A Safeguarding Adult Review (SAR) in Rapid Time – Systems Findings Report template

A new SAR commissioned by Suffolk Safeguarding Partnership

Following the death of May Miller, the Suffolk Safeguarding Partnership (SAB) has decided to arrange for the conduct of a Safeguarding Adult Review (SAR).

The SAB is collaborating with the Social Care Institute for Excellence to develop a new process to enable learning to be turned around more quickly than usual through a SAR. This new process is referred to as a SAR In-Rapid-Time.

What is a SAR In-Rapid-Time

A SAR in Rapid Time aims to turn-around learning in approximately 3-6 week timeframe, following the Set Up meeting. The Set-Up meeting is held after the decision has been made to progress with a review. An outline of the process is captured below.

The learning produced through a SAR in Rapid Time concerns ‘systems findings’. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to do a good job day-to-day, within and between agencies.

Standardised processes and templates support an analysis of a case to identify systems findings in a speedy turnaround time.

The process is supported by remote meeting facilities and does require any face-to-face contact.

Figure 1: Outline of a SAR In-Rapid-Time

1	Set up meeting
2-3-4-5-6-7	Check of agency records
8-9-10-11	Produce early analysis report to structure discussion
11-12	Participants read report in preparation
13	Structured multi-agency discussion
14-15	Systems findings report

This document

This document forms the final output of the SAR in Rapid Time. It provides the systems findings that have been identified through the process of the SAR. These findings are future oriented. They focus on social and organisational factors that will make it harder or easier to help someone in circumstances such as May and David found themselves, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning, the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately.

Each systems finding is first described, then a short number of questions are posed to aid SABs and partners in deciding appropriate responses.

The views and contributions from May's family have been crucial in placing the key findings in context, as well as providing the vital detail in the 'lived experience' of May during her stay at Beech House.

In addition, it is well known that families may have a powerful influence on care and can be very helpful in identifying the history and precipitants of a relative's problems as well as potential future obstacles to the management and/or treatment of mental illness, therefore the contribution from the family of David's family has been highly valuable in both context and findings.

Both families provide their views with regards to the findings which have been embedded throughout the report.

May Miller – written by her family

May Adelaide Miller was born on the 2nd May 1924 in Hampstead, Northwest London. May was the youngest in a family of four children having two sisters and a Brother.

May's schooling was interrupted when she was diagnosed with tuberculosis of the spine causing her to undergo long periods of time in Hospital.

When May left school, she was employed as an apprentice dress maker. However, this was cut short when the Second World War broke out. To do her bit for the war effort May went to work in an ammunition's factory. It was here that she met her future husband, Reginald George Miller, and in 1947 they married and set up home in Kingsbury, North London. They had a family of two girls. May was then employed at a local School as a cleaner and Dinner lady so that she could be at home with her family.

In many respects May had a hard life, aside from her own health issues. May was a widow for 36 years and her daughter Brenda died 3 years ago. But May had a strong personality and overcame these setbacks. May became something of a matriarch for the family of two children, five Grandchildren and ten Great Grandchildren and, over the years they all went to her for advice. When her husband died, May remained living alone in her flat in Kingsbury where most of the time, she could look after herself. When age took its toll, and her movement became difficult she went into a care home in Hitchin, Hertfordshire. May remained there for just over a year until the home gave notification that they were closing.

To be near her daughter Ann, May moved to a Care Home in Halesworth and although her movement was restricted, her mental capacity was good. May lived in London for over 90 years and 30 of those years on her own. She was never attacked or felt threatened during this time. It was therefore ironic that having moved to the Care Home which, after all, was a place of safety, she was attacked with a walking stick. At the Inquest, the Coroner stated that although there were other health issues the assault precipitated her untimely death.

David March – written by his family

Dad lived a full and busy life, we had a fun, happy childhood growing up firstly in towns in Essex, moving to Suffolk in the late 1960s.

Dad was a design engineer who left the rat-race to run a country garage until he retired. He was always tinkering with cars and motorbikes; his other passion was sea fishing along with two close friends in their small boat. Many stories of their numerous adventures and mishaps were told through the years. He was great at DIY and handmade many wooden toys for us and his grandchildren, including dolls houses, desks and a fairy castle with a drawbridge which came down to offer presents at Christmas. We still have some of these.

