Learning from Safeguarding Adult Reviews

Suzy Braye, Independent Consultant
Emerita Professor of Social Work

Cumbria SAB Conference 19th November 2024

Cumbria Safeguarding Adults Board

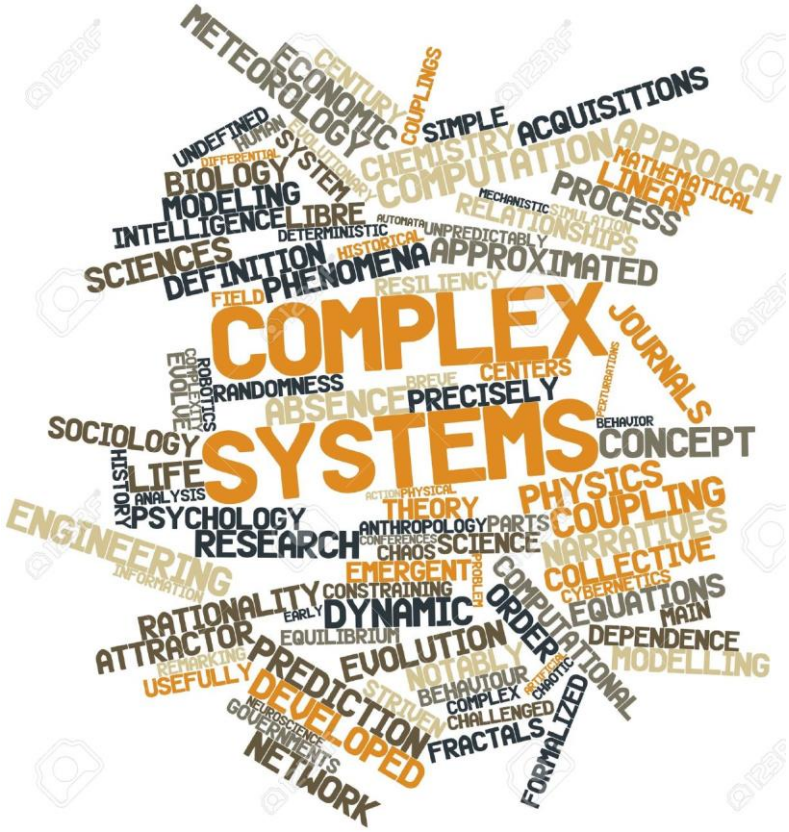
Safeguarding adult reviews

- SAB duty (s.44, Care Act 2014)
  - An adult with care and support needs has died or been seriously harmed through abuse and neglect

  and
  - There is concern about how agencies worked together to safeguard them

- SAB power
  - to review any other case involving an adult with care and support needs

- The purpose:
  - To identify learning and apply it to future practice
  - To improve how agencies work together to safeguard adults

