SOCIAL CARE WORKFORCE RESEARCH UNIT

Serious case reviews: the potential for detailed analysis of care failings

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Orchid View – care failed

West Sussex Coroner Penelope Schofield found that neglect had contributed to the death of Orchid View residents:

- Wilfred Gardner, - the coroner found that the home failed to provide for his nutritional needs and failed to prevent his necrotic wounds from becoming infected;
- John Homes, whose nutrition, hydration and medication needs were not managed by the home;
- Enid Trodden, whose medication needs, dehydration and weight loss were not properly managed by the home;
- Margaret Tucker, whose medication needs and pain relief were not well managed;
- Jean Halfpenny, who died after overdosing on the blood-thinning drug, warfarin.

- Relatives have called for Public Inquiry (see Community Care 9 June 2014)

High profile Adult SCRs

Multi-Systems perspective –

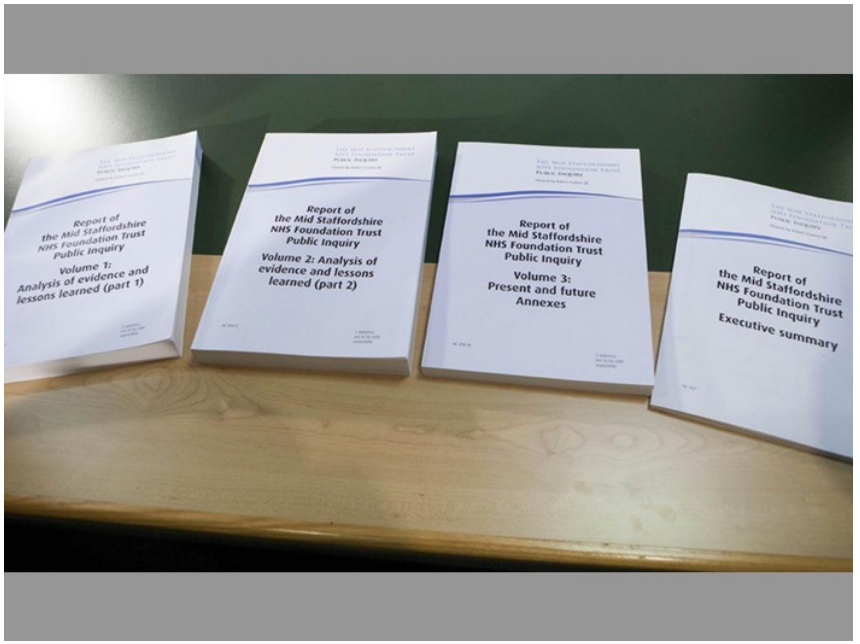
eg why was this home opened in a place with predictable staffing shortages/no public transport? Demand – planning – need - capacity issues

eg why did pharmacist not raise alert?

eg why was CQC so tolerant?

