role of SARs in sharing learning with central government departments and national regulatory bodies and in holding those bodies to account when findings require a response that is beyond the scope of SABs locally to implement.

Further research (for example through the NIHR programme) to inform sector-led improvement initiatives (priorities 12, 28)

12 (para 3.4.8): Comparative research should be commissioned to highlight the effectiveness of different review methodologies.
28 (para 10.4.5): Projects should be commissioned to develop the evidence-base for good practice with respect to preventing, and protecting people from, particular types of abuse and neglect, working to the priorities set out in the main report. This is especially important with respect to those types of abuse and neglect that are prominent amongst the cases in the sample, such as self-neglect, but also those that were added to adult safeguarding by the Care Act 2014, such as domestic abuse and modern slavery, and those that were the focus of what have become “seminal” reviews prior to the time focus of this national analysis but where findings and recommendations have been repeated in SARs in this sample.

Glossary

ADASS – Association of Directors of Adult Social Services	LA – Local Authority
AMHP – Approved Mental Health Professional	LGA – Local Government Association
ASC – Adult Social Care	LGSCO – Local Government and Social Care Ombudsman
CCG – Clinical Commissioning Group	LPA – Lasting Power of Attorney
CHC – Continuing Health Care	LSCB – Local Safeguarding Children Board
CHIP – Care and Health Improvement Programme	MAPPA –Multiagency Public Protection Arrangements
CPA – Care Programme Approach	MARAC – Multiagency Risk Assessment Conference
CPN – Community Psychiatric Nurse	MASH – Multiagency Safeguarding Hub
CPS – Crown Prosecution Service	MCA – Mental Capacity Act
CQC – Care Quality Commission	MHA – Mental Health Act
CSP – Community Safety Partnership	NRM – National Referral Mechanism
DHSC – Department of Health and Social Care	RCA – Root Cause Analysis
DoLS – Deprivation of Liberty Safeguards	SABs – Safeguarding Adults Boards
EDT – Emergency Duty Team	SARs – Safeguarding Adult Reviews
IMCA – Independent Mental Capacity Advocate	SCRs – Serious Case Reviews
IMRs – Individual Management Reports	SI – Serious Incident
IOPC – Independent Office of Police Conduct	VARM – Vulnerable Adult Risk Management

Appendix 1: SAR analytic framework

The questionnaire logs data in 5 overarching categories:

- Case characteristics
- SAR characteristics
- Number of recommendations
- Content of recommendations
- Themes within SAR content

Themes within SAR content and content of recommendations are sub-divided into five sub-categories:

- Direct practice
- Interagency practice
- Organisational features
- SAB features
- National features

Use the Comments boxes to record in free text any explanatory or further detail.

CASE CHARACTERISTICS

1. Safeguarding Adults Board name

2. Local authority name

3. Case name

4. Outcome of abuse/neglect

- [ ] Deceased
- [ ] Alive
- [ ] Not specified

Comments:

5. How many people was this SAR about? (You will be required to provide details about each person on the next page) *

Individual subject to abuse (1)
Provide details about the first person subjected to the abuse / neglect

6. What was the age of the individual at the time of the incident (if not clear, round to nearest five years). Leave blank if unspecified.

7. Gender

- [ ] Male
- [ ] Female
- [ ] Transgender
- [ ] Non-binary
- [ ] Not specified
- [ ] Other (please specify):

8. Sexual orientation

- [ ] Heterosexual
- [ ] LGBTQI+
- [ ] Not specified
- [ ] Other (please specify):

9. Ethnicity

- [ ] Asian/Asian British
- [ ] Black/African/Caribbean/Black British
- [ ] Multiple/mixed
- [ ] White
- [ ] Not specified
- [ ] Other (please specify):

10. Religion

- [ ] Christian
- [ ] Hindu
- [ ] Muslim
- [ ] Jewish
- [ ] Sikh
- [ ] Buddhist
- [ ] No religion
- [ ] Not specified
- [ ] Other (please specify):

11. Health (select all that apply)

- [ ] Acute physical health condition (specify below)
- [ ] Chronic physical health condition (specify below)
- [ ] Physical disability
- [ ] Learning disability
- [ ] Autistic spectrum

- [ ] Mental ill-health
- [ ] Sensory impairment
- [ ] Memory and cognition concerns
- [ ] Substance misuse
- [ ] Impaired mobility
- [ ] Skin viability concerns
- [ ] Diabetes
- [ ] Not specified
- [ ] Other (please specify):