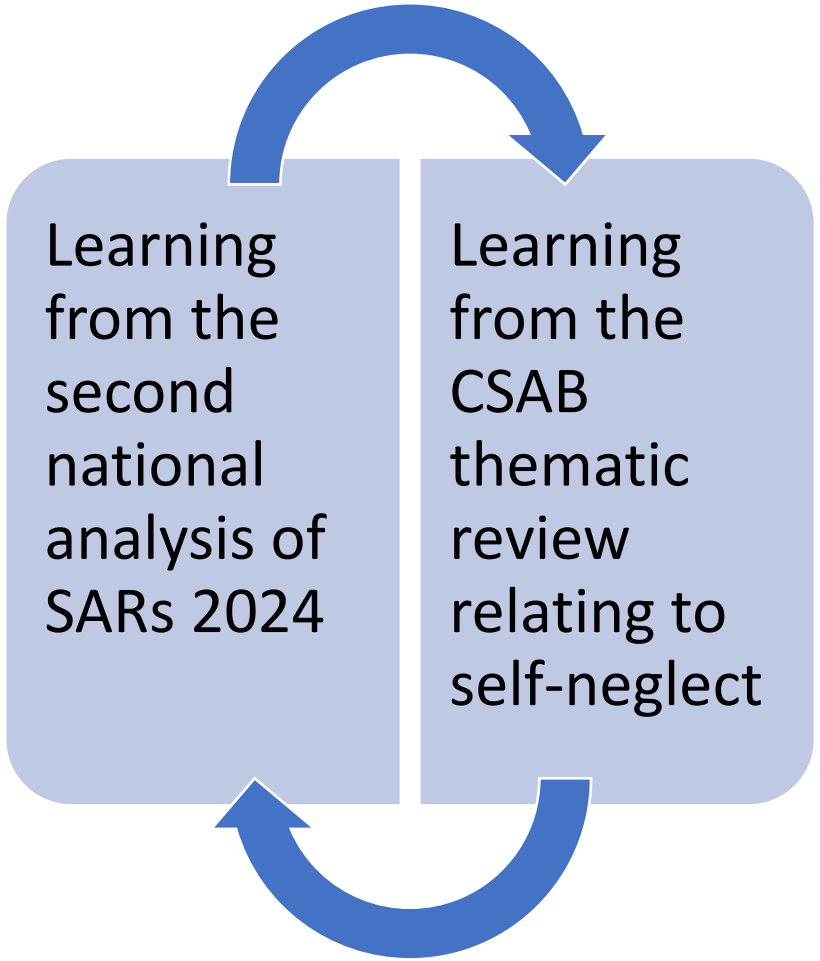


Cumbria Safeguarding Adults Board

In this session we'll look at …

Commissioned by Partners in Care and Health

- SARs between 2019-2023
- Screening: 652 reports
- In-depth: 229 reports – learning from the human stories
- Follow on from first national analysis 2017-19 involving 231 reports



Commissioned by CSAB Independent reviewer

- Six individuals aged early-50s to mid-80s who died during 2023
- Themes that indicate systemic fault lines in self-neglect practice

Cumbria Safeguarding Adults Board

National analysis: 652 SARs, 861 individuals

- 82% of adults were deceased – the majority died from natural causes
- 44% women, 49% men
- High representation of mental ill-health (72%), chronic physical health (63%), substance dependency (46%), impaired mobility (27%)
- 47% lived alone, 30% in a group setting, 10% street homeless
- 9% had experience of care as a child or young person
- Most abuse occurred in the home but there were also cases in hospitals (9%), and care homes (20%) including some featuring resident on resident abuse
- Many protected characteristics were not recorded: ethnicity, nationality, religion, sexuality

Cumbria Safeguarding Adults Board

Types of abuse/neglect

Since 1st analysis…

Marked increase in

- Self-neglect (45% to 60%)
- Neglect/abuse by omission (37% to 46%)
- Domestic abuse (10% to 16%)

Small increase in

- Sexual exploitation (2% to 4%)
- Discriminatory abuse (1% to 2%)

Fall in

- Physical abuse (19% to 14%)
- Psychological abuse (8% to 4%)
- Organisational abuse (14% to 4%)

TYPE OF ABUSE / NEGLECT	% SARs
Self-neglect	60%
Neglect/omission	46%
Domestic abuse	16%
Physical abuse	14%
Financial abuse	13%
Sexual abuse	6%
Criminal exploitation	5%
Psychological abuse	4%
Organisational abuse	4%
Sexual exploitation	4%
Discriminatory abuse	2%
Modern slavery	<1%
Other	10%

Cumbria Safeguarding Adults Board

- Age profile
  - Modern slavery / sexual abuse / sexual exploitation more prevalent at younger ages
  - Neglect / abuse by omission more prevalent in older subjects
  - Self-neglect peak in the mid-years

