Local Government Association | directors of adass adult social services | Partners in Care and Health

Second national analysis of safeguarding adult reviews

Final report: Stage 2 analysis

Analysis of learning

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Introduction

This report forms the second of three outputs from the second national analysis of safeguarding adult reviews (SARs), covering SARs completed between April 2019 and March 2023.

- Stage one of the analysis, available in a separate report, considers the quantitative data from 652 review reports, reporting on the characteristics of the individuals involved, the types of abuse and neglect they experienced, and the nature of the SAR reviewing process.
- Stage two of the national analysis, which is reported in this present report, has focused on the in-depth, detailed learning identified in a stratified sample of 229 SAR reports.
- Stage three, available in a separate report, draws together the conclusions that can be drawn from the analysis overall, and identifies priorities for sector-led improvement.

The analysis of SAR findings in this second national analysis adopts the same approach as was used in the first national analysis, namely it focuses on identified good practice, practice shortcomings and recommendations across five domains of adult safeguarding:

- direct practice with individuals
- interagency practice - the team around the person
- organisational support for best practice
- SAB governance
- the national legal, policy and financial context within which adult safeguarding is situated.

This analytic approach enables comparisons and contrasts to be drawn between this national analysis and its predecessor.

First, the methodology used for stage two of the second national analysis is described.

Sampling approach

Each SAR presents learning from the unique circumstances of the individual or individuals involved – in essence, the human story that is at the heart of the review.

Qualitative data analysis of the SARs was designed to identify common learning themes across the unique circumstances of individual cases. Such analysis provides important explanatory detail to inform evidence

on how safeguarding practice can be improved. Rather than undertake qualitative extraction of the full set of SARs, a stratified sample was selected for focus.

The stratified sample was designed to account for some forms of abuse and neglect that would be represented in low numbers, and some demographic groups that would also be represented in low numbers. The sampling approach was set to ensure that these less represented elements would be included in the selection (up to 100 per cent of SARs for some features), together with a randomised selection of the more prevalent features. This approach was chosen in order to maximise the learning that can be derived.

An initial (first tier) sample was taken of all SARs featuring high priority, low prevalence types of abuse, demographics, or features of the SAR. These were:

- powers of entry
- closed environment
- county lines
- psychological abuse
- sexual abuse
- sexual exploitation
- modern slavery
- discriminatory abuse
- organisational abuse
- criminal exploitation
- ethnicity: Black/African/Caribbean/Black British
- ethnicity: Asian/Asian British
- ethnicity: Multiple/mixed

Cases were selected in order of the factors above. Once a SAR was selected it was removed from the main dataset, selection then continued for the next factor. Due to the overlap between these factors of reviews, sampling 100 per cent of the first-tier factors resulted in a sample of 176 SARs.

The next stage of sampling was to ensure a proportionate sample of more prevalent types of abuse and neglect, and of additional key lines of enquiry, such as homelessness and substance misuse. The 176 SARs selected in the first stage of sampling largely provided this coverage, with the exception of SARs featuring concerns over ‘safe

care at home'. A random sample of those SARs was used to select 41 additional cases, giving a total sample of 216 overall.

Following this sampling process additional SARs were suggested for qualitative analysis by the readers involved in the quantitative screening. Each was screened and those that met the sampling criteria were added to the selection for qualitative data extraction. This led to a final sample of 229 SARs (35.12 per cent of the total), which are included in the following analysis of the qualitative themes and learning.

A template was used to capture the frequency with which the 229 SARs referred to a variety of predetermined elements of practice across the five domains. The narrative detail relating to both good practice and practice shortcomings was captured as free text that was later subject to thematic analysis. The template also logged the diverse sources of evidence referred to by the SARs in evaluating the practice that had taken place and captured both the number and content of the reports' recommendations.

This report sets out the SAR learning domain by domain, reporting good practice and practice shortcomings in turn. Each section opens with the frequencies with which elements of good or poor practice were identified, before proceeding to the in-depth thematic narrative. Embedded within this analysis are observations on the specific policy priorities set out by the commissioner of the analysis. The same domain by domain approach is used in reporting the recommendations made in the SARs, while at the same time noting their emphasis on the need for interconnected, systemic improvements across all domains.

Also reported is the evidence on which SAR authors have drawn to support their reflections on good practice and practice shortcomings. Finally, given the interest in the difference that SARs make to practice and the management of practice, findings are reported on the number of reviews that identified early actions taken by agencies to implement learning from their own reflective analysis of the circumstances being explored.

Domain one: Direct work

Good practice in domain one

Aspects of practice were positively commended in 80 per cent of the 229 reports. The most commonly found positive observations related to risk assessment and risk management, found in 31 per cent of cases. This includes the use of section 42 enquiries under the Care Act 2014. The use of person-centred approaches and/or attention to making safeguarding personal was present in 29 per cent of cases. Recognition of the abuse/neglect drew positive comment in 23 per cent, and good continuity / perseverance in involvement with the individual in 22 per cent. How care and support needs had been met was found to be a positive in 15 per cent of cases. Beyond this, most aspects of direct practice drew very limited commendations. The full picture is found in the table below:

	% of SARs noting positive practice
Risk assessment / management	31%
Person-centred approaches / making safeguarding personal	29%
Recognition of the abuse / neglect	23%
Continuity / perseverance	22%
Attention to health needs	21%
Attention to mental health	16%
Response to care and support needs	15%
Attention to accommodation / living conditions	12%
Responses to reluctance to engage	11%
Attention to mental capacity	11%
Relationship-based work	10%
Use of a 'think family' approach	8%
Access to advocacy	7%
Legal literacy	6%
Trauma-informed practice	5%
Understanding / knowledge of personal history	4%
Attention to substance use	4%
Work with unpaid carers	4%
Hospital discharge	4%
Recording	3%
Transition planning	3%
Professional curiosity	3%
Attention to educational needs	1%
Attention to race and ethnicity	1%
Attention to other protected characteristics	1%
Other*	7%

* Other includes good practice in responding to breach of a restraining order, good responses from GPs, appropriate recall to hospital on relapse, accessible funding for deep-clean interventions, time spent

building trust, and excellent trauma-informed practice. Turning to the in-depth thematic analysis, a number of good practice themes emerged from the narrative data extracted from the 229 SARs. Some of the examples given in the SAR reports are perhaps of practice that one might expect to observe routinely rather than of practice that exceeded expectations. However, reviewers may have differed themselves in how they interpreted this boundary, and therefore in what they each individually recorded. Nonetheless, the SAR process must record the achievements of practitioners in meeting high standards, particularly in the context of the challenges faced, and there is valuable learning to be extracted from a focus on practice working well.

Personal qualities and styles

Practitioners in adult safeguarding, regardless of their employing agency and the type of abuse or neglect observed, commonly witness some of the most distressed and distressing circumstances in the lives of the individuals involved. Many reviews commented positively on the personal qualities that the practitioners brought to their work with often highly troubled and extremely vulnerable people. Compassion, kindness, care, empathy and sensitivity were all noted, along with commitment, dedication, professionalism, skill and diligence.

> "Committed, caring support for X was clearly evidenced across the professional network, from social workers and personal advisers who dropped everything to try to meet her whenever she was seen, to community police officers who recognised a vulnerable young person in an exploitation hot-spot and proactively challenged the safety of the placement..."

This young person had had the same youth worker since the age of 11, someone who "continued to be a consistent support, attending every meeting, including when they were placed far away. Exceptional commitment."

Practitioners were commended for being non-judgemental, responding to individuals' vulnerability and prioritising their wellbeing, even where behaviour was challenging, and providing interventions targeted on safety. In this way, holistic approaches were evident, as well as flexibility, which at times required tenacity and resilience. Phrases commonly used were "going above and beyond", or "going the extra mile".

> "Housing went above and beyond their responsibilities in trying to help this couple over a long period of time and in trying to see X separately from Y: staff should be congratulated for their

persistent tenacious endeavours and compassion."

"There are frequent examples where practitioners provided persistent, compassionate support and adapted their usual practice in an effort to mitigate some risk."

The ability to see beyond the presenting problem, and to find and respect the person beneath, was noted as a strength, for example when working with people whose own behaviour or way of life was placing them at such risk.

"There was no evidence of unconscious bias sometimes identified in reviews, for example, a belief that (alcohol) dependency is self-inflicted or a personal choice, resulting in a mistaken belief that those with dependencies do not deserve care."

Also linked to the presence of personal qualities were examples of good practice in finding creative solutions and practitioners were commended for the ability (and/or courage) to 'think outside of the box', sometimes in the most challenging circumstances. This could sometimes involve varying a standard approach within their agency; examples included an Independent Domestic Violence Advisor maintaining a positive relationship with someone even though the individual had moved away from their area, and an individual being given space in a homelessness shelter despite being intoxicated.

Making safeguarding personal

There were multiple commendations also for the ways in which practitioners had demonstrated the principle of making safeguarding personal in their work. Often this was about the ways in which they had ascertained and paid attention to an individual's wishes and feelings; hearing the person's voice and ensuring that it influenced the intervention.

Practitioners' personal qualities came in here too, with positive commendations for thoughtful, kind and person-centred approaches. And as with the personal qualities explored in the previous section, the strengths in relation to making safeguarding personal were visible across a wide range of agencies.

Examples included:

- consideration of how to approach and communicate with an individual in such a way that enabled them to continue to engage with services
- good attention to an individual's history and tailoring intervention

to take account of their prior experiences

- an individual's wishes, preferences and sought outcomes documented in assessment and planning
- a preference to be tended by female staff noted and respected
- although an individual's allegations regarding a member of staff were unsubstantiated, his wish to no longer be supported by that member of staff was respected
- care staff substituted to meet an individual's personal preference
- inclusion of the individual in meetings to discuss responses to their needs
- activities in both day care and respite care being explicitly tailored to an individual's preferences and interests
- personalisation of residents' rooms and personal space
- hospital discharge arrangements that reflected the individual's choices on living and support arrangements
- recognition of the individual's previous role as a healthcare professional and tailoring conversations in a way that took account of this
- a person-centred approach to supporting an individual through a dental operation, involving a detailed care plan to prepare professionals to address his individualised needs for care and support.

Making safeguarding personal often involved initially focusing on things the individual would accept as means of retaining their openness to contact. It was sometimes necessary to build the service round the individual rather than fit the individual into the service.

> "The diabetes service worked with Valentina at points of crisis as she had difficulty adhering to appointment dates or times. The service understood this and demonstrated flexibility and responsiveness to her."

Making safeguarding personal, however, did not prevent practitioners from keeping sight of their professional goal. Acute hospital staff were commended in one review for providing respectful challenge to an individual's expressed views. Good practice was identified in terms of how practitioners understood and responded to an individual's wishes, explicitly trying to see beyond their challenging behaviour and understand what it meant. In this way making safeguarding personal was about seeing beyond standardised solutions to find interventions

that took best account of an individual's own self-determination, experience, aspiration and preferred options.

Advocacy

One key component of making safeguarding personal is the use of advocacy to support the individual in expressing their views and wishes, and if necessary claim their rights. Some SARs noted good practice in ensuring that advocates were provided. One young person had access to advocacy support across a range of different matters relating to their potential exploitation, need for accommodation and legal representation. Other examples include an individual receiving support from an Independent Mental Capacity Advocate as well as being offered (although declining) a Care Act advocate; an individual receiving formal advocacy in the context of a Court of Protection case; access to an Independent Mental Health Advocate during admission under s.3 of the Mental Health Act.

There were other examples of advocates supporting individuals in disclosing abuse or raising safeguarding concerns, and to participate in best interests decision-making. Care home residents were supported by advocates during investigations into abuse and neglect within the home. In one case the review noted excellent challenge by an advocate to decision-making by a statutory agency.

Engagement

SAR reports commonly noted positive practice in how practitioners had sought the engagement of the individuals involved, particularly where there was reluctance on their part. Here patience, persistence and tenacity – and a refusal to give up - were often noted as good practice. Mental health services, substance misuse services, social work practitioners, social work students, occupational therapists, housing practitioners, primary healthcare practitioners, nurses, and hostel and day centre staff were all commended for their persistence, as were the police and ambulance crew. Efforts to reach the individual were sometimes described as 'over and above' what might be expected, with "hundreds of meetings" in one case. In another the police had extensive interactions with the individual.