Please provide further detail on health conditions

12. Household (select all that apply)

- [ ] Living alone
- [ ] Living with partner
- [ ] Living with partner and children
- [ ] Living with child/children
- [ ] Living with parent
- [ ] Living with friend(s)
- [ ] Living with professional carer(s)
- [ ] Living with foster carer(s)
- [ ] Group living
- [ ] Homeless

- [ ] Not specified
- [ ] Other (please specify):

Comments:

13. Type of accommodation (select all that apply)

- [ ] Owner occupied
- [ ] Private landlord
- [ ] Social landlord (standard)
- [ ] Social landlord (sheltered)
- [ ] Residential care
- [ ] Foster care
- [ ] Hostel
- [ ] Homeless
- [ ] Not specified
- [ ] Other (please specify):

Comments:

Questions 6-13 would be repeated in any case involving more than one person

14 Type of abuse/neglect (select all that apply)

- [ ] Physical abuse
- [ ] Psychological/emotional abuse
- [ ] Sexual abuse
- [ ] Sexual exploitation
- [ ] Financial/material abuse
- [ ] Neglect/omission
- [ ] Domestic abuse
- [ ] Modern slavery
- [ ] Discriminatory abuse
- [ ] Organisational abuse
- [ ] Self-neglect
- [ ] Not specified
- [ ] Other (please specify):

15. Summary of abuse circumstances

16. Location of abuse (select all that apply)

- [ ] Own home – general housing
- [ ] Own home – sheltered housing
- [ ] Supported living
- [ ] Someone else's home
- [ ] Hostel/shelter

- [ ] Community service (eg day centre)
- [ ] Community (eg on the street)
- [ ] Care/nursing home
- [ ] Hospital
- [ ] Prison
- [ ] Not specified
- [ ] Other (please specify):

Comments:

17. Is the location of the abuse a CQC regulated service?

- [ ] Yes
- [ ] Some of the locations
- [ ] No

Comments:

18. Did CQC participate in the SAR?

- [ ] Yes
- [ ] No
- [ ] Not specified
- [ ] N/A

19. Perpetrator of abuse (select all that apply)

- [ ] Partner/relative/friend/unpaid carer
- [ ] Social contact/acquaintance
- [ ] Care provider
- [ ] Other professional
- [ ] Unknown to individual
- [ ] Self
- [ ] Not specified
- [ ] Other (please specify):

Comments:

20. Criminal prosecution

- [ ] Underway but not concluded
- [ ] No
- [ ] Not specified
- [ ] Yes (please provide details of outcome):

Comments:

21. Further details on the case

SAR CHARACTERISTICS

22. Region

- [ ] East
- [ ] East Midlands
- [ ] Greater London
- [ ] North East
- [ ] North West
- [ ] South East
- [ ] South West
- [ ] West Midlands
- [ ] Yorkshire & Humberside

23. Page numbers for each document viewed and whether document published (please leave blank if documents of particular type not viewed)

	Number of pages	Published [Y/N]
Full report		
Executive summary - standalone		
Executive summary - integrated in full report		
Staff briefing		
Board response/action plan		
Family response		
Other (please specify in comments)		

Comments:

24. Source of referral

- [ ] Local authority
- [ ] Police
- [ ] CCG
- [ ] Ambulance service
- [ ] Fire & Rescue service
- [ ] GP surgery
- [ ] Community health trust
- [ ] Hospital trust
- [ ] Mental health trust
- [ ] Housing provider
- [ ] Voluntary organisation
- [ ] Not specified
- [ ] Other (please specify):

Comments:

25. Parallel (or already completed) processes (select all that apply)

	Parallel with SAR	Prior to the SAR
Coroner's inquest	☐	☐
Criminal investigation	☐	☐
Serious incident investigation (NHS)	☐	☐
Serious further offence review (Probation)	☐	☐
MAPPA serious case review	☐	☐
Domestic homicide review (DHR)	☐	☐
Learning disability mortality review (LeDeR)	☐	☐
Children's SCR/child practice review	☐	☐
Independent Office for Police Conduct investigation	☐	☐
Other	☐	☐
None specified	☐	☐

Comments:

26. Type of review: Legal mandate:

- ☐ Statutory (s.44) - mandatory
- ☐ Statutory (s.44) - discretionary
- ☐ Non-mandated
- ☐ Not specified
- ☐ Other (please specify):

Comments:

27. Type of review

- [ ] Standard SAR
- [ ] Learning review
- [ ] Thematic review
- [ ] Other (please specify):