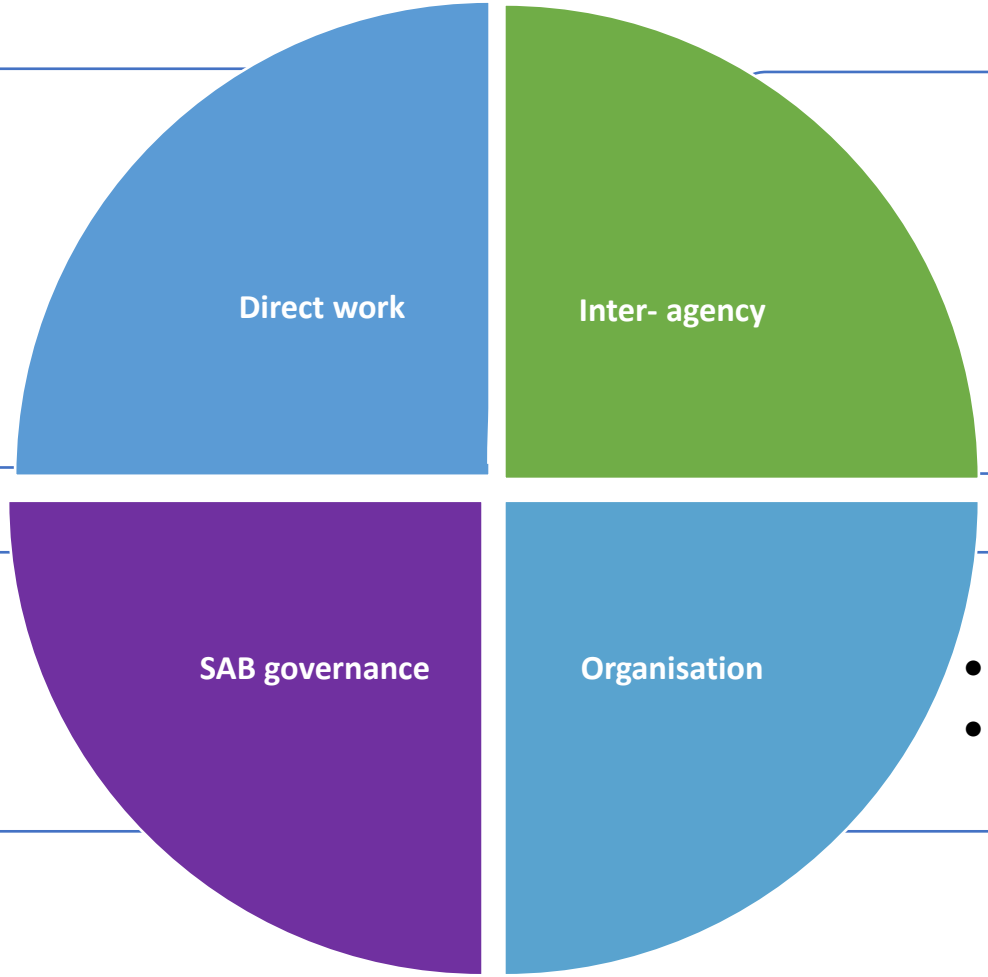
- Gender profiles
  - Psychological / emotional abuse, domestic abuse and organisational abuse more prevalent for women
  - Financial / material abuse and self-neglect slightly more prevalent for men

- Multiple types of abuse/neglect can occur per case (average per case = 1.8) and some are more likely to co-occur than others
  - Physical abuse tends to co-occur with both psychological/emotional abuse and domestic abuse
  - Sexual abuse tends to co-occur with sexual exploitation
  - Financial abuse tends to co-occur with criminal exploitation
  - Self-neglect and neglect/abuse by omission tend to occur in isolation

Cumbria Safeguarding Adults Board

Good practice across the domains (229 reports)

- Risk assessment (31%)
- MSP (29%)
- Recognition of abuse (23%)
- Perseverance (22%)
- Attention to needs (21%)



- Communication across agency boundaries (24%)
- Cross-agency case coordination and collaboration (23%)

- SAR management (3%)

- Supervision (3%)
- Management oversight (3%)