Regular assertive outreach brought good results and flexibility of approach was seen as important: meetings in cafes, use of other contacts in the community, attending to practical needs. Home visits might be carried out by services that were more routinely office or clinic

based. Outreach was seen to be effective in the case of one young woman where practitioners persistently sought her out, presented options, accompanied her at meetings; the attempts at engagement here were described as holistic, assertive and person-centred. In another, a GP offered regular appointments to check a physical health matter about which the individual was motivated to attend, providing the opportunity to monitor their mental health without this being labelled as mental health monitoring. Sometimes designating one professional to be a single point of contact was effective, taking time to build rapport that resulted in the individual participating in assessment and decision-making. Equally important was noticing the signs of disengagement or non-concordance and taking steps to prevent that escalating into a loss of contact. One key element of good practice noted in relation to individuals who may be reluctant to engage was the continuity of involvement that some practitioners were able to provide. Within the reviews there were examples that included the following:

- an individual being supported by the same housing officer throughout his tenancy, at the same time receiving consistent support from the same social worker over many years
- the same support team remaining involved with an individual despite their multiple moves of accommodation and even providing support when he was living outside of the services' usual boundaries
- services remaining involved beyond their usual allotted timescale for contact
- during the COVID-19 pandemic, haematology clinicians taking their service out to an individual's supported living premises to ensure continuity of treatment
- learning disability nursing care being consistently provided over a long period of time
- social care staff, environmental health officers and community nurses continuing to visit regularly, despite an individual's very unpleasant living conditions
- staff continuing to visit, despite constant reluctance and rejection from the individual
- a continuous range of responses tried to overcome missed appointments
- ward staff persistently checking and confronting an individual about fire risk from smoking materials, giving a consistent and repeated message

- a social work student's perseverance ultimately uncovering the extent of the abuse being experienced.

Relationship-based practice

Central to much of the good practice noted in the SAR reports was the power of relationship. Reviewers commended the efforts that practitioners made to build relationships that were sometimes the key to agencies being able to maintain contact.

> "Although she did not keep appointments with other organisations, she would arrive at the diabetes clinic without an appointment and appeared to view reception staff and nurses as a 'substitute family'."

Social workers, care providers, mental health practitioners, GPs, personal advisers and police officers were all noted to have built relationships in which they were trusted, sometimes enabling them to advocate for the individual in their interaction with other services. These relationships provided a strong anchor in times of crisis and also provided a bridge to other involvement.

> "Once allocated, the transition pathway adviser co-worked the case with the social worker for a period of time, providing an opportunity for her to build a relationship with X over time with the support of the social worker, which again was good, relational practice."

> "The professionals involved spent time trying to develop trust between X and the police, to try and obtain consent from X to be interviewed by the police, in order to try and secure a conviction."

They also facilitated intervention at times of crisis:

> "The community nursing team used their relationship with X to negotiate his physical health care, finding alternative solutions to minimise risks where he was resistant. One example: When X had a further fall and declined to attend Emergency Department, they were clear with him about the risks of that choice. Having confirmed he had capacity to make this decision, they instead arranged alternative care to minimise risks, sourcing a bed at the Community Hospital."

Sometimes when formal involvement ceased, relationships didn't end immediately:

> "Despite no longer being her care coordinator, the mental health

care co-ordinator supported X through a court case - she had a good relationship with this practitioner."

"One of the care homes X resided in whilst his home was cleared developed a notably positive relationship with him, preparing him to return home and maintaining contact with him when he left the service."

Trauma-informed approaches

Review reports commended practice that recognised needs arising from trauma in individuals' lives, leading to the use of trauma-informed practice. This could affect how engagement was approached. Reviews noted that approaches based on an understanding of trauma worked well and were aligned with making safeguarding personal in a way that took account of the individual's life experience. Practitioners were able to initiate, reinitiate and sustain engagement over periods of time.

"Practitioners recognised the impact of trauma and sough to provide safe spaces. Some practitioners recognised that she needed time to engage and adjusted their working practice."

Individuals who found it difficult to place trust began to do so, enabling support to be given.

"There are many good practice examples of the trust and connection women had with their keyworker who provided a consistent and reliable source of support. Outreach on two nights a week allowed opportunity for engagement at the level the woman could tolerate, with the backup of other resources/organisations as women increased trust and engagement."

Professional curiosity

One of the skills best tailored to engaging, building rapport and developing person-centred relationships is the exercise of professional curiosity. It is also sometimes an important gateway to identifying abuse and neglect, probing below the surface of appearances to reveal a safeguarding need. SARs gave some examples of good practice here. Professional curiosity about domestic abuse was expressed by midwives and health visitors. An occupational therapist was appropriately curious about an individual's weight loss and was able to alert the GP. Mental health clinicians and a housing provider also demonstrated professional curiosity and made contact appropriately to express safeguarding concerns.

Attention to needs

Individuals whose circumstances were under review frequently had longstanding contact with services, and the SARs noted good practice in how those agencies had met a range of different needs. A range of practitioners were commended: probation staff, community police officers, paramedics, housing support officers, occupational therapists, speech and language therapists, education providers, healthcare staff, voluntary organisation staff, social workers. Maintaining contact with individuals during the COVID pandemic was also noted as good practice. Many individuals had multiple needs arising from complex conditions and good practice was evident where these had been comprehensively observed and assessed. Practitioners sometimes worked beyond their own role in using holistic approaches that identified the need for other agencies' involvement alongside their own.

Other examples of good practice included:

- provision of temporary accommodation close to the hospital at which attendance was required for treatment appointments
- consistent and supportive responses from a voluntary agency involved in homelessness support
- OTs visiting regularly and monitoring whether equipment in place was fit for purpose in the context of changing needs
- care plans amended as needs changed and further risks were identified as a result of concerns raised by other practitioners visiting
- a learning disability speech and language therapist's assessment and advice was in depth and timely
- recognition of the need for psychological support
- intensive therapeutic support was provided
- detailed telephone triage by an NHS Trust, including past history and social triggers, that resulted in an agreed plan and onward signposting
- an individual assessed as not having eligible needs for care and support was nonetheless supported by an adult social care practitioner to attend meetings with the Department for Work and Pensions and to secure council accommodation
- a CHC team ensured there was constant review of the care and support plan, considering solutions to issues raised
- local education providers met young people's educational needs

through college attendance

- proactive assessment of equipment needed to ensure an individual's safe occupation of their home and mobility within it
- care home staff working to meet residents' needs despite poor conditions and inadequate facilities.

A wide spectrum of needs, beyond those related to immediate care and safety, was recognised and became the focus for attention. For example, following a difficult encounter between an individual and local supermarket staff, the individual's support worker accompanied them to visit the store manager and agree the provision of educational material for staff about their condition, improving their community relations significantly. Two individuals were supported to obtain passports and other documentation to prove their eligibility for support from public funds, and in a further case practitioners used a human rights assessment to mount successful challenge to a decision that an individual was denied recourse to public funds. Finally, one review commended the compassionate support given to victims of modern slavery during and after criminal proceedings in which they had given evidence. The SAR observes:

> "Giving evidence after years of enslavement is likely to take immense courage. Supporting individuals to give evidence requires detailed and sensitive care planning that meets the emotional, intellectual and practical measures required to achieve best evidence and support the victims' well-being. The arrangements, led by Police, were an excellent example of this."

Attention to protected characteristics

Legal rules are highly relevant in considering SAR evidence on how the requirements of the Equality Act 2010 were met in practice, particularly in relation to people with protected characteristics. Only one example of good practice was noted here. This related to an individual of Asian heritage, diagnosed with dementia, who was noted to have had a named GP who was of the same gender as they were and was fluent in their first language. The SAR observed that this helped to meet their cultural needs and also meant that the GP could speak directly with them in their first language, assisting assessment of their mental capacity. This GP also made a referral to an Asian mental health helpline, cognisant of the impact of the individual's diagnosis on the family. In the same case, the Acute Trust involved used an independent translator to manage the consent process.

Provision of practical assistance

Sometimes needs were evident at a very practical level and good practice in responding to these were also noted. Examples included offers of transport and sometimes personal accompaniment of individuals in attending appointments, support with welfare benefits claims, a college assisting with a young person's hygiene needs by providing showers and clean clothes.

Attention to health

Some SAR reports commented positively on how individuals' physical health needs had been met. Primary healthcare practitioners featured here – GPs, community nurses, pharmacists and practitioners in other community-based agencies who were proactive in recognising and acting to secure attention to health concerns.

GPs were commended for rapid responses to concerns, making prompt home visits, being attentive to skin integrity, following up on whether individuals had attended blood test and x-ray appointments and recognising the need for specialist health assessment.

A pharmacist was commended for their attentiveness in declining to dispense prescribed medication that was contraindicated in the individual's condition. Some individuals received intensive support with their physical health needs. In one case, an individual was actively supported by staff in a voluntary agency to attend clinics, and full review of health needs resulting from long-term alcohol use was undertaken.

In hospital-based care, good practice was noted in one case in the provision of comprehensive attention to a range of needs, some of which had been undiagnosed prior to admission:

> "The acute trust completed a full range of assessments and reviews, including occupational therapy, dietician and physiotherapy, with clear treatment objectives and plans put in place … His past medical history was well-known and informed decision-making."

Good and responsive care was noted by an acute trust in the context of the COVID-19 pandemic and in a further case an individual was noted to have received good support in undergoing an amputation. Skilled end of life care was noted in a further case.

Attention to housing or accommodation needs

SARs found evidence of good practice in work with street homelessness and rough sleeping, as well as good attention to wider housing and accommodation needs. Practitioners were noted to have made persistent attempts to find suitable accommodation for individuals.

Housing staff were seen to be proactive in responding to homelessness. Referrals to housing/homelessness teams were made for temporary accommodation and night shelters. Bed and breakfast accommodation was provided, also severe winter weather shelter beds. Temporary accommodation was provided to an individual when he reported being homeless after leaving residential care where he had been a looked after child. In one case provision of a hospital bed was continued rather than discharge the individual to homelessness. Temporary accommodation was allocated as a result of domestic abuse being recognised. A temporary tenancy that would have been ended due an individual's anti-social behaviour was continued in recognition of their vulnerabilities and risks.

Attention to mental health

When it came to securing more stable accommodation, there were examples across several cases of good support being provided. A housing association supported one individual to secure a tenancy. Care and support assessment in another case resulted in approval for priority rehousing. A tenancy support officer provided significant support to another individual with their financial affairs. Outreach support and accommodation were instrumental in bringing some stability to the lives of two individuals, who were offered appropriate accommodation quickly after assessment.

Significant numbers of mental health needs featured in the circumstances under review. Some of the SAR reports commented on this aspect of individuals' needs. There was evidence of thorough assessment and proactive attention to mental health, given by both non-specialist and specialist services.

- An individual's mental health was proactively monitored during their visits to collect medication.
- The police responded consistently to support an individual's safety, using s.136 of the Mental Health Act twice to ensure she could be properly assessed.
- Detailed assessment of mental health was carried out during

acute hospital admissions, with good use made of liaison psychiatry teams who were able to refer on to community-based mental health services.

- Mental health clinicians showed professional curiosity, checked records and made appropriate referrals to meet needs relating to substance misuse service and housing needs.
- Agency records provided in-depth knowledge of an individual's mental health history.
- During admission to a mental health hospital, the team undertook thorough medication planning with substitution of drugs likely to be used in overdose and devised a plan that avoided certain drugs due to addiction and overdose risk.
- An approved mental health professional was commended for the thorough and person-centred nature of their assessment.
- Good therapeutic support was provided in hospital, making a key difference to the individual's mental health and enabling him to be discharged feeling ready to engage positively with community supports.
- A community mental health team provided coping strategies and distraction techniques, alongside temporary prescribing of medication to ease anxiety, to assist an individual in dealing with alcohol and drug cravings.
- Interventions went beyond the prescribing of psychotropic medication to assist an individual in engaging with community support.

