WSAB SCR Sub Group

Analysis of Serious Case Reviews 2008-2013:

A report by K Rees (Vice Chair SCR Sub Group)

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1. Introduction

In 2008 Worcestershire Safeguarding Adult Board instigated a Serious Case Review (SCR) Protocol.

The protocol states that the purpose of a serious case review is not to reinvestigate or to

apportion blame, it is:

- To establish whether there are lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard adults at risk
- To review the effectiveness of procedures
- To inform and improve local inter-agency practice
- To improve practice by acting on learning (developing best practice)
- To highlight any good practice identified in the course of the Review
- To provide an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

Five years on from the introduction of this protocol and in the interests of continuous improvement it is prudent to review the process and the lessons that have been learnt as well as the actions that have been taken.

WSAB has commissioned five serious case reviews and has published four. SCR05 is underway at the time of writing this analysis.

The criteria to undertake a SCR can be found in the WSAB SCR Protocol

Whilst it is not mandated that SCRs are published, many Safeguarding Adult Boards have published their executive summaries and a number of these have been reviewed against the Worcestershire findings to provide an overview of national picture against local findings.

2. Scope

This paper does not seek to address how far the recommendations have been achieved, as this piece of work has already been commissioned by from the Audit Sub group, but seeks to address a thematic analysis and deliver the recurrent themes across WSABs SCRs in order that messages can be delivered related to areas of greatest concern and learning. No recommendations are made in this report as issues pertinent to each individual Serious Case Review have already been addressed at the time of the Review. There are, however, Pointers for Practice to aid further learning.

12 other Serious Case Reviews from across the country, including the findings from the Winterbourne View Case have been reviewed in order to ascertain any similar themes that may have been identified, in relation to the Worcestershire cases.

3. The National Picture

In studying the SCRs from other areas of the country it has been possible to identify that the application of thresholds to undertake a SCR is wide and varied and does not always come directly from the point of view that abuse or neglect has occurred to an adult at risk. In some instances an adult has died and it is felt that there may be lessons to learn for the way in which agencies work together to support adults at risk but there has been no evidence of abuse or neglect in the death of the adult.

Association of Directors of Adult Social Services (2006), guidance on serious case reviews identifies three criteria for conducting a serious case review:

> "A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the SGAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
>
> A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults (See section 5 for commissioning guidance).
>
> Serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case." ADASS (2006) p3

Brown(2009) identifies that in Kent and Medway there is a clear threshold set for conducting serious case reviews that states that abuse or neglect has to be a factor in the death or serious injury **and** that there are lessons to learn. She argues that there is not any benefit from reviewing a case that meets the abuse/neglect threshold but that agency have worked well together.

> "a case might be serious because of the devastating effects it has had on an individual, or because of the complexity of the abusers and their motivation, but it should only be presented for review where it has proved too much for local safeguarding practice to deal with." Brown 2009 p40.

Manthorpe & Martineau (2010) concur with the need to be clear about thresholds and criteria for SCRs if national analysis is to have any congruent meaning. Both Brown (2009) and Manthorpe & Martineau (2010)agree that there are other reviews that can deal with other issues where leaning is felt to be important.

WSAB has developed a protocol to deal with cases that fall below the threshold of a SCR which enables SCRs to be focussed on cases that meet the criteria and lower level reviews can be commissioned for looking at those other cases.

Because of the wide variety of issues addressed in serious case reviews nationally there is no clear picture of recurring themes or the possibility of identifying specific risk factors in carers that makes adults at risk increasingly vulnerable to serious injury or death from abuse and neglect. The issues that arise are as varied as the cases that are investigated.

From reviewing the 12 other Serious case reviews some broad themes for learning became evident:

- Importance of thorough and robust risk assessment and care planning
- Information sharing at an early stage esp. related to maintaining intelligence of on-going/previous concerns
- The right placement at the right time and reviewed as needs change
- Importance of face to face reviews
- Addressing carer needs
- Importance of application of Mental Capacity Act
- Recording and system issues
- Managing patients who refuse support/services/treatment
- Managing Self Neglect

4. Summary of Findings WSAB SCRs

Appendix One provides a breakdown of the four cases for which executive summaries have been published.

From these it can be seen that all of the published reviews were very different in nature and covered a wide range of ages and risk factors.

There were no identifiable comparisons in the preceding circumstances of the four individual adults whose deaths resulted in a SCR and therefore no specific issues that can be highlighted to recognise an increased risk of harm to any given individual, due to their circumstances alone. However significant learning for all agencies involved in the SCR was identified.

This therefore matches the national picture. The national picture is also matched in that it is arguable that WSAB hasn't necessarily applied the criteria for a SCR robustly and could have made use of the lower level case reviews in two cases i.e. case 3 and 4. (*This needs further exploration in the SCR Sub Group.)*

There are some learning and recommendations within WSAB SCRs that are very specific to those individual cases. Some of these were also found in National reviews e.g. Importance of early information sharing (SCR01) Importance of face to face annual reviews (SCR01), thorough risk assessment and care planning (SCR02) and the right placement at the right time with an early review as needs change (SCR02).