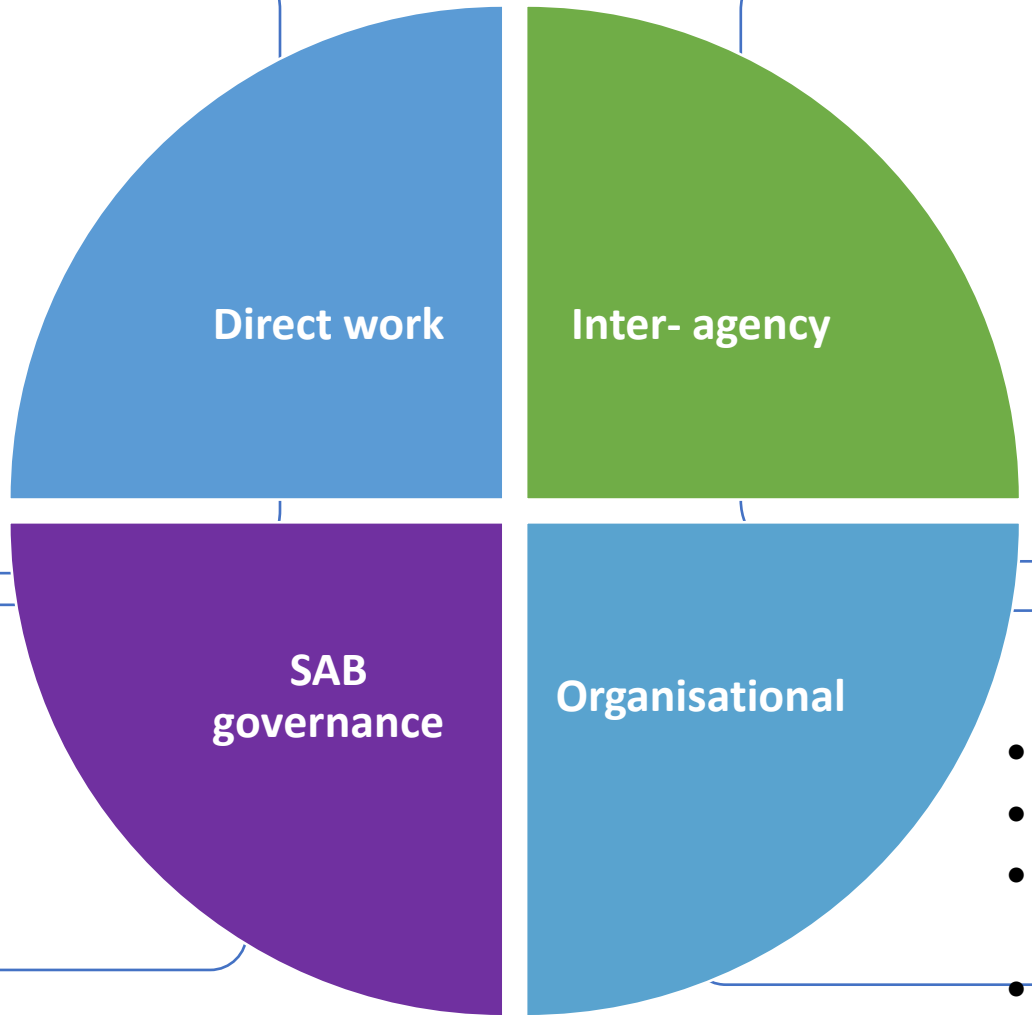
Good practice themes

- Compassion, kindness, care, empathy and sensitivity, commitment, dedication, professionalism, skill and diligence
- Able to see beyond the presenting problem, to find and respect the person beneath
- Going above and beyond; able to ‘think outside of the box’ to find solutions, sometimes in the most challenging circumstances
- Making safeguarding personal to the adult by ascertaining and taking account of an individual’s wishes and feelings
- Patience, persistence and tenacity in engaging with people who were reluctant or withdrawing; personalised approaches to contact/meetings and assertive outreach approaches
- Building trusted, trauma-informed relationships; using these to support at times of crisis and advocate for the individual, including to other services.