There was also evidence that physical health needs were identified during treatment for mental health conditions, enabling a more holistic overview of an individual's health.

Attention to mental capacity

Some good practice was noted in relation to how mental capacity was addressed, with SARs commenting on good understanding and application of the Mental Capacity Act 2005 in certain contexts. Good practice in completing mental capacity assessments was observed by practitioners involved in specific decisions – paramedics, emergency departments and hospital self-discharge episodes are examples. Capacity was in some cases appropriately assessed repeatedly where the circumstances warranted it. A manager was commended for

challenging a practitioner's finding that an individual lacked capacity to decide where to live on the grounds that the assessment lacked detail. The best interests provisions under the Mental Capacity Act were used to ensure examination for eye treatment in a situation where an individual's resistance to this was assessed as arising from a lack of capacity. An AMHP involved in a Mental Health Act assessment recognised a medical emergency that required use of the Mental Capacity Act for physical health treatment in their best interests. Good practice in providing support for decision-making was noted.

> "Agencies supported X's decision making, helping him to weigh up options and risks and considering his capacity. This was evident in the GP helping him to consider treatment options including the impact of amputation. It was also evident in hospital when X made a decision to self-discharge."

Referrals for Independent Mental Capacity Advocates were made appropriately and in some cases escalation to the Court of Protection took place.

In this example, recognition of the impact of executive dysfunction was also noted.

> "A behavioural assessment of dysexecutive syndrome assessment found that X's frontal lobe damage adversely affected her executive functioning, supporting a more nuanced approach to assessing her capacity in respect of decisions around her accommodation and risk management. She refused to move to a new and appropriate placement, a professionals meeting was convened and legal advice sought in respect of legal options to compel this move. This resulted in an application being made to the Court of Protection for an order authorising Sylvia's placement move and deprivation of liberty."

Finally, a practitioner raised concern with the Office of the Public Guardian about the actions of a relative holding lasting power of attorney (LPA), resulting in a process to remove the relative's power and replace it with local authority control of the individual's finances

Legal literacy

Use of legislation such as the Mental Capacity Act is linked to the question of legal literacy in practice. Here too some good practice was noted, with SARs commending understanding and use of legal rules in particular circumstances:

- legal options such as Community Treatment Orders and use of

the Deprivation of Liberty Safeguards were explicitly considered

- an individual's absence from hospital prompted application for a collection order from the High Court to empower the police to search for and return them to hospital
- applications were made to the Court of Protection for authorisation of an individual's move to a more suitable placement and for resolution of conflicts in best interests decision-making
- police bail conditions supported by power of arrest were used to prohibit a perpetrator from approaching the individual
- a Domestic Violence Protection Order was used to provide 'breathing space' in which to work with the individual.

Transition

A number of SARs noted good practice in safeguarding young people transitioning to adulthood. This requires good alignment between children's services and those for adults, which was clearly achieved in some cases.

Flexibility in the boundary between services was seen as important. Examples include children's services extending support beyond 18 while awaiting adult social care assessment; a social worker remaining involved in a young person's care post-18 in order to provide consistency while awaiting the outcome of a leaving care service restructure; an adolescent mental health unit place remaining available while a suitable adult placement was sought.

Good transition planning was noted between child and adolescent mental health services and those for adults, assisted by an established, robust transition pathway. In other contexts joint working sometimes eased the transition:

> "X maintained her relationship with a known social worker who was qualified to work with her complex circumstances. Once allocated, the transition pathway adviser co-worked the case with the social worker for a period of time, providing an opportunity for her to build a relationship with X over time - good, relational practice."

Leaving Care Services came in for praise, with relationships built, home visits made and supportive responses to young people's requests for help, in some cases building on strong foundations set by children's services.

> “X had good care from a social worker he worked with for 6 years, a long-term stable foster placements and lots of services working with him. He received a considered and good quality service from the Leaving Care team.”
>
> “X received good support from the team with a much higher level of contact than the minimum of every 56 days that the service uses as the measure for meaningful contact.”

Hospital discharge

A further form of transition is from hospital-based care to community settings. A number of SARs documented good practice during the hospital discharge process. Good work on planning discharge was noted, along with appropriate referrals for ongoing treatment for conditions such as pressure ulcers and dietary needs.

In some cases discharge was appropriately delayed in recognition of actions that needed to be taken before it could be safely effected. Examples include recognition of an individual’s severely hoarded home environment and identification of the need for a mental health multidisciplinary team meeting and of the need for care and support to be in place.

Also commended were the comprehensive nature of assessments undertaken prior to discharge:

> “Efforts were made to ensure a timely hospital discharge to the care home, including care home staff visiting the hospital prior to discharge. His discharge was agreed with the son. Prior to discharge, assessments were completed by the falls team, community mental health, and OT, with a referral also to the continence team. When in the care home, there were prompt responses and input to meet health and care needs, including tissue viability assessment, diabetes monitoring and dementia assessment.”

An individual who was discharged from the National Rehabilitation Centre had access to a multidisciplinary team with a wide range of expertise, who undertook a series of assessments to define their care and accommodation needs and to inform decisions in his best interests.

Another discharge was described as an ‘ideal hospital discharge’: full assessment and planning including explicit risk assessment, home occupational therapy assessment, home fire safety assessed by the

Fire and Rescue service, referrals for community services, and all necessary equipment in place.

Risk assessment and management

One common feature in the lives of the individuals featured in SARs is the presence of risk and in some cases, reviews found evidence that professionals had made persistent and determined efforts to identify, assess and manage risk.

- The police found positive ways of managing difficult community situations and 'went the extra mile' to safeguard the individual in risky situations.
- Call handling staff showed professional insight in identifying serious concerns underlying a call about a neighbourhood dispute.
- Good triage of NHS 111 calls was noted when an individual's call was transferred to 999 and resulted in ambulance attendance.
- Good risk assessments were carried out by ward staff.
- Risks of self-neglect and pressure ulcers were recorded in a care plan.
- The signs of safety model worked effectively in identifying and managing risk.
- A day centre recognised and raised concerns about issues in relation to Percutaneous Endoscopic Gastrostomy feeding (use of a feeding tube) and put a risk management plan in place;
- A community mental health nurse's risk assessment took full account of past incidents of violence and aggression;
- Paramedics managed to gain access to an individual's home and gave a good account of the risks they witnessed;
- Risks from an individual keeping her back door unlocked were recognised and raised with her.

Responses to risky situations were on occasion tireless:

> "X was reported to the police as missing on 98 occasions over a six-year period. Every report was responded to through active police searches to locate her at all known addresses.
>
> "Staff at her various placements applied a proactive approach

> and would respond to requests to pick her up from agreed locations once she made contact."

Fire prevention work was also commended in a few cases, with positive comment on appropriate referrals to fire and rescue services for home fire safety visits, active fire prevention work and proactive fire mitigation practice.

Safeguarding

Where there is risk, there is safeguarding, and unsurprisingly the SAR reports focused extensively on how effectively the individuals concerned had been safeguarded.

Recognition of dangers that individuals faced was an important first step and practitioners were commended for identifying cuckooing and drug dealing, coercion and control, domestic abuse, stalking, financial abuse, exploitation, healthcare mismanagement, alcohol dependency, neglect by unpaid carers and self-neglect. This could require vigilance outside the practitioner's own professional frame of reference.

> "During a medical review at home carried out by a doctor not only were X's mental and medical state and capacity considered but also the environmental and social issues that were having an impact on his care, with suspicions of cuckooing and the state of his flat."

Reports made multiple mentions of appropriate and timely referrals by a range of practitioners: community nurses, hospital clinicians, GPs, police officers, care providers, voluntary organisations and banking staff, as well as by those in specialist roles such as Relevant Person's Representative. Referrals were noted to be comprehensive and detailed.

Conduct of safeguarding enquiries was commended for being undertaken promptly, effective information gathering, following a clear plan, recognising the need to protect other residents from harm in a group care setting, keeping the individual informed and providing feedback to referrers and families, rapid instigation of protection plans.

> "The safeguarding enquiry was detailed, well evidenced and proportionate considering the nature of concerns raised and ongoing criminal investigation."

> "The Section 42 enquiry into the fall in the care home was very thorough, with family involvement, an outcomes meeting and actions followed through by the care home."

Specific actions taken to safeguard individuals were also commended. Police officers conducted home visits and ejected people from an individual's accommodation. Domestic abuse, stalking and 'honour'-based violence (DASH) assessments took place and referrals to multi-agency risk assessment conference (MARAC) and the Independent Domestic Abuse Advisor service were made. A locker at a fire station was made available to help an individual flee domestic abuse. A local authority acquired appointeeship to reduce risk of financial exploitation. An individual was referred to the Court of Protection in order to safeguard her from assaults and exploitation when she could not keep herself safe. Flexibility by agencies was commended:

> "The decision to keep X in hospital over the Christmas period, partly to ensure that she was not returned to the care home before the safeguarding concerns were finalised, was a positive decision that showed prioritisation of X's needs."

This could involve escalating concerns elsewhere:

> "Although X did not disclose to Border Force officers any information that raised concerns of modern slavery or human trafficking, there was good adherence to Home Office protocols about missing minors … resulting in a National Referral Mechanism referral and assessment."

Evidence of exemplary practice was provided in one case:

> "The response from identification of the initial safeguarding concern for X throughout the safeguarding enquiry to completion was exemplar practice in terms of its practice and recording, which supported the criminal investigation whilst upholding Ben's human rights as an adult at risk lacking capacity."

'Think family'

Beyond the range of strategies noted above to seek out and engage the individual at risk of abuse or neglect, some SARs commented positively on how families had been involved.

Involvement commonly took the form of keeping family members informed about intervention, explaining risks, seeking their views, actively involving them in planning for hospital discharge, harnessing their support for the individual, facilitating attendance at best interest meetings and other discussions, and supporting them during end-of-life care. There was good practice noted too in how agencies responded to families' questions, concerns and occasionally complaints. There were examples of good practice in all of these, and sometimes of plans

being adjusted in the light of family intervention.

'Think family' also sometimes involved practitioners challenging family members about their care of or impact on the individual. In one case, a practitioner recognised the implications of difficult family relationships for the individual's mental health. In another, the individual's siblings were supported to address conditions in the family home that were presenting risk. A further manifestation of 'thinking family' was in cases where the individual was a parent of children who were affected by the abuse and neglect within the home. Proactive provision of support to children was noted in the case of an individual's attempted suicide; in another case children were appropriately safeguarded having witnessed domestic abuse. A further example was the provision of significant support from a school, which maintained a positive relationship with the individual as a parent, facilitated contact with the children, and provided advice and support to the family.

Records and recording

Finally, SARs found evidence of good practice in how practice had been recorded, often providing insight into the ways it had been conducted. Cognitive impairment and dementia services were noted to have documented an individual's needs well; another individual's preferences and sought outcomes were recorded; an Emergency Department kept good and detailed records; a care home had made good use of an ABC chart setting out antecedent, behaviour and consequence. A community occupational therapist's records were described as:

> "… well set out, actions were clearly recorded with the decision-making process laid out and evidence of good consultation with X, her family and other professionals. The records demonstrate a holistic approach to X's situation that appropriately balanced and managed risk whilst respecting X's right to control her home environment."

In other cases, person-centred assessment and planning were well documented, a Care Act assessment was well written, and hospital staff fully documented their discussions with family members about their concerns and complaints, and had recorded actions taken in response. A record could give a clear picture of the individual:

> "The plan provides a good picture of X, his likes and dislikes, what he wants to get out of life and the challenges that he faces because of his disability. The plan sets out what is needed to

meet his daily needs and how to keep him safe.

It is well laid out and provides a platform for X to say what he wanted to achieve and the kind of assistance he wanted to maintain his dignity and keep safe."