SCR on Orchid View West Sussex SAB 2014

Context of Francis Inquiry (5 preceeding) + media inquiries

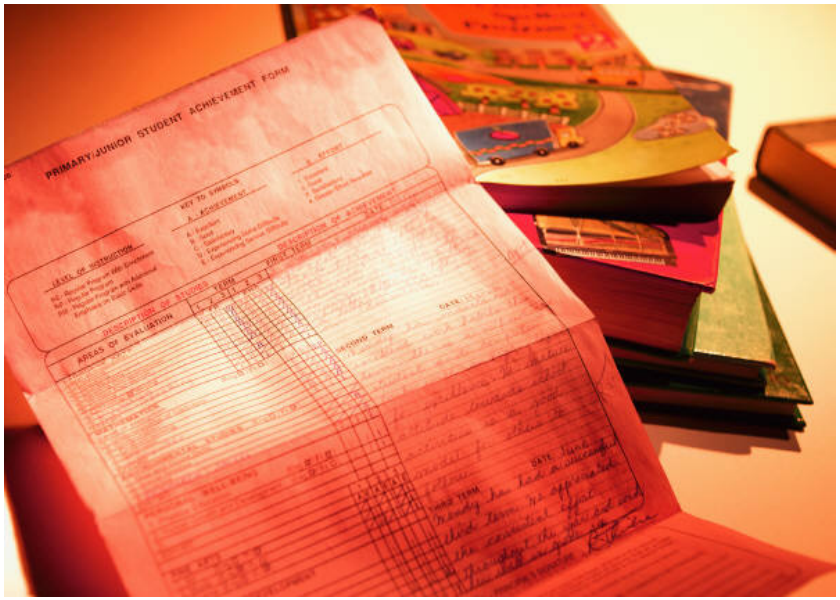


A decade of Adult SCRs

- Not mandatory to hold a review for adults unlike children (where death & protection concerns)
- Over 140 have taken place – unique accounts of care as evidence based, multiple information, chronological, focused on learning lessons

Adult SCR Lessons

Our analysis of Adult SCRs found commonalities:



- Communication problems
- No lead agency
- Training needed
- Whistle-blowing problems
- **Poor care**

Reading or learning

- Some practitioners 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

Care of Mrs Foster – 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.

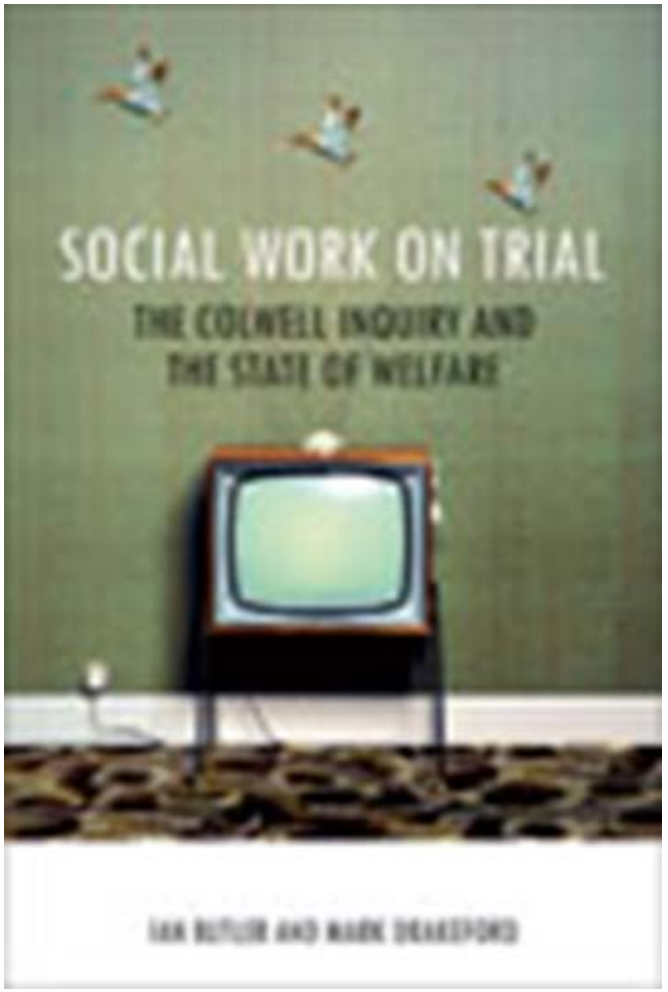
14 recommendations + 23 lessons

- ranging from exploring disciplinary action to greater use of Assistive Technology

The seductive phrase ‘learning lessons’

Looking back – what did work? Who did not?