Comments:

28. Methodology

- [ ] Traditional (document analysis only)
- [ ] SCIE Learning Together
- [ ] SILP
- [ ] RCA/OACM
- [ ] Welsh model
- [ ] Hybrid (combining approaches)
- [ ] Not stated
- [ ] Other (please specify):

Comments:

29. How was evidence collected? (select all that apply)

- [ ] Chronology
- [ ] IMR
- [ ] Practitioner/manager event or learning event
- [ ] Interviews
- [ ] Not specified
- [ ] Other (please specify):

Comments:

30. Number of agencies from which information was sought:

31. What time period did the SAR review evidence from? Provide your answer in number of months, eg 1.5 years = 18If unknown, leave blank.

32. Does the SAR consider events before/after the formal time period?

- [ ] Yes
- [ ] No
- [ ] Not specified

Comments on the SAR time period:

33. Was a SAR panel set up for the specific case?

- [ ] Yes
- [ ] No
- [ ] Not specified

34. Length of SAR process

- [ ] 0-6 months
- [ ] 6-12 months
- [ ] 12+ months

Comments regarding the length of the SAR process:

35. Involvement of the individual (select all that apply)

- [ ] Not applicable (person deceased)
- [ ] Not invited
- [ ] Invited but did not participate
- [ ] Input to ToR/review focus
- [ ] Member of panel/review group
- [ ] Conversation with reviewer(s)
- [ ] Reviewed report
- [ ] Contributed to report
- [ ] Supported by advocate
- [ ] Not specified
- [ ] Other (please specify):

Comments:

36. Family involvement (select all that apply)

- [ ] Not applicable (person deceased)
- [ ] Not invited
- [ ] Invited but did not participate
- [ ] Input to ToR/focus
- [ ] Member of panel/review group
- [ ] Conversation with reviewer(s)
- [ ] Reviewed report
- [ ] Contributed to report
- [ ] Not specified
- [ ] Other (please specify):

Comments:

37. Date of sign-off by the SAB. If unknown, leave blank.
DD/MM/YYYY

38. Date of publication. If unknown, leave blank.
DD/MM/YYYY

39. Referenced in annual report

- [ ] Yes
- [ ] No
- [ ] Unknown

Comments:

40. Report contains comment on SAR process issues

- [ ] Yes
- [ ] No

If yes, please give details:

41. Other documents referenced in the report (select all that apply)

- [ ] Research findings
- [ ] Statute
- [ ] Statutory national policy guidance
- [ ] Other national policy guidance
- [ ] Codes of practice
- [ ] Other SARs commissioned by the SAB
- [ ] Other SARs commissioned by other SABs
- [ ] Local policies/procedures/protocols
- [ ] Inspection reports

☐ None referenced

☐ Other (please specify):

Comments:

42. Other SAR characteristics not listed above (please specify)

43. Details of the reviewer eg independent / in-agency staff

NUMBER OF RECOMMENDATIONS

44. Number of recommendations made by this SAR in total:

45. How many recommendations per agency:

Local authority adult social care	
Local authority housing	
Local authority other	
Police	
CCG	
Hospital trust	
Mental health trust	

GPs	
Community health trust	
Fire & rescue service	
Ambulance service	
Housing provider	
Social care provider	
Interagency working	
The work of the SAB	
The work of a national body (specify which)	
No named agency	

Comments:

46. Changes made by agencies on their own initiative (where these do not appear as recommendations from the SAR itself):

THEMES AND RECOMMENDATIONS

47. Direct practice (select all that apply)

	Theme (good practice)	Theme (poor practice)	Recommendation
Care and support assessment/planning/review	☐	☐	☐
Risk assessment	☐	☐	☐
Knowledge and understanding of history/traumatic life events	☐	☐	☐
Responding to reluctance to engage	☐	☐	☐
Continuity/perseverance of involvement	☐	☐	☐

	Theme (good practice)	Theme (poor practice)	Recommendation
Attention to ethnicity	☐	☐	☐
Attention to mental capacity	☐	☐	☐
Attention to mental health	☐	☐	☐
Attention to substance misuse	☐	☐	☐
Attention to living conditions (eg aids, hoarding, homelessness)	☐	☐	☐
Responding to coercive control	☐	☐	☐
Responding to domestic violence	☐	☐	☐
Responding to exploitation	☐	☐	☐
Responding to health needs	☐	☐	☐
Responding to social needs	☐	☐	☐
Personalisation/person-centred approaches/MSP	☐	☐	☐
Relationship-based work	☐	☐	☐
Use of advocacy	☐	☐	☐
Work with family/carers	☐	☐	☐
Transition planning	☐	☐	☐
Safeguarding	☐	☐	☐
Hospital discharge	☐	☐	☐
Use of legal rules	☐	☐	☐
Recording	☐	☐	☐
Restraint	☐	☐	☐
Other (please specify below)	☐	☐	☐
None	☐	☐	☐