Practice shortcomings in domain one

Despite the often-stated wish to include learning from good practice, negative observations outnumbered positive observations by some measure in most aspects of practice. Of the 229 SARs included in the stage 2 analysis, 99 per cent identified aspects of practice that could or should have been improved. So, for example, although risk assessment and management drew positive comment in 31per cent of reports, it was also the most commonly occurring shortcoming, with poor practice featuring in 82 per cent of the SARs.

In other aspects of practice too, negative observations outweighed the positive. Poor attention to mental capacity was noted in 58 per cent of cases, lack of recognition of the abuse/neglect in 56 per cent, and absence of person-centred approaches/making safeguarding personal in 50 per cent. Appearing in between a third and half of the reviews were problems relating to care and support needs assessment, planning and review (43 per cent), professional curiosity (44 per cent), attention to mental health needs (41 per cent), legal literacy (40 per cent), responses to reluctance to engage (38 per cent), use of a 'think family' approach (38 per cent) and attention to health needs (37 per cent). The full list is given in the table below.

	% of SARs in which this aspect of poor practice was noted
Poor risk assessment / management, use of safeguarding s.42	82%
Absence of attention to mental capacity	58%
Poor recognition of the abuse / neglect	56%
Lack of personalised approaches making safeguarding personal	50%
Absence of professional curiosity	44%
Poor attention to care and support needs	43%
Poor attention to mental health	41%
Absence of legal literacy	40%
Poor responses to reluctance to engage	38%
Absence of a think family approach	38%
Poor attention to health needs	37%
Poor recording	28%
Poor attention to unpaid carers	27%
Lack of understanding of personal history	27%
Poor recognition of trauma / trauma-informed practice	24%
Shortcomings in hospital discharge	24%
Poor attention to living conditions	23%
Lack of continuity / perseverance of involvement	21%
Lack of access to advocacy	21%

	% of SARs in which this aspect of poor practice was noted
Poor attention to substance use	20%
Poor transition planning	15%
Poor attention to race / ethnicity	12%
Poor attention to additional protected characteristics	10%
Absence of relationship-based practice	10%
Poor use of restraint	2%
Attention to educational needs	1%
Other*	19%

*'Other' includes over-use of anti-psychotic medication, safeguarding concern raised by individuals with lived experience not given due weight, lack of knowledge by a utility company about an individual's vulnerability, no use of interpreter services, insufficient attention to diet/weight, lack of early intervention, non-compliant lifting and handling, breach of medication guidance, individuals not seen individually in a case of domestic coercion/control, potential age bias in acceptance of behaviours in older people that would be questioned, recognition of child sexual abuse but not of child criminal exploitation, lack of crisis management, use of Mental Health Act 1983 as a threat to secure compliance, incidents seen as 'one-offs' rather than as part of a pattern, absence of crisis management planning, poor understanding of the impact of domestic abuse, failure to consult/involve an individual holding Lasting Power of Attorney, delay in securing tissue viability nursing, failure to focus on the need for equipment, poor pain management, poor attention to financial situation, absence of Deprivation of Liberty Safeguards (DOLs) authorisation where circumstances would have warranted it, lack of challenge to an individual holding LPA despite decisions that were not in the person's best interests.

Turning to the in-depth thematic analysis, as might be expected from circumstances that have had tragic outcomes for the individuals involved, multiple shortcomings in practice are evident. Better practice might have led to death or serious outcome being prevented, although it is rare for SAR reports to be explicit in these terms.

More commonly, they observe that an individual's circumstances could have been improved by a different approach, and it is this learning that provides the evidence for service improvement priorities.

There is rarely one single thing that has gone wrong – more often there have been multiple shortcomings, which when combined result in a poor outcome.

This is particularly the case where poor direct practice is not picked up by checks and balances elsewhere, such as within the interagency,

organisational or governance domains of safeguarding, adding up to system failure.

As with good practice, the learning on poor practice is presented here in themes, broadly in the same order as used in relation to good practice.

Personal skills and qualities

Shortcomings in practitioners' knowledge, skills and values sometimes drew comment in the SARs, along with what were sometimes termed professional cultures that negatively affected how practice was carried out. Some negative attitudes were noted, including towards individuals whose risky and distressed behaviour was assumed to be a 'lifestyle choice' and involving judgements about both alcohol use, use of other drugs and homelessness. This sometimes showed in the language used in records or by practitioners. Some inappropriate descriptions were used or accepted without challenge, including references to a young woman being a street worker, engaged in prostitution and targeting males in bars and clubs, rather than being seen as vulnerable and exposed to situations she could not control. In another case, the language used in the records for the safeguarding enquiry minimised the individual's vulnerability to exploitation and portrayed her as a willing accomplice. One SAR noted that seeing an individual as attention-seeking and 'dramatic' may have caused practitioners to underplay her vulnerabilities. Other potential bias was evident in use of labels such as 'non-engagement' or 'non-compliant'. In another example, a SAR described the language used by practitioners when discussing the individual's risk as 'sanitised', and failing to highlight the risk of death if medication was not taken.

Stereotyping of people with a learning disability was noted in several SARs, with covert attitudes affecting understanding and communication during contact with practitioners. One SAR noted that a deficit-based approach by professionals was a serious barrier to engagement with the individual. In another case, the culture was noted to have positive features relating to choice and empowerment, but this limited practitioners' confidence to challenge and explore, and resulted in insufficient focus on risk.

One SAR noted 'a culture of resignation' about a family's behaviours and a sense that these were to be managed rather than addressed. Comments such as 'that's their way – there's not a lot we can do' may have had a distorting effect on seeing the abuse for what it was.

In other cases, there was an apparent acceptance of an individual's circumstances:

> "One of the most concerning aspect of this case was an apparent lack of a consistent appreciation of and desensitisation to the adult's lived experience in that smelly, dirty and unsafe house where there was no water, electricity or heat or urgency required to resolve this."

On another case, an over-pessimistic view of the individual's potential led to his aspiration for change not being harnessed. Although challenged by trauma, alcohol dependency and poor health, he was clear that he wanted to lead a sober life and be a family man again. The SAR observes "there is a need for practitioners to be able to have the positive belief that change is possible". Conversely, professional optimism was also seen at times to be misplaced:

> "Staff convince themselves of the impact of their involvement and the commitment and capacity to change of the service user".

Knowledge and confidence were sometimes missing, and there were examples of professional judgement being undermined by the impact of interactions that took place. In one case where an individual denied receiving poor treatment this was not explored further.

> "Her denials were taken at face value, perhaps because of fear experienced by staff in relation to her daughter".

Making safeguarding personal

SAR reports made multiple references to practice that fell short of the principle of making safeguarding personal.

Shortcomings in responding to how communication needs were met resulted in difficulties identifying individuals' wishes, feelings and sought outcomes.

Practitioners struggled to communicate well with people experiencing a variety of conditions - aphasia, dementia, difficulties with sensory overload or information-processing - and in situations where non-verbal communication was necessary.

> "There was a lack of understanding of X's communication style, what his profound disabilities meant for the best approach to maximise his non-verbal communication skills and no plan to help him develop his communication skills or thoughtful discussion of how best to communicate with him… He was not

> enabled to communicate his feelings about life at home and the lack of focus on developing his communication skills meant that this would have been difficult to achieve. He needed a professional to “stand in his shoes” and consider what life was like for him, as well as a plan to develop and maximise his communication skills so that he could indicate what life was like from his own perspective.”

There were similar themes emerging from several SARs in which individuals’ personal perspectives, goals and aspirations remained hidden, or were interpreted by a third party.

> “X could not communicate verbally. He did use some sign language but this was not a recognised sign language and was a form of communication between himself and his parents. Some professionals admitted to a reliance upon X’s parents to communicate his wishes and feelings … they deemed them to understand him and to effectively communicate his wishes. But (this) silenced his voice and resulted in some professionals neglecting to communicate with him directly.”

> “Not all professionals knew of communication passports and consequently did not ask to see X’s”

Despite the value of hospital passports in setting out communication needs, they were not always effective.

> “X's hospital passport had not been updated to include details about his deteriorating health or his communication preferences, including what might calm and reassure him, vital as he was unaccompanied.”

Even where family members were not providing communication support, individuals were sometimes not seen privately enough to gain an understanding of their independent perspectives. In some cases a family member would always be present, often speaking for the individual without the individual’s consent to this arrangement being checked. Their wishes, feelings and desired outcomes were not ascertained directly; family and agencies made the decisions, including those in which a family member declined services on behalf of the individual and the case was closed.

> “Very little was done actively to directly find out from X himself his views, wishes and feelings. All too often workers across all services relied either instinctively or deliberately on communicating through his mother – contributing to her becoming the seemingly unchallenged decision-maker. His brain injury left him with memory and communication difficulties and

> he was described as being slow to respond, quiet and shy. He appears to have been spoken to directly on very few occasions."

In one case, practitioners relied on the mother of an individual with profound learning disability to make decisions for her, despite knowing that the individual had been neglected as a child and that the mother was unable to meet her basic care needs. The mother's refusal of an onward referral for support when the family moved areas was not challenged, an omission later compounded when Adult Social Care in the new area, alerted by the police to the individual's living conditions, merely sent her a written invitation to contact them. Beyond this there were multiple examples of access to the individual being restricted or services terminated at the request of a relative without seeking the individual's own views.

In circumstances involving potential domestic abuse, with coercion and control suspected, as well as sometimes exploitation, two parties to a relationship were sometimes not seen separately, limiting the potential for their individual perspectives to be identified.

In other examples, individuals were sometimes left out of meetings, despite knowledge that involvement in decision-making was much valued by them, leaving decisions to be made by professionals.

One individual was consulted about some matters, such as managing health needs, but not about major decisions that concerned her. The omissions in practice played through into records:

> "A feature of all assessment and referral documentation was the limited voice of X himself. X's views of his needs, diagnosis, wishes and aspirations, and involvement in decisions about care and support did not come across strongly."

Further omissions involved practitioners failing to gain any personalised picture of what might be important to an individual, or what might lie beneath their behaviour.

> "No professional assessments or reviews said anything person-centred about him. He appeared both socially and culturally isolated. There was no reference to cultural or religious connections."

> "Neither X nor Y appear to have been asked if they felt safe or what would help them to protect themselves from harm - they were known by their behaviour and not as whole people."

In several cases of severe self-neglect, there was no evident consideration of the suitability and impact of the observed home environment, or how it had descended into such a neglected state.

Little was known of what the individuals concerned really thought about their situation and what their desired outcomes were. Nor were the causes explored, the focus remaining on the symptoms. Another SAR observed that it was more a case of fitting the individual into services than finding ways of enabling them to achieve outcomes that they themselves valued.

Advocacy

As one key means of making safeguarding personal, advocacy remained underused. In several cases SARs found that advocacy would have been appropriate in the circumstances of the case but was not sought. No evidence was found, for example, that consideration was given to appointing advocates for care home residents who had no known family or friends. Other examples included:

- failure to consider the appointments of advocates during care and support needs assessments
- late consideration of how an advocate could have helped resolve divergence between the individual and other parties involved
- a need for advocacy agreed but not actioned
- delays in appointing an Independent Mental Capacity Advocate
- a need for earlier appointment of an Independent Mental Capacity Advocate as safeguarding concerns escalated
- independent Mental Capacity Advocate referral declined on the grounds that providing support with finances was outside of the Independent Mental Capacity Advocate remit
- a further Independent Mental Capacity Advocate referral declined on the ground that the individual had family involvement, the SAR commenting that this was contrary to General Medical Council guidance
- failure to appoint an Independent Mental Health Advocate
- lack of clarity about the respective roles of an Independent Domestic Abuse Adviser and an Independent Sexual Abuse Adviser.

In some cases the need for advocacy was not recognised as it was assumed that family members were advocating for the individual, including in one case was where it was well known that the individual had been neglected by their family. In one case where an advocate

was in place, the SAR comments that the role was not well used to promote making safeguarding personal principles in communicating with the individual. In another, an advocate was appointed but their role and remit was unclear and they undertook insufficient outreach to engage the individual. One SAR is critical of an absence of support for fathers from children's services after a father's needs for appropriate representation at meetings were not recognised. A further SAR observed that the involvement of advocates could have better facilitated the conduct of difficult conversations.