The following themes are the main emergent themes that touch all or most of WSAB reviews (as well as the unpublished SCR- 05)

4.1. Recording

Recording remains a complex issue with many different systems in place. Some work has been undertaken to address these issues E.g. streamlining of Frameworki, greater access by Adult Mental Health Staff to Frameworki, and planned change to a new system by Worcestershire Health and Care Trust thereby reducing the number of systems within the Trust (this new system will also be compatible with Frameworki).

Recording system issues is reflected nationally and is not an issue to Worcestershire alone

4.2. Mental Capacity Issues

These issues have emerged in various forms through all reviews either because mental capacity has been assumed or because lack of capacity has been assumed without appropriate assessment.

In cases where there has been an assumption of capacity, issues such as self neglect or refusal of services have been measured against the fact that the person in question has capacity and is therefore making a lifestyle choice. In fact as capacity was not tested, it can't therefore be assumed that this is a lifestyle choice. This issue is well reflected in serious case reviews nationally.

There is also a presumption that capacity is lacking in some persons and as such capacity is not tested on a decision specific issue. This is again reflected the national picture.

4.3. Carer Issues

There are two themes that emerge from 3 of the 4 reviews (as well as the unpublished SCR) and they are:

> *Risks to carers* directly form the person they are caring for and from the stress of being a carer.
>
> *Lack of carer assessments* to identify and meet the needs of carers.

This is a consistent feature and would have provided better insight into the issues and needs within a family/relationship. Again this is a theme that emerges nationally

4.4. Patient/Client refusal of services

In several cases declining of services was accepted as a patient/client right without further exploration of capacity or the client/patient or understanding of what could happen if treatment /service is refused or further work towards encouraging acceptance o f services without it being seen as a weakness (i.e. "we/ I can manage"). This was a significant feature of several reviews nationally as well as locally.

4.5. Managing Self Neglect

This has been the subject of 2 WSAB SCRs (one published and one unpublished) and several nationally. It is therefore worthy of mention and links very closely with two themes above i.e. Mental Capacity issues and refusal of services/support.

5. POINTERS FOR PRACTICE

From the above issues the following will provide useful pointers for practice in the future:

5.1. Recording

Whilst recording on systems is important and systems are complex, it is important that staff do not rely on systems alone and should ensure that information is shared verbally at an early stage as well as being documented clearly and concisely along with rationale for action being taken. In the advent of electronic communication it is important to note that a verbal two way conversation remains important.

5.2. Mental Capacity

The assessment and recording of capacity that is decision specific is of utmost importance, particularly where services are being refused and/or a person is deemed as self neglecting. Only by doing this can we be sure that this is indeed a lifestyle choice. The reassessment of capacity should be carried out as mental capacity can fluctuate and deteriorate.

Likewise, where it is assumed that a person lacks capacity, this must be assessed and recorded on a decision specific basis, especially where decisions are apparently being made in the person's best interest.

5.3. Carers

Assessment processes must identify who carers are e.g. there may be two adults at risk who care for each other- both could be seen as carers and both could be seen as being cared for.

Carers assessments must be offered in all cases and where refused, the reasons identified, explored and re-visited at regular intervals throughout the intervention. Clear documentation with detail of the outcome of acceptance/refusal of Carers Assessments is necessary.

5.4. Refusal of Services

Where a patient/client/carer refuses services it is important to consider mental capacity. It is also important to ensure that the patient/client understands the implications of refusal of services and that this is documented. Staff should revisit the offer of services/support at regular intervals and not accept service refusal as final their decision. It is sometimes difficult for patients/clients to admit that they now need a service that they previously refused.

5.5. Self Neglect

It is important in cases of apparent self neglect that the above guidance on Mental Capacity and refusal of services is applied. WSAB is currently producing guidance on Self Neglect for Practitioners to provide guidance in managing this complex issue.

6. CONCLUSION

Adults at risk may die or be seriously injured as a result of abuse or neglect. The threshold for when a SCR is undertaken needs review by WSAB SCR sub group in light of research and national guidance.

The SCRS that WSAB has commissioned have provided a wide range of learning across the varied issues that have presented in the cases reviewed.

There are, however, some key recurring themes that have been subject of recommendations on more than one occasion and have again emerged in the current unpublished review. This therefore leads to the pointers for practice that are presented in this analysis for further consideration by WSAB.

7. ACTIONS REQUIRED

This paper was presented to Worcestershire Safeguarding Adults Board on 17.09.2013. It was determined by the Board that this document would be circulated to member agencies for onward circulation and to Chairs of WSAB sub groups for discussion of areas of relevance to their own remits.

