Safeguarding people with dementia: Are there lessons from Serious Case Reviews?

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Outline of presentation

• Social work knows SCRs – it has ‘history’
• The legacy of Adult SCRs
• The Dementia focus
• The new Safeguarding Adults Reviews (SARs)
• Three seats for social workers (& others)
The service legacy: an example

‘Social work on trial’
Ian Butler & Mark Drakeford, 2011, Policy Press
Pre report: media coverage of trial and inquiry

• The Sun: ‘Anger flares the Maria Inquiry’, 1 Nov 1973
• Daily Mirror: ‘Mob jeer social worker after fury at inquiry’, 6 Nov 1973
• Daily Mirror: ‘The lifesaver: Barbara speeds up report to help the battered babies’ 2 Sept 1974
The charge sheet

- Culture of anxiety
- Demoralised professionals
- Risk averse practice
- Blame and shame
- No real learning
- Not cost effective
- Focus on bad apples not bad barrels
Part 2: 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
Smaller in scale – Adult SCRs

Perennial issues identified in a sample of Adult SCR Reports (n = 22) by mentions/recommendations

• Inter-agency communication suboptimal 17
• No agency took lead 5
• Training needed 13
• Threshold issue (appropriate action) 5
• Whistle-blowing policy or practice (adequacy of) 3
• (In)adequacy of advocacy/representation during SCR 4
• Comment (some problems) on SCR process 6

Note: many SCRs raised more than one issue.
Manthorpe and Martineau BJSW 2011
Golden threads: Dementia and SCRs

Of 84 SCRs available, we analysed 14 involving a person with dementia + a possible further 7.

Discrete themes:
1) situation of self-funded residents;
2) potential for poor care quality in all settings for people with dementia, and by different staff and family carers,
3) the lack of communication with family members
4) poor collaboration over care for people with dementia.

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1) Self funders

A care home was being investigated for possible neglect, fraud and copious environmental risks (White, 2011). Social workers moved all the LA funded residents to other homes but privately funded residents ‘chose to stay’. Social workers’ ‘numerous attempts to meet and liaise with the families of the 5 privately funded residents, with limited success’

Other SCRs conclude that privately funded residents seem disadvantaged by their lack of access to social care assessments and reviews.
2) Poor Care
3) Lack of communication with families

- MCA unclear
- All communications fragile
- Some families part of problem
- Some positive evidence of families being part of review
4) Un-co-ordinated care

- Mattering because little knowledge of impact of dementia
- Poor records
- Scattered and unshared information
- ‘Closed’ locations of care
- Lack of ability to raise concerns & complaints (vulnerability)
Part 3: Wider remit of Care Act 2014
Safeguarding Adults Reviews (SARs)

Safeguarding Adults Boards required to arrange SAR under certain conditions related to impact of abuse or neglect on an individual. Now free to arrange SARs where it believes there is value in doing so, e.g. any other situations involving an adult in its area with needs for care and support.
No unfair blame

‘It is vital, if organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information to obtain maximum benefit from them. If individuals and their organisations are fearful of SARs their response will be defensive and their participation guarded and partial’ (Care Act guidance14.140).

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Part 4: Three Seats

Your case
• Feelings
• Smoke without fire?
• Role of supervision
• Understand what are the SAR’s Terms of Reference
• What model are they adopting?
• Support pre & post?
Another seat: you’re writing the report and need

- Strong leadership and ability to motivate others
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics
- Collaborative problem solving experience and knowledge of participative approaches
- Good analytic skills and ability to manage qualitative data
- Safeguarding knowledge
- Inclination to promote an open, reflective learning culture (Care Act guidance)
An implementation seat

• What needs to be done in relation to the findings to help prevent similar harm in future cases?
• Who is responsible?
• How will you know it has happened?
Food for Thought

• Dementia SCRs involve many parties; often inconclusive
• Best interests and MCA framework helps
• As in many safeguarding investigations people with dementia may have died prior/during events – potential for justice and closure
About us
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Thank you for listening!