Engagement

Many SARs identified problems in how agencies had failed to engage individuals who may have been reluctant or unable to accept support. Lack of assertiveness or persistence on the part of practitioners was noted, with time not taken to build rapport that could generate trust. Sometimes individuals had been 'signposted' to a service but not supported to make that initial contact.

Practitioners were seen to have lacked understanding about how an individual's life experience impacted on their 'reachability' and failed to recognise the complexity involved. The assertive outreach that would be required in order to overcome the barriers was not provided and practitioners failed to undertake work to understand the individual's history, and what might lie behind their reluctance.

> "There were significant gaps and missed opportunities to understand what was happening to X, why she did not want help from agencies despite it being clear she was unwell and in distress. There was a significant and long-term lack of professional curiosity about her, her family, her needs and her safety, including not trying to understand why she and her family felt so strongly about not engaging with statutory services when this could have been so helpful."

Alternative means of contacting people were not tried: practitioners failed to consider that individuals may not have literacy skills to read appointment letters; another individual would write letters but proved hard to reach face to face, resulting in case closure; a family member successfully reached one individual through intercepting her while out shopping, but services attempting to provide support did not try this approach; in another case there was no follow-up to missed appointments by an individual who due to poor mobility was unable to attend. Even where an individual's history might be well understood, engagement sometimes remained superficial.

> “Despite continuity of relationship, professionals struggled to secure X’s full engagement with the support designed to protect her, and break through her evasiveness about her activities, whereabouts and people she was associating with both male and female. A recurring observation was that while on one level X was polite, friendly, and superficially co-operative, she would not offer more when pressed or would reject the advice and support offered.”

Services were often quickly withdrawn if the individual gave no initial response, sometimes without any further risk assessment. Mental health and substance misuse services were both noted to have lacked perseverance, quickly discharging individuals from their services. In one thematic review relating to individuals with complex and multiple needs, mental health services were noted to be the least engaged in addressing their needs. Individuals were seen when in crisis, in Emergency Department or custody suites, but did not attend follow-up appointments and were quickly discharged from the service. In a number of cases an individual’s non-attendance at appointments was mistakenly seen as ‘did not attend’ when in fact it should have been seen as ‘was not brought’ through neglect by a family member.

In other cases, individuals’ responses were taken at face value, with no ‘Plan B’ for pursuing the very real concerns raised.

> “Given the history that was known and the presentation, it is the panel’s analysis that an acceptance of X’s reluctance to engage and his explanations for his wife’s condition and ability to cope were too readily accepted.”

There was a failure to recognise the significance of repeated patterns of engagement followed by disengagement. Practitioners commonly did not explore the reasons for this with the individual. Disengagement or non-attendance at appointments sometimes led to agencies ceasing their involvement, rather than recognising the risk factor and the situation required more, not less, input.

> “X's disengagement from services coincided with her condition worsening; more assertive approaches were needed at this time.”

> “X’s non-attendance at health appointments were not flagged as an area for concern despite multiple safeguarding concerns being raised by professionals and neighbours.”

Some agencies lacked flexibility in their expectations of engagement. For mental health services, sending a letter warning of case closure without contact within seven days was the standard approach. The

Department for Work and Pensions were described as “either unwilling or unable” to engage with two brothers, failing to understand how a learning disability impacted on their engagement with the process of claiming benefits and requiring documentation that they simply could not provide.

Relationship based practice

Some SARs commented that no attempts to build a relationship with the individuals had been made. One in particular commented on the reactive management of an individual’s behaviour rather than an attempt at relationship-building to develop a holistic understanding of her needs, wishes and fears. In a specific example relating to the police, one SAR notes that different police officers dealt with different allegations of sexual abuse/exploitation, which made it difficult for anyone to build consistent rapport and relationship with the individual.

Trauma-informed approaches

SARs found an absence of trauma-informed practice in circumstances where such an approach would have been highly relevant. Often the impact of trauma in the individual’s life was not recognised, with a failure to recognise how current behaviours stemmed from that trauma and the individual’s attempts to manage it.

The failure to identify past trauma sometimes arose because the individual presented ‘well’, the challenges they experienced remaining hidden. Or it resulted from practice that was confined to managing current presenting problems rather than seeking their underlying causes. Treatment would be focused on medical or practical interventions at the expense of recognising adverse childhood experiences, abuse, loss, bereavement or other trauma in individuals’ lives. Labelling presenting behaviours as uncooperative or resistant obscured how they were related to previous experience, and how addressing them without understanding their causes could result in removing the individual’s coping mechanisms. At times unrealistic expectations were set, for example the expectation that an individual remain abstinent while accessing temporary accommodation, an aim that was unlikely to be achieved without trauma-informed support.

The impact of trauma on decision-making and on mental capacity was also not recognised:

> “The impact of trauma on X's decision-making was not

> considered or understood by people working with him, or how this may have related to behaviours linked with self-neglect."

In a further case the individual's decision-making capability was described as "eroded", as a result of which she was very vulnerable and was trafficked and exploited. A further SAR notes how multiple Emergency Department presentations were not recognised as communications of distress, nor was an individual's physical presentation seen as evidence of accumulative trauma. Responses were to presenting problems and immediate crises rather than locating these in full appreciation of her past and its impact. One SAR comments that the individual's own avoidance of the past was understandable alongside what often accompanies trauma, namely feelings of stigma, isolation, mental distress and constant crises.

Sometimes trauma was recognised but not taken account of in treatment plans:

> "The trauma of previous episodes of rape was not incorporated within the risk assessments for the sexual exploitation reported by X."

In one case treatment was not offered because of the presence of alcohol in the individual's life, with the view that this precluded therapy until the alcohol use had ceased. In other cases the absence was related to lack of specialist knowledge and understanding of what might constitute trauma-informed practice.

> "Knowledge across partner agencies of the multiple traumas X had experienced in childhood including a head injury, exposure to physical and emotional abuse and insecure accommodation, should have resulted in proactive early intervention and practical support to ensure that she was able to engage in education. Better understanding of trauma-informed care and development of a specialist Emotional Health Service are likely to have provided better support to X and embedding relational practice across partner agencies would have created greater resilience across support networks."

Professional curiosity

One key omission in practice, noted in multiple SARs, was the absence of professional curiosity.

In many cases practitioners had not sought sufficient information to provide understanding of what was happening beneath the surface in many circumstances of abuse and neglect. There was a failure to look

beyond the presenting circumstances, and to interrogate the superficial features in order to reach for a deeper understanding.

> “Some professionals appear to have based their decisions on information received from X and her family member and accepted this at face value, although their explanations didn't fit with other information that was available.”

Professional curiosity was particularly lacking during the initial stages of engagement and assessment of needs and risk, with practitioners not showing sufficient curiosity to enable them to understand an individual’s reluctance, or to piece together an understanding of their situation, or to gain a full understanding of risk. Attention tended to be focused on what was presented rather than seeking out what was not, and upon the presenting problem rather than on asking questions that could reveal its causes. Practitioners sometimes relied on self-reports by the individual, for example that they were taking their medication, in the face of evidence that they were most probably not. In one case, practitioners failed to see beyond self-soiling behaviours that could have been forms of communication about underlying distress, merely accepting that ‘this is her’.

One SAR notes that a greater degree of professional curiosity would have enabled practitioners to see through the disguised compliance shown by a mother who was severely neglecting her daughter. There were clues such as smells that could have been explored but these were not picked up. Another criticises a lack of focus on the reasons for frequent Emergency Department attendances. Another notes, in relation to an individual who was a non-smoker but had died in fire, that the focus of intervention had remained on risks that could be clearly seen rather than those that required teasing out: “there was insufficient curiosity about X’s experience of spiritual distress and his mental health. Greater probing might have revealed that he lit joss sticks to keep spirits away”.

Yet even where the individual provided information that should have alerted a practitioner to the need to probe further, there was evidence of a failure to do so. A SAR reviewing multiple cases of modern slavery reports that one GP record stated: “he says he was abducted by gypsies … he comes up with a very strange story of being abducted by travellers and being made to work … “ The individual was indeed later found to be a victim.

The rationale for individuals’ decisions was sometimes not explored:

> “The rationale for X's decisions was not explored, little professional curiosity about why he preferred informal carers,

> why he declined detox or about his background and how this may have influenced his decisions. Services withdrew when he declined their support rather than explore his decision with him. There was no exploration of whether his decision-making was influenced by duress or coercive and controlling behaviour."

Sometimes the lack of curiosity was linked to professional optimism that led the practitioner to accept the assurances of an individual that they could manage and did not require assistance, without deeper questioning about their circumstances. In some cases the absence of professional curiosity had a tangible impact on intervention, with care hours being cut because they were not being used:

> "There was a lack of curiosity demonstrated by the reviewing social worker, which led to a significant reduction in X's hours of care. X's whole situation and history were not accounted for in this review, nor the reasons why she was not utilising the part of her care package that would help her to access the community."

Sometimes, however, the examples of limited professional curiosity were linked to challenges practitioners experienced in interaction with the individual – raising probing questions was not easy, or possibly sometimes not even safe.

Attention to needs

Shortcomings in how needs were met fall into two distinct themes: situations in which needs were not recognised, and situations in which needs were recognised but were not met well.

Needs poorly recognised

In some cases, an individual's history, had it been explored, would have indicated a range of complex needs, but that exploration did not take place. This sometimes meant that certain needs, such as physical needs, were recognised and explored but others were not. More likely to be overlooked were less tangible features such as psychological needs, or the need for therapeutic input. For example, an assessment undertaken by a care home focused on the individual's physical health needs and did not consider if they could care for a person with significant mental health needs. There were multiple failures to recognise mental health needs and missed opportunities for counselling.

> "Professionals didn't seem to understand X's triggers, fears or needs sufficiently to offer him what he needed when in crisis."

> “The management of X's third sexual assault triggered traumatic memories of the first two; the lack of prosecution resulted in her feeling that she was unworthy of attention or help. She had no further support regarding this assault, no referral to counselling or Sexual Assault Referral Centre, or revisit to see if she wished to have the support of an Independent Sexual Violence Advisor.”

When one young woman was booked in by a hospital ante-natal service, her mental health history of medicated depression and suicidal ideation was not identified, despite being noted in documentation provided by her GP. In another case, no consideration was given to the individual’s learning disability and its impact on her as a parent, on her self-neglect, or on her ability to keep herself safe without support. Another young mother returned to drinking when her baby was taken into care and placed for adoption, with the mental health needs arising in those circumstances not addressed. In another case, the emotional impact on an individual of intervention to clear and clean his severely hoarded property was not recognised, with the follow up plan taking a narrow focus on his physical care, not on his distress or emotional wellbeing. One individual had been waiting for an autism/ADHD assessment for six years by the time he died, with practitioners lacking the specialist information to underpin their care of him. Probation services involved with an individual prior to prison discharge failed to recognise and refer for health and accommodation needs to be attended to on discharge. In a further case, needs arising from sensory impairment were not recognised. In another, assessments undertaken did not take account of the individual’s acquired brain injury, resulting in the care provided to him being ineffective. For others similar specific elements of care were missing.

> “The lack of occupational therapy home based assessment was a vital missing element in his care. Occupational therapy may have used strategies, techniques and equipment to help X adapt to his home environment and improve his safety and wellbeing. Crucially, an OTs skill in home-hazard assessment may also have identified and mitigated fire risk.”

> “There was an imbalanced focus on health issues, rather than social circumstances and the challenges in the relationship. This meant that other factors were not adequately considered. Despite the engagement of social work professionals, the overwhelming focus was upon the health needs of the couple. This narrow lens meant that the social circumstances, although considered, did not have sufficient prominence in professionals’ thinking.”

Assessment of needs might take place outside of the context in which the individual lived, resulting in a less than complete picture. Several SARs note that practitioners did not have a good enough understanding of an individual's home circumstances. In the case of an individual in a care home, the SAR observes that the staff were reliant on the limited assessments that were completed in a hospital setting by practitioners who did not know him well. In a further SAR, the report observes how a poor assessment undertaken in a different context influenced the care the individual received in the care home to which he moved.