- Influence of Ghosts...
- Do we learn from mistakes or from appreciative inquiry or systems reviews?
- SCIE work on Children’s SCRs



Long-standing problems with learning

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

  Trystan Jones, BBC News, 17 Sept 2013

Analytical challenges

- Huge problems of distilling SCRs
- Few Adult SCRs are in full
- Temptations of ‘benefit of hindsight’
- Some potential participants don’t engage
- Some thematic eg Hampshire SAB review of incidents of choking; Parry on Housing; our analysis of Mental Capacity + Dementia
- Timeframes + other processes (eg Orchid View closed 2012; SCR 2014)

Feelings of frustration that lessons remain unlearned

... ‘there are no new messages to be communicated but powerful lessons to be learned’ (Aylett J. p 9).

Learning the lessons form abuse inquires in training: findings & recommendations, JAP, 10(4) 2008, pp 7-11,

The future of SARs

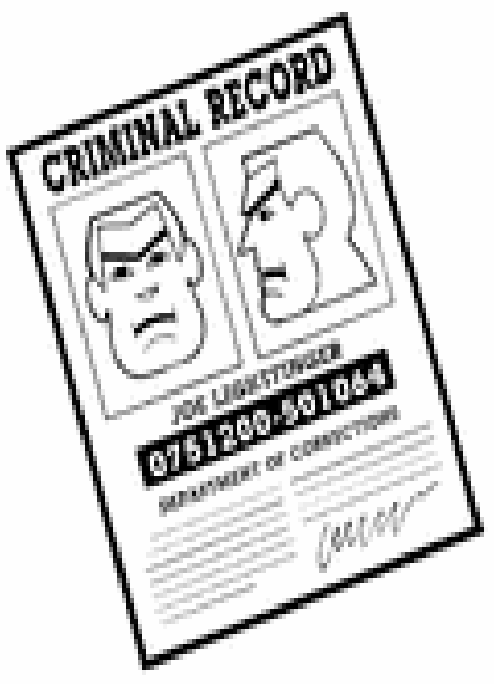
Care Act 2014 (to be implemented)

A 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.

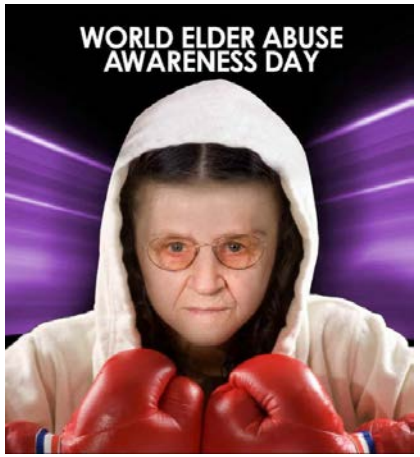
Legacies of SCRs?

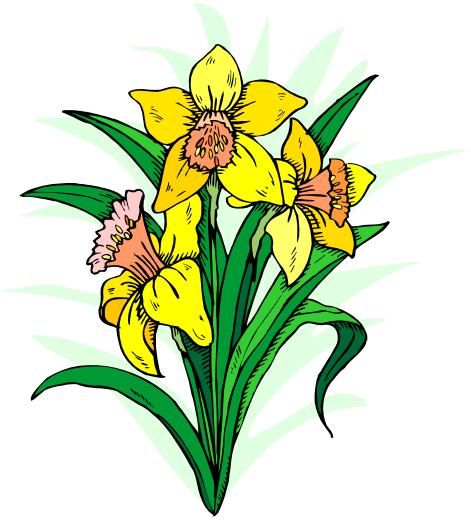


- Culture of anxiety?
- Demoralised professionals?
- Risk averse practice?
- Blame and shame?
- Not cost effective?
- Focus on bad apples not bad barrels
- Overlap with other inquiries eg Multi-Agency Serious Incident Reviews (MASIR), Domestic Violence Reviews, Coroner Inquiries

The potential of SCRs

- For gerontological researchers – content and ‘social noise’; unpicking of concepts and ideologies; critical gerontology – what is not included; whose voices are heard; which questions are asked; which recommendations are accepted?
- What might be better systems of accountability, analysis, learning?





Thanks for listening

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