Cumbria Safeguarding Adults Board

Practice shortcomings across the domains

- Poor risk assessment (82%)
- Lack of attention to mental capacity (58%)
- Poor recognition of the abuse (56%)
- Lack of personalised approaches (50%)
- Absence of professional curiosity (44%)



- Cross-agency case coordination (72%)
- Communication across agency boundaries (70%)
- Interagency safeguarding (38%)
- Use of multi-agency risk management panel (37%)
- Interagency procedures (24%)

- Policies, procedures and guidance for practitioners (14%)

- Management oversight (31%)
- Agency policies (28%)
- Staffing levels (27%) and training (23%)
- Commissioning (24%)

Practice shortcomings themes

- Negative attitudes and professional culture: risky/distressed behaviour judged as ‘lifestyle choice’, attention-seeking, non-compliant; resignation and low expectation of change
- Safeguarding not personalised; adults with communication needs, learning disabilities, neurodiversity and mental health needs excluded from decisions/discussions
- Failure to recognise the significance of repeated patterns of engagement / disengagement; lack of flexibility in expectations/approach
- Transition (young people to adult services / hospital discharge) lacking coordinated assessment and planning; support significantly reduced
- Absence of risk assessment and risk management strategy
- Uncertainty about when and how to share information without consent; key information not shared as ‘too sensitive’
- Significant lack of mutual understanding about the roles, powers and duties of different agencies with regards to safeguarding

Cumbria Safeguarding Adults Board

National legal, policy and financial context

- Positive impact from the funded, national policy initiative "everyone in"
- Impact of the Covid-19 pandemic on services, unemployment, loss of routine, loss of social contact, isolation, reduced support
- Impacts from economic context, legal frameworks, national policy and commissioning
- Interconnected features compounded the impact: pandemic *alongside* austerity and available legal powers; changes to health or social care policy *in the context of* austerity
- Impact of welfare benefit rules, poverty and inequality on disabled people and on people from minority groups
- Absence of an adult safeguarding power of entry in England

Features of the national context	% of SARs
Covid-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
Health/social care policy	5%
National commissioning	3%
Statutory guidance	2%
Immigration policy	<1%
Regulation of services	<1%