> "The nursing need assessment undertaken to determine the type of care X needed was inaccurate. It described him as having one condition, did not describe his other physical health diagnoses and described his behaviour as 'attention seeking'. This contributed to the labelling and discounting of his distress at being in a care home. Practitioners perceived his presentation as negative behaviour rather than the manifestation of a physical or mental health need. Care home staff described him as 'demanding and impatient' without considering the high level of anxiety he may be experiencing at the beginning of a residential placement he had been very reluctant to commit to."

Particular mention was made of the challenges in identifying the needs of individuals moving across geographical borders. Engagement might sporadic or piecemeal, resulting in needs not being fully understood by agencies in any location.

This could be particularly the case for homeless people, who were one group for whom needs were less likely to be fully recognised. Many needed 'wrap around support', but the support provided was very task-focused - night shelters and temporary provision. In addition, for some their uncertain immigration status may have made them reluctant to disclose life histories and reveal needs. Individuals coming to attention for other reasons were sometimes not recognised as having housing needs and were not referred for housing or homeless support. Other needs that were overlooked related to the need for support with the impact of sexual violence and with sexual health.

In some cases needs assessment was limited, for example the use of a Rockwood Frailty scale to assess needs and make decisions about the clinical support needed, when the scale is not sensitive enough to assess people with a learning disability and is generally not used in these circumstances. In another case, no baseline measures had been taken that would allow an individual's health to be tracked and monitored. In a further example:

> “A discharge to assess process was used in X's discharge from the acute trust; carers were present for five days but did no assessment, concluding that Harpreet had no care needs. Adult social care did not consult her family but accepted this assessment.”

Sometimes the presence of one agency militated against another becoming involved. In two cases Adult Social Care did not complete care and support assessments or respond to safeguarding referrals because they saw the case as being about mental health. So although the individual had care and support needs, these were not assessed or responded to.

Sometimes complex or multiple needs were identified but the connections between them were not well understood. One example was the complex relationship between alcohol dependency and experiences of domestic abuse. Others were the impact of pain and mobility on mood and compliance with care, and the impact of an individual’s health condition on their care and support needs, their decision making and risk-taking. While a number of specialist assessments might take place, the needs identified in each were not understood holistically and the interrelationships between them were missed. In one complex case, there were embedded linkages between executive function, mental capacity, compulsive behaviours, self-neglect, use of street drugs, cyclical patterns of medication compliance/non-compliance and the possible cuckooing of his flat, yet little understanding was reached of how these factors affected his behaviour. In another case:

> “The assessment of needs in the social care records were largely focused on X’s need for support with activities of daily living rather than a broader, holistic assessment of X as a person. The social care records did not set out the wider potential impact of the disease, neurological, psychological as well as physical.”

Care plan review processes were noted to focus on what practical measures were needed to deliver to an individual’s changing care needs, rather than on the underlying causes of those changes.

Needs poorly met

Some powerful examples of needs not being met lie in the SARs relating to abuse and neglect in care homes. In one case, criminal court proceedings revealed that the residents were subjected to systemic neglect, seclusion without food, fluids, heating or toilet access, and physical assaults, alongside orders to test their compliance. In another

care home, care workers may have caused tissue damage due to unsafe manual handling and faulty hoists.

> “She was left with faeces on her back and legs for up to 4 hours whilst soaked in urine, poor care may have contributed to further skin damage. Community nurses found X lying in wet pads. There were gaps off up to seven hours in repositioning and it is unclear whether she was nursed continuously on a pressure-relieving mattress. By the time her health had rapidly deteriorated, she had been seriously neglected by the home.”

In another case poor practice was identified in how residents were treated, with specific allegations of violence and abuse from staff to residents, and serious concerns about the overall neglect of residents. There were multiple concerns about people left in soiled clothes and bedding for long periods of time, with associated damage to skin integrity, and of medication mismanagement. In another care home, a significant omission was discussion of Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPRs) arrangements in end-of-life care planning.

There were multiple examples of care and support services under the Care Act 2014 not being provided. In some cases assessments did not take place; in one example, Adult Social Care rejected a referral for assessment of care and support needs having concluded in advance that the individual, who was self-neglectful and experiencing domestic abuse, did not have care and support needs. In another, the offer of assessment was made by standard letter to someone known to be reluctant to engage, with no follow up or assertive outreach despite the circumstances notified in the referral. In a further case, an individual never received a Care Act assessment despite his and his family members’ repeated requests, resulting in a negative impact on his wellbeing, health and ability to manage personal care and care of his accommodation.

In other cases, needs were assessed but services did not follow, despite evidence of eligible needs. In one example, when assessment of care and support needs finally took place, the individual’s needs were not found to be eligible needs because they arose from her alcohol problem. An equally narrow view was taken in another case where needs arising from addiction were not seen as care and support needs. In another, Adult Social Care concluded that an individual who was subject to cuckooing only had housing and health-related needs, not needs for care and support.

Home conditions were sometimes noted to be severely lacking in

hygiene and in some circumstances unsafe but were seen as acceptable despite their impact on health and wellbeing.

Care plans for both health and social care were sometimes not subject to timely review. One review found no evidence that a continuing healthcare had been reviewed three-monthly, in line with national guidance. However, in one case a Care Act 2024 review withdrew an individual's care and support package when he was found not to have a brain injury, leaving him without support for his mental health and substance misuse issues.

Concerns about unsafe domiciliary care arose. One individual was left by care workers in an unsafe seated position rather than in bed, with no-one informed. Community nurses had advised that she should not be moved without equipment, but the equipment was not delivered. Pressure ulcer care was not given. In another example, conditions in the home were highly unsuitable – a dark, cold, cluttered room, a low bed that made personal care difficult, no bedsheets, no television. This seemed to have been accepted as normal by the carers, who did not escalate it, nor did they record or notify the individual's level of distress. In a further case, an individual who had been receiving care at home was admitted to hospital and immediately noted to have a serious wound, which should have been identified and escalated by her care workers.

Elsewhere, there were delays in concluding a moving and handling plan for safe transfers, in supplying appropriate continence products, and in resolving wheelchair concerns. The COVID-19 pandemic took its toll in some circumstances. One SAR notes that the individual was 'forgotten' and for some months had no interaction with agencies supporting her. As a result the support she needed happened too late to prevent escalation of her self-neglect.

Community healthcare also had shortcomings. In one case, community nurses did not visit weekly as intended, contributing to a decline in skin integrity. In others, occupational therapy assessments were severely delayed.

Care in hospital was not always appropriate. One SAR refers to an unreliable occupational therapy assessment that indicated an individual had returned to her pre-admission baseline, triggering the previous care package to be re-started, when in fact she was unable to bear weight and her care needs had significantly increased.

Mental health services fell short in some cases:

> "The failures to consider what supports X needed regarding his mental health and neurological needs before and after discharge

meant that he had limited support for his many complex needs."

The challenge of sequencing responses to differing needs also surfaced, the most common being the insistence on treating substance misuse before mental health needs, or a requirement for stability in an individual's life before therapeutic intervention. For individuals whose needs were so intertwined and interdependent, this could mean no intervention at all took place.

There were a number of examples where individuals were placed in settings that were not suitable for them. In one case, the placement meant that the approach to the individual's distress was medication and cognitive behaviour therapy, rather than the dialectical behaviour therapy that would have been best practice treatment for her emotionally unstable personality disorder. In another case:

> "The LA assessment appeared not fit for purpose in concluding that his placement was appropriate. It is also not clear how much consultation was undertaken with the accommodation provider staff, who had repeatedly expressed their inability to cope with X's behaviour and had resorted to locking themselves in the office for their own protection on at least three occasions. The Police had also expressed concerns about the safety of the placement."

One final aspect of needs relates to economic need. In one case, no consideration had been being given to whether an individual had sufficient funds to keep appointments, or to keep himself fed and warm. In another, the SAR criticises what it describes as a 'piece meal' approach taken to his benefits. When the individual was finally able to claim back benefits, there was no discussion with him about using this unexpected windfall. A further individual was noted to be struggling with debts as well as homelessness, yet no structured support was provided.

Attention to protected characteristics

SARs noted failures to take proper account of characteristics protected under the Equality Act 2010, with most examples related to race, gender, disability, religion or age.

In relation to race and ethnicity, several examples of poor practice involved a failure to secure interpreting services. In one case a policy about not using friends or family members to translate was in place but was not followed. In another, interpreters were not always arranged or available when actually needed, resulting in delays in service provision.

There were occasions when practitioners did not speak to individuals in the language of their choice or in settings comfortable to them. Care plans were written in English. In another case, although the hospital had a translation and interpreters policy, it was not used when the individual was admitted. This meant that in the initial assessment covering patient consent for the assessment and referrals, sections on ethnicity and religion, social background, activities of daily living, safeguarding risks, and vulnerability were not completed. Her husband was assumed to be an appropriate translator and she therefore had no opportunity to speak with staff without a family member present.

In another case, cultural insensitivity led to failure to accurately identify an individual's heritage, leading to assumptions being made about him, his background, cultural needs and relationships. Another individual had experienced challenges from how his mixed heritage had been treated, but this was not explored with him, nor in another case was there sufficient attention to the possible interaction between the individual's ethnicity, her cultural background and upbringing and her possible experiences of discrimination and racism in explaining the difficulties services experienced in engaging with her. In a further case the SAR found a lack of attention to how the individual's experiences as an African-Caribbean man may have impacted on his engagement with statutory services. Services had not recognised how his ethnicity may have affected his ability to access mental health services and on his trust in statutory agencies. In another case, understanding of racial, ethnic and cultural heritage was poor:

> "The services had a shallow knowledge of X and his situation, including his cultural and ethnic heritage, his beliefs, the nature of his family and other relationships with individuals or community-based groups with which he might have engaged. This extended beyond X's death when the culturally appropriate mourning period was not understood or respected by mental health services who wished to make early contact with his family."

One individual's mother believed that her views were disregarded because her English was strongly accented and practitioners believed she did not understand the language, despite consistent assurances that her understanding of English was excellent.

In another case, an individual had declined to cooperate with the police during investigation of her exploitation by drug suppliers, her reticence caused by anxiety that information would get out to members of her ethnic community. Her concern was not recognised and because of her lack of cooperation little was done to safeguard her. A further SAR

refers to a lack of understanding of the individual's ethnic background as a member of the Irish traveller community. In relation to religion:

> “X's faith was forgotten, and because nobody asked her about why she was refusing to eat it only came to light during the review, in speaking to her family, that as a Hindu X may have been choosing not to eat because of her beliefs about end of life preparation.”

In relation to gender, in two cases a woman requested a female practitioner, but their requests were not met. Another SAR found evidence of gender bias in poor recognition of the domestic abuse of men, with such bias being an influencing factor in recognising one man’s experience of this form of abuse.

In relation to disability, there were multiple examples of failure to make reasonable adjustments. An optician omitted to make appropriate adjustments to manage the eye testing and eye care of an individual who found it difficult to be examined. A GP practice failed to consider whether any reasonable adjustment was required to assist communication, for example making a home visit. No reasonable adjustments were made in supporting a disabled person who was a parent. A hospital lost an individual’s hearing aids and glasses, but failed to remedy this and she was assumed to be not willing to engage, when in fact she was not able to. An individual with learning disability and autism did not receive adjusted responses from services, nor did his mother who had learning disability.

Mental ill-health was not appropriately recognised as a disability by the Department for Work and Pensions. Without reasonable adjustment being made, it impacted on an individual’s ability to engage with the department in relation to their claim for Personal Independence Payment

The one mention relating to sexual orientation indicated that the review had not found any evidence of direct discrimination in respect of the individual's sexual orientation, but noted that his sexual orientation was also not discussed, nor were any experiences he may have had earlier in life that could have affected his relationships with services.