48. Comments on direct practice: Good practice:

49. Comments on direct practice: Poor practice:

50. Comments on direct practice: Recommendations:

51. Interprofessional / interagency work (select all that apply)

	Theme (good practice)	Theme (poor practice)	Recommendation
Legal literacy	☐	☐	☐
Use of safeguarding procedures	☐	☐	☐
Information sharing/communication	☐	☐	☐
Coordination and working together (including multiagency meetings, conferences etc)	☐	☐	☐
Leadership	☐	☐	☐
Interagency procedures/protocols	☐	☐	☐
Thresholds	☐	☐	☐
Record sharing	☐	☐	☐
Cross-boundary working	☐	☐	☐
Other (please specify below)	☐	☐	☐
None	☐	☐	☐

52. Comments on interprofessional / interagency work: Good practice:

53. Comments on interprofessional / interagency work: Poor practice:

54. Comments on interprofessional / interagency work: Recommendations:

55. Organisational / agency features (select all that apply)

	Theme (good practice)	Theme (poor practice)	Recommendation
Supervision	☐	☐	☐
Staff support	☐	☐	☐
Training	☐	☐	☐
Access to specialist advice	☐	☐	☐
Management oversight	☐	☐	☐
Records and recording	☐	☐	☐
Agency culture	☐	☐	☐
Quality assurance	☐	☐	☐
Staffing levels/workloads	☐	☐	☐
Resources	☐	☐	☐
Commissioning	☐	☐	☐
Agency policies/procedures: Assessment	☐	☐	☐
Agency policies/procedures: Risk assessment	☐	☐	☐
Agency policies/procedures: Mental capacity	☐	☐	☐
Agency policies/procedures: Self-neglect	☐	☐	☐
Agency policies/procedures: Transition	☐	☐	☐

	Theme (good practice)	Theme (poor practice)	Recommendation
Agency policies/procedures: Escalation	☐	☐	☐
Agency policies/procedures: Hospital discharge	☐	☐	☐
Agency policies/procedures: Care pathways	☐	☐	☐
Agency policies/procedures: Commissioning	☐	☐	☐
Agency policies/procedures: IT systems and information-sharing	☐	☐	☐
Agency policies/procedures: Other (please specify below)	☐	☐	☐
Other (please specify below)	☐	☐	☐
None	☐	☐	☐

56. Comments on organisational / agency features: Good practice:

57. Comments on organisational / agency features: Poor practice:

58. Comments on organisational / agency features: Recommendations:

59. SAB governance (select all that apply)

	Theme (good practice)	Theme (poor practice)	Recommendation
Membership	☐	☐	☐
Leadership	☐	☐	☐
Quality assurance mechanisms	☐	☐	☐

	Theme (good practice)	Theme (poor practice)	Recommendation
SAR process - commissioning and management of reviews	☐	☐	☐
Links between SAB and other governance structures	☐	☐	☐
Training	☐	☐	☐
Dissemination of SAR learning	☐	☐	☐
SAB policy/procedures: Assessment	☐	☐	☐
SAB policy/procedures: Risk assessment	☐	☐	☐
SAB policy/procedures: Mental capacity	☐	☐	☐
SAB policy/procedures: Self-neglect	☐	☐	☐
SAB policy/procedures: Transition	☐	☐	☐
SAB policy/procedures: Escalation	☐	☐	☐
SAB policy/procedures: Hospital discharge	☐	☐	☐
SAB policy/procedures: Referral pathways	☐	☐	☐
SAB policy/procedures: Commissioning	☐	☐	☐
SAB policy/procedures: IT systems and information-sharing	☐	☐	☐
SAB policy/procedures: Other (please specify below)	☐	☐	☐
Other (please specify below)	☐	☐	☐
None	☐	☐	☐

60. Comments on SAB governance: Good practice:

61. Comments on SAB governance: Poor practice:

62. Comments on SAB governance: Recommendations:

63. National legal and policy context

- [ ] Yes (please specify)
- [ ] None

If yes, please specify:

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