Cumbria Safeguarding Adults Board

SAR recommendations

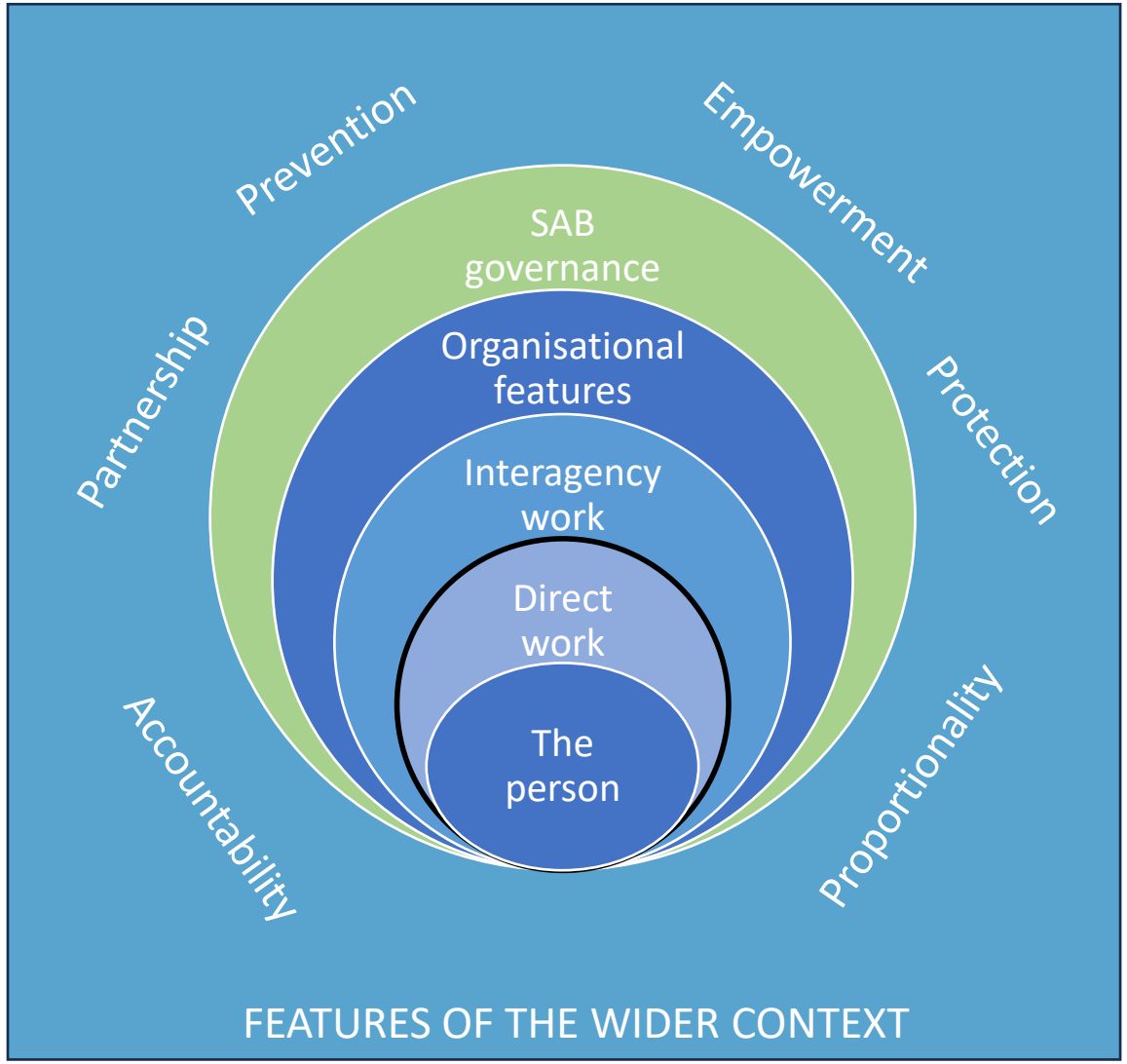
- Average of 9 per SAR (range = 0 to 36)
- Most frequently occurring number = 5
- Addressed to SABs, named agencies and national bodies
  - Most frequently LAs (51%), mental health trusts (27%), ICBs (23%), hospital trusts (19%), police (18%)
- Across all domains
- Recognition of the need for whole system change

Domain	%
Direct practice: MSP, professional curiosity, mental capacity, legal literacy, hospital discharge	93%
Interagency practice: Communication, case coordination and multiagency risk management	85%
Organisational features: Procedures, guidance, supervision, management oversight, training, commissioning	70%
SAB governance: (i) SAR processes (ii) assurance on multi-agency adult safeguarding practice	52%
National context: DHSC, DWP, CQC, CPS, NHS England, MoJ, PCCO and other national bodies	15%

Cumbria Safeguarding Adults Board

CSAB thematic review Self-neglect

- Circumstances followed earlier SARs relating to self-neglect
- Focus therefore on systemic features that require improvement
- Sources of information
  - Chronologies of involvement
  - Agency reflective reports
  - Family perspectives
  - Practitioner perspectives



Cumbria Safeguarding Adults Board

Good practice findings

- Acute physical health, primary care needs, specialist services
- Some risks clearly articulated
- Family involvement in assessment
- Concerns about a family member's needs raised
- Some adjustment of intervention due to protected characteristics
- Interagency liaison, referrals and safeguarding escalation
- On-scene joint working
- NHS 111 communication with primary care
- Safeguarding strategy meetings
- Practitioner access to decision-tools, training, supervision, advice, support
- Management scrutiny of key decisions