Attention to health

In relation to age, one SAR notes a normalisation and de-prioritisation of the risk of violence from older people with dementia. In the case in question, this meant that despite recorded incidents and known risks, the alleged perpetrator's behaviour escalated without any additional

management measures. Another SAR observes that practitioners may accept (and not question) behaviours in older people that they would not accept (and would question) in younger people. It also recognises the intersectionality in experiences of people with protected characteristics, for instance where age intersects with race and/or gender or indeed any other characteristic. Practitioners sometimes did not grasp the requirements on them to meet the needs of people with dual or multiple protected characteristics.

Beyond shortcomings in the categories of need identified above, there was evidence that specific health needs were not well attended to.

There were multiple shortcomings in pressure ulcer care.

- One SAR notes variable adherence to the skin integrity care plan by care workers providing domiciliary care. Despite appropriate equipment being provided, along with instructions for its use, there were repeated failures to use equipment properly, in particular the pressure-relieving equipment and dressings. The ToTo (automated) turning system was at times turned off, despite repeated instructions to the contrary. Carers were using items such as Kylie sheets (absorbent bed pads for incontinence), which were potentially worsening X's skin integrity.
- Another report notes that an informal carer was given brief training on pressure ulcer care but there were no follow-up checks to ensure the pressure ulcer care was being done properly and no follow-up support offered.
- In another case there were missed opportunities to explore pressure ulcer development when skin integrity concerns were identified by paramedics and hospital staff.
- Pressure ulcer care at a nursing home was inconsistent and it was poorly monitored.
- The increased risk of pressure ulcer when dehydrated was not considered.

Shortcomings in healthcare for people with learning disabilities were identified, with annual learning disability health checks sometimes not conducted and physical illness sometimes overlooked.

> "Diagnostic overshadowing might have taken place - the tendency to attribute symptoms and behaviours associated with illness to the learning disability, and for the illness itself therefore to be overlooked and routine investigations not undertaken. This can be a particularly problematic when someone with a learning

> disability is in pain and can only communicate distress through behaviour such as screaming."

In other examples, the seriousness of health concerns was not understood or well communicated by staff outside of healthcare. Different healthcare specialisms were sometimes unfamiliar with practice in each other's domains; for example where a GP surgery and a mental health service lacked awareness about safe prescribing of a particular medication for an individual who was pregnant. In one SAR, multiple shortcomings were identified in how healthcare was monitored:

> "Delayed identification of medical deterioration or increased risk, delays in seeking specialist care, delays in following up specialist care referrals and on occasion delays in effectively implementing specialist advice, contributed to the circumstances that led to the poor quality of care in some instances subject to this review."

Other examples of failure to attend to health needs included:

- lack of access to health support and GP oversight
- crisis-driven responses, with individuals' only access to healthcare being in the Emergency Department
- absence of physical health checks required in the context of a particular medication for mental illness
- over medication
- connections between diabetes and eating disorder insufficiently understood
- medication prescribing errors
- medication reviews conducted only by telephone
- delays in carrying out biopsy and starting chemotherapy
- failure to identify and support an individual as a frequent Emergency Department attender
- delay in GP response to a community nurse's request for attention to an individual in poor health
- little focus on the impact of homelessness on health, in particular how medication needs would be met on discharge from an Emergency Department
- an individual's voice not heard, resulting in her symptoms being without treatment for an unacceptable length of time
- symptoms of pregnancy missed while being thought to be from a

different cause, causing delay in the individual being safeguarded from ongoing sexual abuse and delayed identification of the perpetrator.

In one case, periods of refusing food and fluids were labelled by the care home as ‘hunger strikes’ and seen as wilful rather than requiring investigation, resulting in an absence of intervention that could have prevented health deterioration.

Some SARs noted lack of attention to weight, diet and exercise:

> “It did not appear that any services were working with X to address her weight, or to support her with healthier eating and living. Actions taken to support her mobility could have been done alongside health promotion and disease prevention strategies to support her to improve her overall health. All these actions could have started earlier to enable her to move around her home comfortably.”

In two examples, health monitoring and physical examination were impeded by lack of facilities in GP surgeries. In one case, a GP was unable to examine the individual as nothing was in place to support people who needed to use a ceiling hoist and the surgery did not suggest a home visit. In another:

> “X’s physical weight was not taken in the GP surgery as they did not have the facility or capacity to weigh patients that are non-weight bearing. Instead, his parents would report a weight that they said had been taken at the Day Centre. However, the day centre did not have the correct equipment either and they were of the opinion that the GP was monitoring his weight.”

Attention to housing or accommodation needs

SARs also commented on shortcomings in how housing and accommodation needs were met, as well as in work with people who were homeless.

There were instances of unsuitable accommodation being used, sometimes for long periods and interspersed with intermittent rough sleeping, when what was needed were more personalised and trauma-informed responses. One SAR noted “*very sluggish”* referrals for more suitable accommodation even though serious misgivings about the current situation were recorded and a failure by all agencies to fully consider the escalating impact on all involved of living in a property which was so clearly unsafe, unsavoury and uninhabitable. In another

case a placement was made in ‘Bed & Breakfast’ accommodation because it was available, rather than because it met the individual’s needs; it also lacked appreciation of the risks the individual would pose to other residents.

Care and support plans lacked attention to individuals’ needs for accommodation. A thematic SAR noted little recognition of the individuals’ housing needs and lack of awareness of duties to refer or respond. Much fuller consideration of the need for supported accommodation should have been considered when making decisions about care and support needs.

> “They were likely to have met the definition of multiple exclusion homelessness yet the interaction between their housing situation and the instability in their lives was not fully comprehended.”

In another case, practitioners were seen to be waiting for stability in the lives of the individuals concerned, when in fact their lives were too unstable for them to engage with services.

In consequence, service responses tended to be reactive in response to crises and were hampered by housing instability involving frequent changes of accommodation and moves to different areas.

There were examples of missed opportunities for referrals relating to homelessness, and also lack of suitable response when referrals were made. In one case, housing and homeless hostel staff lacked knowledge of emotionally unstable personality disorder, which impeded their assessment and led to the offer of shared housing, which was not appropriate for the individual.

There was no consideration of whether he could manage in such setting or of his vulnerability to exploitation.

For people with no recourse to public funds there was an additional layer of complexity. In one case where an individual had remained homeless for a long period, poor recording had resulted in them being seen as intentionally homeless and without high priority medical needs. The SAR considers the homelessness was preventable.

A Human Rights Act 1998 assessment had been contemplated but had not taken place. Some practitioners were either unaware of the obligation to consider human rights assessments or had experienced difficulty in securing assessment and believed that they were not commonly utilised.

The SAR observes that human rights assessments should be standard practice where a person experiencing homelessness has no recourse to public funds. Finally, practitioners at a learning event for one SAR

questioned whether there is unconscious bias against homeless people and those with alcohol and drug misuse issues, with consequent missed opportunities to explore people's situation in depth.

Attention to mental health

SARs gave evidence on a range of shortcomings in how mental health was addressed. For some individuals, mental health conditions were either not diagnosed or not fully understood. There were missed opportunities to assess mental health. Examples include:

- absence of referral, despite repetitive self-harm
- absence of assessments despite a referral stating that the individual had expressed suicidal ideation and was believed to have overdosed
- an individual discharged from hospital before full exploration of their mental health and its impact on their ability to manage their physical health
- failure in primary care to identify mental health needs and suicidal ideation

In one case, practitioners assumed that poor mental health was a direct response to an individual's immediate circumstances, closing down exploration of the impact of underlying problems in their life. In another, the SAR describes the absence of understanding of the individual's mental health as "a significant gap in practice".

The impact of poor mental health was misunderstood:

"She was treated as making 'poor lifestyle choices' rather than understanding the impact of her mental ill-health."

Another SAR notes a significant gap in understanding how mental health needs were impacting on the individual's behaviour and the lack of clarity in diagnosis restricted practitioners' ability to understand and meet their needs. In another case:

> "X presented as demanding and professionals found this difficult to cope with. Not all services were aware that this was because of the impact of his emotionally unstable personality disorder (EUPD) on his ability to form relationships and social awareness skills. He struggled to engage with what professionals were trying to achieve with him, resulting in missed appointments, paranoia, anxiety, and threatening behaviour for which he was at times arrested. Some agencies had limited understanding of

EUPD and its impact."

The risks of self-harm and suicide were underestimated and even where suicidal ideation was recognised risk management responses were limited. In one case, the focus on the individual's drug use obscured her serious suicide risk. In others, the mental health risk assessment was insufficiently focused on the individuals' autism or, in one case, on its combination with borderline personality disorder. The needs of people with Autistic Spectrum Disorder (ASD) sometimes went unrecognised:

> "A greater sensitivity to the impact of ASD on the individual should have initiated a more thorough discussion of the relative importance of psychiatric treatment and autism-sensitive responses in relation to the adult's care. It is arguable that the focus was for too long on pharmaceutical responses to his psychiatric diagnosis at the expense of exploration of his autism-related needs."

In some cases, assessment of the need to admit to mental health hospital under the Mental Health Act was not conducted, despite in one case multiple referrals. In another case, practitioners believed that the individual's problems arose from her alcohol addiction and that she was therefore exempt from consideration under the Act. In another, there was no immediate mental health crisis response from either the police or the home treatment team when an individual in acute distress threatened his family. The absence of Mental Health Act assessment was described as a "significant omission."

Where assessments of mental health were conducted, they were sometimes noted to be less than thorough, resulting in missed opportunities for risk management planning. One SAR notes that an individual's rights under the Act were not explained to them; another comments that the process of gaining entry under s.135 of the Act was not well managed.

Even when needs were recognised, they were not always met, with individuals discharged back to primary care and an absence of GP follow up. Some SARs noted therapeutic support was missing. A psychiatrist rejected a request for therapy as not being appropriate until the individual was more settled, which was unlikely to be achieved until he had received therapy. In another case, no treatment plan was in place:

> "The mental health trust did not consider strategic, long term, planning for X to be able to function within the community. The focus was on her behaviour, rather than the impact of the

> trauma, mental illness, and substance misuse on her ability to care for herself. This meant that X was trapped in a cycle of self-harm, assessment, emergency treatment and discharge, without a clear plan for how she could escape the cycle."

Intermittent responses of this kind were common, despite recognition of complex needs and deep-seated trauma. In several cases, long-term mental health support was not provided. There were examples of cases closed by mental health services without risk assessment while the individual was still actively suicidal. In one case where two individuals had been discharged from detention in hospital and were entitled to aftercare under s.117 of the Mental Health Act, there were no written care plans as required by both national guidance and local procedures. In another case, disagreement over whether a s.117 plan was meeting an individual's needs were not resolved due to missed opportunities for formal review. One individual's Care Programme Approach Plan was described as "neither robust nor consistent". The plan recorded:

> "contradictory observations about the level of his deterioration and his mood or level of engagement. Plans that were agreed were not always implemented (especially relating to the frequency of visits to check on his welfare). Days became weeks, which became months before he was seen by a mental health practitioner. This is not the standard of care that was required."

Attention to mental capacity

Determining whether an individual has mental capacity to make decisions is a central element of practice; the outcome of capacity assessment plays a pivotal role in determining the future direction of intervention. In the SARs included in this analysis, determinations that an individual had mental capacity sometimes meant that services 'walked away' without further consideration of their ability to keep themselves safe. Yet there were many practice shortcomings in how capacity was addressed. They fall into distinct themes: (i) situations in which consideration of mental capacity was absent and (ii) situations in which capacity was considered but poorly addressed.

Capacity receiving insufficient attention

In multiple cases, SAR reports noted that capacity assessments had not taken place in circumstances where they should have been expected.

> "There are no references to assessment of mental capacity -

> despite X and Y's dependence on alcohol and X's head injury. Executive capacity not considered and assumptions made about capacitated decision making. X's health records note alcohol dependence syndrome which numerous SARs have noted as an indication for MCA assessment."