References

Association of Directors of Adult Social Services (2006), *Vulnerable Adult Serious Case Review Guidance: Developing a Local Protocol.*

Brown, H (2009) The process and function of serious case reviews *The Journal of Adult Protection* 11(1): 38-50

Manthorpe, J. & Martineau, S (2010). Serious Case Reviews in Adult Safeguarding in England: An Analysis of a Sample of Reports *British Journal of Social Work* 41 (2): 224-241

Appendix One

Issue	SCR01	SCR02	SCR03	SCR04
Age	22yrs	91yrs	59yrs	41 yrs
Year Review Completed	2008	2009 (published much later due to on-going investigations)	2010	2011
Gender	Male	Female	Male	Female
Ethnicity	White British	White British	White British	Lithuanian
Disability/Diagnosis	Severe Learning disability	Vascular Dementia.	Mental Health Illness /Behavioural issues and anxiety disorder	None, although alcohol dependency of some degree is a possible factor. Was detained on s136 MHA. Stated suicide intention. Evidence of previous self harm
Cause of death/injuries	In April 2008 X's body was discovered in the back garden of the family home. He had been dead for some time. This followed the discovery of the body of X's mother elsewhere.	Found outside of her nursing home having died from hypothermia.	The cause of death was recorded by the Coroner as "pneumonia, paranoid schizophrenia and inanition" (exhaustion from lack of nourishment; starvation). 03 was found at home having been deceased for some days, date of death not known. Circumstances in home very unkempt.	Found hanging in public toilets at railway station.
Adult Protection Plan in place at time of death/serious injury/incident?	Concerns had been reported but procedures not followed.	None- not identified as at risk of significant harm.	For SCR 03's mother- 03 seen as a perpetrator.	Not previously known to services.
Known Family/Carers	Mother main carer.	Husband	Mother – although he was	Contact made with

Issue	SCR01	SCR02	SCR03	SCR04
			also seen as mother's carer	family via Lithuanian consulate post death.
Carer difficulties	Parents separated	Recognised and supported as a carer.	Elderly and increasingly frail	N/A
Carers assessment offered/completed	Not offered	Formal carer's assessment not offered	Not offered for either mother or son. Report shows 'carer confusion'- ot clear how was caring for who	
Involvement of agencies				
• **Adult Social care**	LD Team	ACS	ACS (Mother)	
• **Other agencies involved**	PCT GP	CMHT PCT- DNs PCT-GPs Out of Area council CQC Several Nursing/Care homes	CMHT (03) PCT-GP PCT-District Nursing Housing Association Acute Hospital West Mercia Police	West Mercia Police Worcs MHP Trust Safer communities Board Contributed to the Review. Not registered with a GP or know to any service prior to s136 detention. Had been attended by WMP on one other occasion.
Key Case Issues identified	Family seen as very supportive and caring. Good planning and support over transition from child to adult services	Good level of support delivered by all agencies involved. Increasing dementia and physical health issues.	Diagnosis of Schizophrenia had been changed as behaviour no longer consistent with diagnosis but family and GP records didn't appear to be aware.	Nothing known about 04 history. Some details of life in Worcestershire obtained from employer.

Issue	SCR01	SCR02	SCR03	SCR04
	Disengagement from various services not joined together. Annual reviews not undertaken in LD and continence services.	Several changes of care and respite facilities in attempt to meet needs. Care sometimes declined by couple. Out of area placement created visiting difficulties for husband. Formal capacity assessment not documented or understood. Contingency and long term care planning weak. Recording systems reported to be an issue- too many places to record and leads to duplication.	03 seen as a hard to engage patient. 03 appeared to access services on his terms. Misuse of OTC medication largely unknown to services. Seen as self neglect and having capacity. Overlap as this case had 2 Vulnerable adults, one seen as perpetrator and other (03) as victim.	S136 policy not followed or well understood by staff involved. Interpreter not used. Police cells as place of safety not considered best practice for case of this nature. Released from custody without MH assessment or on-going signposting or support..
Level of family co-operation	Disguised compliance from Mother	Care sometimes declined. Otherwise cooperative.	03 engaged on his terms related to obtaining prescribed medication . Family concerned re stigma and shame related to 02 and didn't share concerns as they were told that concerns would be shared with 03 and they were	Family have not made contact.

Issue	SCR01	SCR02	SCR03	SCR04
			fearful of this.	
Key Action taken by WSAB	Review of LD Service Review of repeat prescribing and uncollected prescriptions in GP practices and process for continence reviews for vulnerable adults by the PCT. Review of Safeguarding training across partner agencies. Importance of Carers assessments Introduction of 'Good Practice Sub Group' of WSAB	Continued work on CSCI inspection improvement and previous SCRs. Formal carers assessments to be offered. Capacity assessments should not be assumed but should be recorded on a decision basis, particularly where an adult is vulnerable and is deemed to have increasing inability to make decisions. Agencies to ensure that pre placement assessment is adequate	Development of Prevention Strategy Strengthen information sharing guidance. Better recognition of carers required. Issues of recording systems being separate and not talking to each other to be looked at again. Flagging system Re Vulnerable adults to be explored. Thresholds Guidance to be recirculated. Supervision systems to be addressed. Guidance for problematic prescribing for vulnerable adults. Stronger links with coroner. Address issues related to self neglect and links with Safeguarding.	Full review of s136 Protocol. Review of information available in custody suites for signposting. Roles and responsibilities to be clearer for all involved in s136 detentions. All agencies to understand importance of recording decision making rationale. Community Safety Partnership will engage employers of migrant workers and also develop a resource that can be given to employees regarding services available e.g. GP and support services etc..