Cumbria Safeguarding Adults Board

Meeting needs

- Focus often on the most evident need, immediate and unplanned; not the holistic picture; deterioration hidden from view
- Unsafe hospital discharge
- Barriers to needs being met
  - Reluctance to engage
  - Signposting insufficient
  - Silo vision
  - Absence of or incomplete assessment
  - Shifting of responsibility
- Needs not recognised as unmet

Cumbria Safeguarding Adults Board

Managing risk

- Potential risk not recognized/explored
- Missed opportunities
  - Lack of professional curiosity
  - Risk downplayed
  - Prioritisation of physical health concerns and practical tasks over other sources of risk
- Recognition of risk not resulting in effective risk management
  - Absence of or incomplete risk assessment
  - Absence of risk management planning
- We don’t worry enough or soon enough …

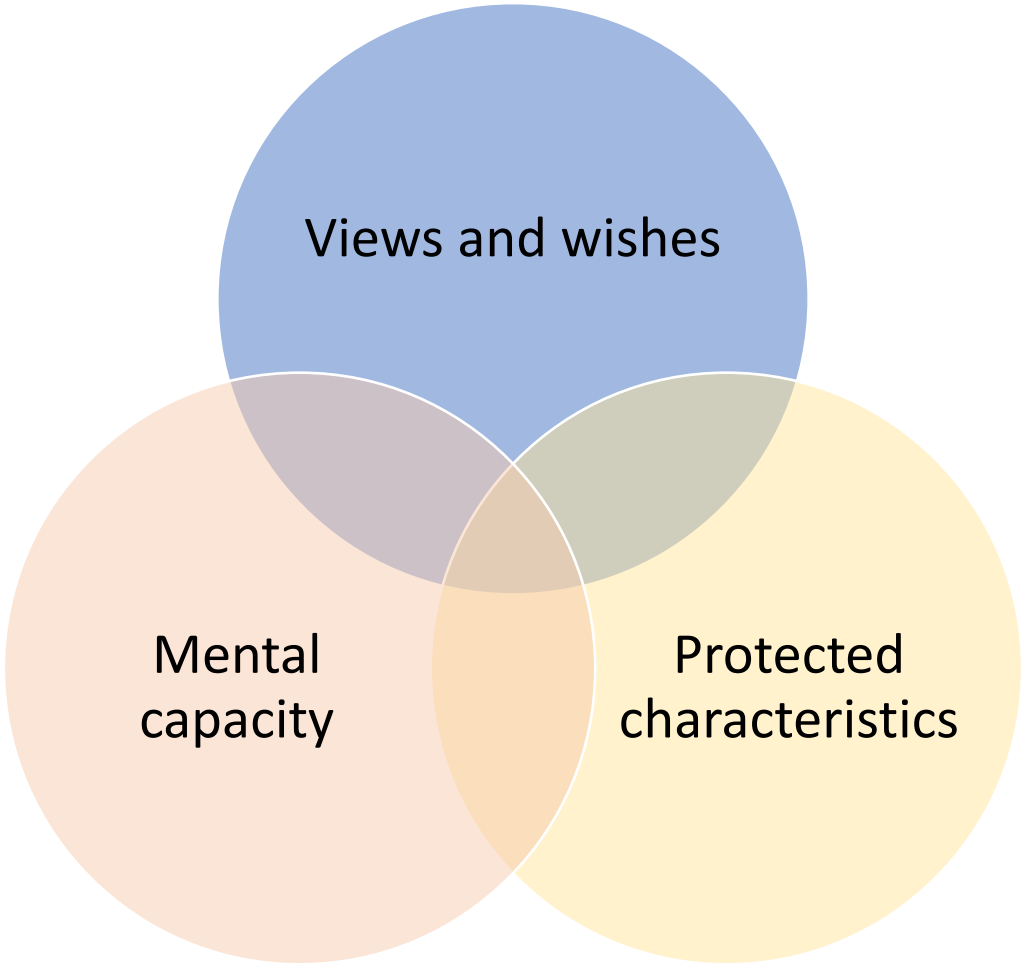
Cumbria Safeguarding Adults Board

Safeguarding processes

- Self-neglect not seen as a safeguarding matter
- Thresholds not understood
- Advice not sought from in-agency advisers
- Not reported due to assumption that other agencies would act
- Vulnerability reported but not passed into safeguarding
- Safeguarding vs case management
- Triaged out as not meeting s.42 threshold
- Concerns about telephone referral route
- Failure of action, even when risks apparent

Cumbria Safeguarding Adults Board

Making safeguarding personal



Common for agencies to claim views and wishes identified, respected and acted upon, but:

- Failure to reach out sufficiently
- Absence of face-to-face contact
- Failure to question the individual's views: absence of respectful challenge – acceptance at face value
- Articulate communication masking vulnerability
- Risk information not shared without consent
- Means of communication not appropriate
- Reliance on third party
- Absence of advocacy

Cumbria Safeguarding Adults Board

Mental capacity

- Over-reliance on assumption of capacity
  - Capacity not assessed even in high-risk situations
  - Terminology: ‘deemed to have’ capacity; ‘able to consent’
- No assessment even with cognitive decline
- Executive function not considered despite risk factors
- Inconsistency of outcome of assessment