Once in Suffolk he took full part in village life, becoming Chair of the parish council and was involved with the drama club. He painted scenery for many productions.

Dad was loving, generous and fun, family and friends used to look forward to the many organised games and treasure hunts he instigated when they visited through the years. He was very sociable and a great storyteller. Musical gatherings were enjoyed with his wonderful ragtime style of piano playing - he couldn't read music! He often played the part of Father Christmas at schools I was working in, making every child feel special.

When Mum became ill with dementia, Dad was a great carer. Friends in Halesworth often mentioned that it was lovely to see them in the Thoroughfare always holding hands as they visited the local shops.

He was a wonderful Grandad to his four grandchildren. He had a new great-granddaughter and enjoyed cuddles before he died.

Systems findings

Focus of this SAR in Rapid Time

May Miller was assaulted at Beech House Residential home by fellow resident, David March. May was admitted to hospital and subsequently died. A Coroner’s inquest has been undertaken and concluded that the assault may have hastened May’s death.

David March had moved to Beech House from warden-controlled accommodation 5 days prior to his assault on May. David had been asked to leave his warden-controlled accommodation due to unacceptable behaviours, including those linked to delusions and hallucinations he was experiencing and the risks that these posed to others at the accommodation.

To understand how May came to be exposed to harm we have looked at how David March came to be in the same place as May. We have looked at how professionals understood and communicated about the risks that David posed to himself and others prior to his admission to Beech House.

Following the assault on May, Adult and Community Services completed a s42 safeguarding enquiry into allegations that Beech House had failed to protect May from David. The enquiry found that the allegation against Beech House was unsubstantiated. Measures had been put in place by the family after it had been found that Mr March had entered May's room. Beech House stated that they had no warning from any agency about the risk David posed prior to his admission. They were unaware that the reason for his admission to Beech House was that he was being evicted from his tenancy due to his unacceptable behaviour.

Since May's death there has been a Coroner's inquest. The Coroner subsequently issued a regulation 28 report to prevent future deaths to Suffolk County Council. The Coroner gave her view that there could be further deaths unless action is taken in relation to problems of information sharing, in particular where confidentiality may act as a barrier to this. With this in mind the SAR in rapid time has focused on the events that led to David moving, as a privately funded resident, from warden-controlled accommodation in into the same residential home as May.

The nature of a SAR in rapid time means that this focus is necessarily narrow. For this reason, we do not include events in the report which do not directly link to the assault on May Miller. This includes consideration of how the Mental Health Act assessment following the assault was conducted and how David's admission to psychiatric care was delayed. Conversations during the SAR process highlighted that whilst these delays were undesirable, they did not impact on the safety of David or other residents at Beech House.

Looking beyond this case

The SARs In Rapid Time methodology distinguishes between the case findings, and systems findings. Systems findings are the underlying issues that helped or hindered in the case and are systemic rather than one-off issues. Each finding attempts to describe the systems finding barrier or enabler and the problems it creates. This requires that we think beyond May and David in this case to the wider organisational and cultural factors. It also requires that we hold off at this stage from solutions or articulating what is needed, to specify first what the current reality of barriers/enablers is, that the SAR process has helped us understand.

What are the key barriers/enablers we have learnt about that make it harder/easier for good practice to flourish and that need to be tackled in order to see improvements?

FINDING 1. There is no way currently to report information relating to risk if a vulnerable adult has caused harm to someone who is not a vulnerable adult. In consequence, key information is not available to allow full risk assessment.

Systems finding

In a safe system, if an adult with care and support needs acts in a way towards others which may cause harm, there is a process for reporting this regardless of whether actual harm has occurred, or the 'victim' has care and support needs of their own. In a regulated care setting the Disclosure and Barring Service (DBS) fulfils this function in relation to staff moving between settings. In a safe system, there is a process in which such information can be reported about vulnerable adults, can be accessed, and used to assess risk posed by the adult should they move from one setting to another.

The SAR has found that there was no clear system to report risks posed by a vulnerable adult who has not already abused another vulnerable adult. It was also identified that there is no helpful system to report harm caused to staff by a vulnerable adult that would result in supportive intervention to mitigate the risk to staff or consider whether others could be at risk.

