Safeguarding and
Adult Serious Case Reviews

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Personal & Public Presence

• Daniel Pelka: Do serious case reviews work? (still being asked of new system)

• Trystan Jones, BBC News, 17 Sept 2013
But not just children’s services..

“Orchid View: Families question case review's independence”

“Orchid View care home scandal review 'not enough'”
SCRs are you

• What do you remember about SCRs where you have worked?

• What was the impact of the both the process and the findings?
A changing picture.....

• Introduction of Safeguarding Adults Reviews by the Care Act 2014

• Will this make a difference?
The “problem” in children’s services

- SCRs = a key forum for reviewing practice both nationally and locally
- Messages from SCRs often resonate with practitioners and managers
- However also highlight difficulties that remain obstinately difficult to change
- There remains a national debate over the efficacy of SCRs
Themes and learning points

• The capacity to understand the ways in which children are at risk of harm is complex and requires clear thinking.

• Practitioners who are overwhelmed, not just by the *volume of work* but also by its *nature*, *may not be able to do even the simple things well*.

• *Good support*, supervision and a fully staffed workforce is crucial.
Recommendations from children’s reviews

• SCR recommendations are still very numerous
• The endeavour to make them specific, achievable and measurable (SMART) has resulted in a further proliferation of concrete or procedural tasks to be followed through

• Does best learning from SCRs may come from the process of carrying out the review?
The attraction of systems

• Active failures are like mosquitoes, they can be swatted one by one but they still keep coming.
• The best remedies are to create more effective defences and to drain the swamps in which they breed.
• The swamps, in this case, are the ever present latent conditions
• —James Reason
On reading a SCR

• **Hindsight bias** leads us to grossly overestimate how reasonable an action would have looked at the time & how easy it would have been for the worker to do it.

• It is only with hindsight that the world looks linear because we know which causal chain actually operated - domino theory of causation.
Some holes due to active failures

Other holes due to latent conditions (resident “pathogens”)

Successive layers of defences, barriers and safeguards
Adult Serious Case Reviews

- Winterbourne View SCR commissioned and published 2012
- But most local (use similar criteria)
- Not yet statutory
- Many areas have never had one
- Some overlap with other investigations

BBC Panorama 2011
Recent Adult SCR – Surrey CC

‘There are certainly lessons to be learned here and by implementing the actions recommended, we are looking to ensure the circumstances which caused Mrs. Foster to be without care for several days can be prevented from happening again’ - Surrey SAB Chair.

14 recommendations + 23 lessons
- ranging from exploring disciplinary action to greater use of AT.
Our recent thematic analyses

Adult SCRs – about 140 have been held

• Taking Mental Capacity Act as focus
• Variations of setting + event
  – Comments on lack of MCA assessments
  – Some comment on lack of IMCAs
  – Hard to establish ‘facts’
  – Illustrate care sector issues
  – Huge limits of Exec Summary
Using SCRs in training and professional development

Some people have read a SCR
Most know about them through the media
A local one will possibly be circulated or discussed in various ways, possibly with methods and mechanisms for change, possibly with means of follow up
A national one will have wider implementation investment eg Winterbourne View
Value of thematic analyses

• Huge problems of distilling SCRs
• Possible to do narrow remit (eg Hampshire SAB review of incidents of choking)
• Problems of ‘benefit of hindsight’
• Few Adult SCRs are in full
• Care Act creates local Safeguarding Adults Boards (SAB) which must commission Serious Adult Reviews (SARs) with duty to co-operate
• Each member of the SAB must co-operate in & contribute to the carrying out of the SAR with a view to
  – (a) identifying the lessons to be learnt from the adult’s case, and
  – (b) applying those lessons to future cases.
• Reviews should ‘focus on learning from experience and improving services for users’
When to hold a SAR

Proposals: An SAB must arrange for there to be a review of any case in which

(a) an adult in the SAB’s area with needs for care and support (whether or not the local authority was meeting any of those needs) was, or the SAB suspects that the adult was, experiencing abuse or neglect, and

(b) the adult dies or there is reasonable cause for concern about how the SAB, a member of it or some other person involved in the adult’s case acted.
For Managers

• Being part of SAR commissioning – TORs always important
• Duty to co-operate
• Authoring IMRs – or similar
• Supporting users/carers/staff
• How would you know which staff can do this?
For Practitioners

- Problem of knowing what is happening & what is expected
- Find someone to talk to
- The IMR matters
- Use near misses as wake up call
- Don’t resent writing things down
Answering my own question: Changes from Care Act

1) More SARs (time and money)
2) Explorations of interconnections of reviews
3) Potential for system accountability
for listening!

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