- Capacity found to be lacking, but no best interests decision
- Service ‘doesn’t assess capacity’

Cumbria Safeguarding Adults Board

Protected characteristics

- Little evidence found that protected characteristics were identified during involvement with the individual
- Age, sex, disability and mental health occasionally mentioned (though disability thought “not to be a protected characteristic”)
- Duties in the Equality Act seem to be below the radar

The Equality Act 2010

Cumbria Safeguarding Adults Board

Work with families

- Varying degrees of contact:
  - Frequent contact and involvement through to no contact
  - Generally only contact when sought by family
- Family as mediator to gain access or assist communications, but the individual's own voice absent
- Family views expressed but no impact on approach to intervention

Cumbria Safeguarding Adults Board

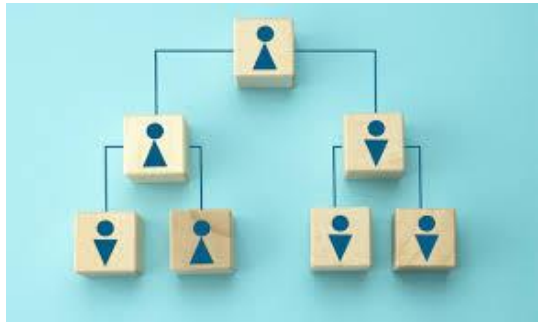
Working together

- Information sharing
  - Not consistent between agencies involved
  - Some agencies out of the loop
  - Absence of feedback on referrals
- Failure to communicate directly with other agencies
- Absence of multiagency meetings
- Disconnect between health-led MDTs and the wider network
- Absence of shared risk assessment and management
- Absence of case coordination
  - Multiple parallel lines of intervention
  - Movement of an individual's case between teams
- Calls for a multiagency framework/pathway for cases that do not meet the safeguarding threshold

Cumbria Safeguarding Adults Board

Contextual factors

- Resources
  - Teams running with vacancies
  - Volume of demand
- Agency culture
- Limited training on self-neglect
- Multiple sources of guidance: agency-specific and CSAB
- Little evidence of use of legal advice
- Covid: “taking years to recover”



Cumbria Safeguarding Adults Board

Where to from here?

- National analysis
  - 31 priorities for sector-led improvement, across all domains
  - SABs, National Network of SAB chairs, National bodies
- CSAB thematic self-neglect SAR
  - Continuation of analysis
  - Further liaison with families
  - Submission of report with recommendations for system improvement priorities
  - Decisions on publication/dissemination of learning
  - CSAB-led action plan

Cumbria Safeguarding Adults Board