In David and May's case, the consequence of this is that there was no objective information that could be used in the assessment of the risk posed to others by David's behaviour at the point he came to move. In consequence assumptions were made about the role his dementia was playing in his behaviour without further relevant information about his past behaviour being available to professionals. During discussions, professionals told us that had there been a mechanism in place to report David's behaviour, they would have used it.

Families' perspective and views:

Until the sad death of May, her family trusted that adequate checks were made for all residents placed together in a care setting, and in doing so they believed that May would be well cared for and kept safe from harm.

Both families are of the view that the background information, crucial in identifying risk and David's mental capacity, were inadequate. They are shocked at how different the level of detail sought in seeking and identifying a suitable care setting for a person can be based on an individual's funding status. The Family of May are certain that it should be a professional's duty to report concerns.

In addition, an inability within the system for paid care staff in the community to report concerning behaviour leaves all vulnerable adults at risk unless this gap is closed.

Questions for the SAB and partners

- What mechanisms are in place to make sure all relevant information about risk is available to professionals across agencies without relying on family members for this information?
- How can the partnership enable current systems for reporting safeguarding incidents to have a preventative focus such that, where no serious harm has occurred to a vulnerable person, the potential for harm can still be considered?
- Is there a process, to enable information about harm caused to staff to be reported and used in assessments, while avoiding criminalising the vulnerable adult inappropriately?

FINDING 2. There is a culture of a task focused approach by agencies in responding to a person's needs and risk. This minimises the chances that potential future risks are adequately identified in order to allow preventative measures to be put in place.

Systems finding

Within a safe system, if a person’s care and support needs are considered holistically their potential for harm to themselves or others is fully considered. Risks and their implications are identified, and plans can be made to mitigate any future risk.

The SAR has found that in this case all agencies took a task focused approach to interventions and assessment. The person’s immediate circumstances were considered, and any immediate action required by the agency was taken. If no further action was required, the task focus deterred practitioners from considering what the future needs and risks might be and how they might be mitigated. Where there was contingency planning, it was minimal. This task focus acted as a barrier to professional curiosity about areas that were not directly related to the immediate task.

This is demonstrated in this case when the Care Act assessment of need and the dementia screening in primary care were undertaken. There was minimal consideration of future risks based on what was known about David’s past behaviour. There was no detailed contingency planning to support David and his family might look like if he acted in a risky way again. Professionals commented that work pressures and a culture of ‘assess and forget’ acted as barriers to ongoing enquiry.

Families’ perspective and views:

The family of David described the emotional, and at times contradictory challenge of the expectation placed on families to make decisions and take action in their role as care givers and assessors when faced with a perceived risk during a mental health crisis. There is an emotional challenge in knowing the loved one and trying to help and understand them whilst trying to look at behaviours objectively and know when to inform professionals. A robust and ‘curious’ assessment may have picked out the relevant information to inform risk as well as provide opportunity to ‘passport’ this information on to care providers as well as support the family in their decision making.

Questions for the SAB and partners

- Have the partnership considered how task focused approaches to interventions and systems can act as a barrier for professional curiosity and how these can be overcome?
- Is the partnership currently able to ascertain cultural norms that have developed and their causes? For example whether, when agencies carry out statutory or other assessments they are routinely thinking of future potential harms and how these could be mitigated?
- Is there a role for the partnership in assisting all agencies to support, allow and encourage practitioners to consider prevention of future harm as part of all assessments and interventions?

FINDING 3. The service a person receives differs greatly depending on if they are funding their own care or not. This creates a disparity that sees full person-centred assessments only conducted for people funded by the local authority, increasing the likelihood that self-funders’ needs and risks are inadequately understood and shared between statutory sector, residential and other providers.

Systems finding

The Care Act 2014 places a duty on local authorities to undertake assessments for anyone who may have care and support needs regardless of their financial situation. In an effective system all adults receive the same service and attention to needs and risks, regardless of how their care is funded.

The SAR has found that there is a pattern where if care is set up by the person or their relative and there is no liability for funding on the local authority then full, person centred assessments are not routinely carried out. By contrast the SAR learnt in discussion with managers that where an individual is transferred from one regulated provider to another there is a full assessment of need and risk which is routinely shared.

Information from assessments when a person is self-funding is not routinely shared with providers. In consequence full information is not obtained, risk is not considered, and information is not routinely shared with other agencies. It is not clear why this different approach is taken although we could infer from responses that this due in part to resource pressures.

In this case the assessment focused mainly on David's ability to care for himself. The assumption that this is the sole purpose of an assessment of need acted as a barrier to fully considering the reasons why he was being asked to leave and given these, the risks inherent in his moving into a residential care home. Conversations during the SAR process highlighted that this is routine practice when a person is privately funding their care.

Families' perspective and views:

Both families expressed shock at the vast disparity in depth of assessment, information sharing and research between state funded and self-funding resident applications, with the enormity of this impact made apparent in the case of May.

In addition, as discussions progressed, the availability of consolidated information for families supporting their relatives and navigating the adult care system appears to be lacking. For example, both families sought advice from their GP. Although the GP and questions may have differed, in seeking this information from a trusted professional there is an opportunity to provide 'hard copies' of information for families on matters such as mental capacity, decision making, adult care, dementia and mental health in an easy read document with further information signposted. In addition, salient information on how to choose a care provider was also cited by both families as something needing clarity.

Questions for the SAB and partners

- Is the partnership assured that objective risk assessment is always carried out as part of assessments regardless of a person's funding status?
- Are the drivers of such a disparity of approach to assessments adequately understood?
- What would enable practitioners to be supported, allowed and encouraged to undertake full risk assessments and appropriately share them when a person is privately funding their care?
- Are there implications of this finding for non-statutory care providers including care homes, housing providers, hostels, or domiciliary care arrangements?

FINDING 4. A routine misinterpretation and misapplication of the Mental Capacity Act 2005 that places responsibility for managing risks onto the person themselves, prohibits professionals from conducting their own effective and objective risk assessments and mitigations.

Systems finding

In a safe system, even where a person has decision making capacity or where decision making has been legally delegated, professionals understand and carry out their continuing duty to protect vulnerable individuals and prevent future harm.

Jenkinson et al (2020) found that social workers in a recent study appeared to believe that the Care Act or the Mental Capacity Act prohibited them from formulating their own assessments even when there are grounds to suspect that a person might not be the best judge of their wellbeing or when following their wishes might not promote their wellbeing.

The SAR has found that consistent with the above research finding, when faced with situations of potential risk there is a tendency to rely on an interpretation of the Mental Capacity Act that allows responsibility for managing the risk to be passed onto the person themselves, if they have capacity, or to those with Power of Attorney if not. It is not routinely questioned whether all needs and risks have been fully understood and mitigated. This inadequate understanding of the Mental Capacity Act acted as a barrier to undertaking the professional duty to assess risk to self and others and share information about risk with other agencies, consistent with safeguarding policies.

We are aware that there has been repeated training around the Mental Capacity Act however, the SAR has found that in practice this is used as a barrier to appropriate consideration of ongoing risk. During conversations as part of the SAR process it became apparent that this is the default position for practitioners across agencies.

This was evident at all points of intervention in the lead up to David’s admission to Beech House. Although practitioners believed that David had capacity to make decisions about where he was living and about onward referrals, decision making was effectively delegated to his daughter. This assumption of capacity was cited as a reason not to further explore risk or seek objective information about reasons for David’s eviction from his tenancy.

Families’ perspective and views:

There were no questions raised about May’s mental capacity and decision making, therefore the information discussed in this finding came as surprise to the family. In particular the lack of exploration of David’s capacity.

David’s family expressed how they were unsupported in the identification of any risk that he posed to others, in particular correlating behaviours in one situation attributed to a delusion and foreseeing a risk in a different setting. More importantly, the responsibility placed upon them to log each behaviour and ensure it was passed on. The family believe an assessment focussed on both needs and risks in David moving to Beech House would have supported this collation and transfer of information.

Questions for the SAB and partners

- Do the partners understand why repeated training on the Mental Capacity Act has led to use of the Mental Capacity Act to justify failure to undertake effective risk assessments leading to preventative action to protect vulnerable people?
- What does the partnership know about post-training support to enable practitioners to use the Mental Capacity Act effectively?
- Is there a role for the partnership in supporting a refinement of the commissioning specification for any future Mental Capacity Act training and evaluation of ongoing implementation?
- Does this finding indicate an additional need for support for practitioners in undertaking difficult conversations about, and taking action to, mitigate risk?
- What mechanisms are in place to reduce the risk of practitioners using inaccurate understandings of the Mental Capacity Act?

FINDING 5. In relation to older adults, it is too readily assumed that inappropriate behaviours are related to the onset of dementia without adequate examination of other possible explanations and therefore risks are minimised. This increases the chances that people are left subject to sexual harassment or other abuse, particularly residential staff and residents who do not have the choice of removing themselves.

Systems finding

In a safe system, practitioners do not allow assumptions about a person's age, diagnosis, and gender to act as a barrier to having difficult conversations with adults or their families about risk. Practitioners are supported and encouraged to have these conversations with adults and their representatives. Practitioners share their findings about these difficult conversations with other agencies in order to prevent harm in line with information sharing protocols.

In a safe system, practitioners respond to behaviours that present risk regardless of whether these could be the result of mental disorder or other causes.

The SAR has found that there is a culture such that age, gender and assumptions about dementia can act as a barrier to practitioners directly questioning adults and their families about behaviour that has potential to harm others. This meant that information about risk behaviours was not fully explored, shared or able to be mitigated.

There is also a culture such that it is expected that professionals may tolerate sexually inappropriate behaviour or other abuse as a normal part of their professional role which does not warrant specific action. This belief means that risk is not identified or that when it is, it is minimised and not viewed as essential to respond to or share with others.

For the reasons outlined above professionals did not fully examine the risks that had been shared from a variety of sources or consider how these may impact on others. Professionals were reluctant to consider criminalising David. They did not share information about risk where it reflected badly on David, where it may have been attributable to dementia or may have jeopardised his chances of being accepted by providers.

Families' perspective and views:

The family of May and of David agree with this finding.

Questions for the SAB and partners

- What do the partners know about systems that are in place to encourage practitioners to identify ‘red flags’ irrespective of an individual’s mental health issues, age or gender?
- What is the partnership doing to ensure that partners support practitioners across agencies in conducting difficult conversations about risk with individuals and their representatives?
- Does the partnership have a role in addressing concerns such as sexual harassment or other abuse towards care and support staff, including unpaid carers, where the perpetrator is believed a vulnerable adult?

Overview of findings:

FINDING 1. There is no way currently to report information relating to risk if a vulnerable adult has caused harm to someone who is not a vulnerable adult in consequence key information is not available to allow full risk assessment.

FINDING 2. There is a culture of a task focused approach by agencies in responding to a person’s needs and risk. This minimises the chances that potential future risks are adequately identified in order to allow preventative measures to be put in place.

FINDING 3. The service a person receives differs greatly depending on if they are funding their own care or not. This creates a disparity that sees full person-centred assessments only conducted for people funded by the local authority, increasing the likelihood that self-funders’ needs and risks are inadequately understood and shared between statutory sector, residential and other providers.

FINDING 4. A routine misinterpretation and misapplication of the Mental Capacity Act 2005 that places responsibility for managing risks onto the person themselves, prohibits professionals from conducting their own effective and objective risk assessments and mitigations.

FINDING 5. In relation to older adults, it is too readily assumed that inappropriate behaviours are related to the onset of dementia without adequate examination of other possible explanations and therefore risks are minimised. This increases the chances that people are left subject to sexual harassment or other abuse, particularly residential staff and residents who do not have the choice of removing themselves.

References

Legislation.gov.uk. 2014. Care Act 2014. [Online] Available at: **https://www.legislation.gov.uk/ukpga/2014/23/contents/enacted** [Accessed 25 November 2020]

Legislation.gov.uk.2005. Mental Capacity Act 2005.[Online] Available at: **https://www.legislation.gov.uk/ukpga/2005/9/contents** [Accessed: 25 November 2020]

Jenkinson, A. Mathorpe, J. Juanchich, M. Sirota, M. NIHR SSCR (2020) ***Optimising the Quality of Social Work Decisions in Supervision***, Research Findings 065. [Accessed: 22 December 2020]