The absence of assessment is attributed to a number of factors. The SARs provided evidence that knowledge of mental capacity amongst staff in some agencies was variable. Some agencies were not aware of their responsibilities to complete capacity assessments and others lacked confidence in doing so. At times, there were disputes between practitioners from different agencies about who should undertake an assessment, reflecting lack of clarity and understanding about the status of decision-maker. In one case, a money management service, community safety team and support agency reported that they did not undertake capacity assessments but relied on Adult Social Care to undertake these, despite the money management service reporting that a lack of capacity assessment related to finances was a hindrance to their work with the individual. In some cases, practitioners failed to recognise the impact of acquired brain injury or developing conditions such as dementia on capacity to make decisions, as well as the impact of substances that could cause capacity to fluctuate. In other examples, practitioners relied on historical information about whether the individual was judged to have capacity, rather than conducting a decision-specific and time-specific assessment about the decision in hand. In other cases, decisions that capacity should be assessed were simply not carried forward into practice, with no rationale for the omission. In a number of cases the SAR comments that practitioners placed undue reliance on an assumption of capacity.

> "The review found that mental capacity obligations and powers were not employed robustly, and that capacity was assumed by practitioners when X's behaviour indicated that a full assessment could be of value."

> "Too much weight was given to an assumption that X had the capacity to make decisions about how she operated within a world of drugs and sex work."

Sometimes this assumption was based on the individual's presentation, despite knowledge of factors such as psychosis, cognitive impairment or dementia that could call capacity into question and justify an assessment taking place. There was also evidence of assumption of capacity in one aspect of decision-making being applied to other, more complex decisions:

> “While he was most likely capable of day-to-day decision making about his care, his ability to comprehend and anticipate risk may have been compromised, suggesting the need for increased professional awareness of these issues in relation to mental capacity.”

Assumption of capacity was sometimes linked to a misinterpretation of the third principle of the Mental Capacity Act, that a person is not to be treated as unable to make a decision merely because they make an unwise decision. One SAR refers to the erroneous belief that this is tantamount to a right to make unwise decisions, creating uncertainty about what interventions may be possible to respond to unwise decisions that place individuals in situations of extreme risk. Even when uncertain, practitioners did not assess:

> "In three of the four cases there is a record of questioning the adult’s capacity in the context of an apparently unwise decision but there is no evidence of a mental capacity assessment.”

The unwise decisions principle also underpinned practitioners’ conclusions in some cases that an individual’s behaviour arose from a ‘lifestyle choice’ – a concept applied in a range of circumstances including self-neglect, drug use, sex work and alcohol dependency.

In some cases, the assumption of capacity appeared to have been reversed into an assumption of lack of capacity – practitioners concluding from an individual’s presentation that they lacked capacity, without carrying out an assessment. One SAR observes “there was an assumption of a lack of capacity rather than one of capacity”. Another notes that it was assumed by all involved in the case, rather than being assessed, that the individual lacked capacity, quoting one agency response “X was deemed to not have capacity; a full capacity test was not necessary on this occasion as X was conveyed to hospital”. The SAR notes that “such global statements are not compliant with the Mental Capacity Act 2005”. In a further case:

> “There was no reflection in the assessment of his needs of his capacity related to personal care, emotional and physical wellbeing, communication and links with the community and how his capacity needs would impact on the completion of the set goals. There was no discussion about undertaking a mental capacity assessment regarding the decision to take medication prescribed by a consultant psychiatrist. In many circumstances, it was accepted that X lacked capacity without a formal capacity assessment and that his parents were acting in his best interests. This evaluation did not meet the requirements of the

MCA."

Ceding decision-making to parents was noted as poor practice in a further case:

> "Professionals mistakenly gave parents the power to make the decision for X. X does not appear to have had a voice in this decision and there is no evidence that a mental capacity assessment was done."

Other SARs found evidence that medically authorised covert medication to have been given without record of any mental capacity assessment or best interests decision. A further reason for an absence of capacity assessments was the failure to recognise the role of executive function in decision-making. An individual's articulate, verbal presentation may give no cause to question capacity, yet their inability to follow through on stated decisions demonstrates potential loss of executive function, potentially making it difficult for them to follow through on decisions about safety or follow advice given about handling risky situations. In two examples:

> "Rather than presume X's mental capacity to make specific decisions, the concept of executive capacity needed to be understood and how X's adverse childhood experiences, trauma and 'enmeshed' situations affected her decision making."

> "There was a need to understand the impact that X's health conditions, alcohol dependence and prior head injuries had on his motivation and executive capacity. On occasion he was told to 'just stop drinking'."

Finally a number of SARs noted insufficient attention to the impact of coercion and control on an individual's decision-making and ability to freely express their wishes. While decisions made under the influence of a third party would not of themselves constitute a lack of capacity within the meaning of the Mental Capacity Act, exploration of relationships was believed to be an important component of understanding an individual's decision-making.

One review concludes that the absence of capacity assessments in the case was because practitioners believed they would not be able to conclude the individual lacked capacity within the meaning of the Mental Capacity Act because their decisions were affected by coercive and controlling relationships.

The SAR reflects that what this missed was the impact of an underlying lack of capacity in relation to the relationships themselves. One SAR sums up the complexity of factors that can lead to an under-emphasis

on capacity:

> “All three individuals were assumed to have mental capacity to make decisions and choices, their choices appear to have been seen more as lifestyle choices and the context of these not fully understood. The influence of alcohol use was not explored, nor that of brain damage. How addiction or brain damage affected 'executive function' was not considered. The impact of the coercion of others on decision making was not understood.”

Capacity considered but poorly addressed

In addition to the examples above of situations in which mental capacity was neglected, the SARs found shortcomings in how it had been addressed when assessments had been carried out.

One SAR presents evidence that practitioners found these assessments challenging, commenting on the breadth of factors such as fluctuating capacity, executive capacity and impulse control that needed to be taken into account. The impact of this range of factors on individuals’ decision-making was sometimes not taken into account when capacity was being assessed. SARs note a lack of consideration given to the impact on capacity of cognitive impairment, trauma, mental health, substance use and coercive control. Some assessments focused on discussion of the individual’s decision (for example in terms of keeping themselves safe), omitting consideration of their ability to carry that out when they needed to do so. One report observes that practitioners who assessed the individual’s mental capacity needed to consider not only whether she could understand and retain relevant information but also whether she could use or weigh it.

> “Complex clients with repetitive self-harming behaviours may be able to understand and recall information about the risks associated with, for example, going home and keeping themselves safe, but will be unable to use that information to keep themselves safe.”

Fluctuating capacity was a particular challenge. One report notes a lack of clarity from professionals about how to address the fluctuating capacity of people who are alcohol dependent/intoxicated. Another SAR observes:

> “Fluctuating capacity was considered but lack of understanding in the interpretation of X’s differing presentation meant that its implications were not understood and professionals ended up disagreeing about the extent of the issues and threat posed.”

One feature noted in several SARs was the absence of best interests

decision-making following assessments that the individual lacked capacity. As a result there were no full risk assessments or safeguarding plans to meet the individual's best interests. In one case:

> "There was considerable evidence that the parents were not always acting in X's best interests despite their care. A meeting called to discuss the concerns arising from his mother's overdoses and threats to kill him did not address the issue of X's best interests and no further best interests meetings were considered or held."

In another, no recourse was had to the Mental Capacity Act when family members were disputing treatment plans. Best interests decision-making was lacking and there was no application to the Court of Protection for resolution of the matter. In other cases also Court of Protection applications were either not considered or were delayed.

In some cases there was confusion about the use of Deprivation of Liberty Safeguards. A mental health team's response to an individual objecting to his placement in a care home was to refer him for authorisation of the deprivation of his liberty that would be needed if he was to remain there. Yet he had not been assessed as lacking capacity to make decisions about his care and accommodation. In another case an application for deprivation of liberty authorisation was not pursued, despite the fact that the individual was not free to leave his flat and was under continuous supervision, monitoring and control. In addition, an application for authorisation was a recurrent agreed action from two meetings. The SAR notes that had it been pursued:

> "X would have had a 'voice' as part of the assessment and best interest discussions, and potentially an advocate to enable a focus on his past and present wishes."

The individual's voice was sometimes not heard, compromising the extent to which their wishes, feelings, beliefs and values could be ascertained. One report observes that information was not given to the individual in a way that she could understand, in a failure to observe a key principle of the Mental Capacity Act. Several SARs refer to a failure to appoint an Independent Mental Capacity Advocate.

Legal literacy

Finally, shortcomings in relation to how an individual's wishes were observed were noted. In one case involving the presence of someone with lasting power of attorney, practitioners doubted whether the individual would have had the mental capacity to confer that power. In

another there was confusion about whether an advance decision covered the treatment that was being proposed, the treatment then being given in possible contravention of the advance decision.

Some SARs noted poor use of legal powers and duties, including in some cases a failure to consider possible legal interventions and in others legal rules poorly applied. Examples of poor legal literacy included:

- assessments did not make reference to eligibility for aftercare services under s.117 of the Mental Health Act or specified which aspects of the individual's care fell within this defined category
- poor understanding of the statutory role of Nearest Relative in the context of the Mental Health Act
- muddled understanding of the distinctions between next of kin, lasting power of attorney and appointeeship, leading to missed opportunities to identify financial abuse as a significant safeguarding concern
- practitioners confused regarding section 44 of the Mental Capacity Act and section 42 of the Care Act, with some assuming the former replaced the latter
- no human rights assessment that may identify if an asylum seeker has recourse to public funding
- lack of awareness of provision for transition assessments in section 58 of the Care Act
- Section 179(2)(f) Housing Act 1996 (requiring advice and assistance on housing and homelessness to people with mental illness) overlooked
- Section 136, Mental Health Act powers not used appropriately and with questionable judgment
- uncertainty about whether allegations of crimes could be reported to the police without an individual's consent, leading to delays and loss of evidence
- differing interpretations of the Homelessness Reduction Act 2017
- no legal advice sought about the potential financial exploitation of a person for whom the local authority was a court appointed deputy
- no consideration of the use of inherent jurisdiction
- little clarity over ordinary residence rules

- poor understanding of the legal framework for transition from children to adult services
- lack of legal literacy regarding homelessness legislation and entitlements
- the placing of a high threshold on access to care and support assessments
- lack of knowledge and understanding of duties within the Mental Capacity Act.

A number of SARs noted a lack of clarity about what constituted care and support needs, and a lack of awareness of section 11, Care Act, requiring assessment without consent in certain circumstances, including where risk of abuse or neglect is present. In one case, practitioners seemed unaware they had a power to meet *any* care and support need (beyond those seen as eligible) (section 19, Care Act 2014). In another, the section 19 power to provide care and support services urgently, prior to assessment, was not understood.

The legalities around disclosure of information posed some challenges, with uncertainty about when information could be lawfully shared. In several cases, practitioners had believed that a safeguarding referral could not be made without the individual's consent, and that a lack of consent prevented all information being shared. In a case in which a young woman risked HIV infection from a partner known by agencies to be HIV+, a decision not to disclose his status to the woman was made without legal advice or consultation with medical experts.

> "The decisions not to disclose key medical information was made by professionals who did not fully understand the issue, or the options available to them, as a result their decision making was based on ill-informed information and personal opinion."

In one case the SAR notes a need for a better understanding of the interface between mental capacity and mental health legislation, including of when mental health legislation can be used in the context of drug and/or alcohol misuse, of assessment of executive function and of the impact of duress/coercion influence on decision making.

One SAR notes the real challenges that lay in the practical application of the complex legal framework encompassing wellbeing, care and support, human rights, choice and control, and safeguarding, and observes that practitioners took a simplified, standardised position: "Practitioners believed 'any imposition of care [was] an infringement of their rights".

Substance misuse

SARs found evidence of shortcomings in the approaches taken to substance misuse. Attitudes to alcohol use were sometimes coloured by a lack of understanding of the role of alcohol in the individual's life and an assumption that drinking was a 'lifestyle choice'. In one case little consideration was given to how it impacted on the individual's ability to coordinate her life, and to make and keep appointments. In another family members understood how using drugs was a form of self-medication for the individual, but this was not considered by practitioners involved. In many cases there were limited attempts to understand the causes underlying the use of alcohol and the trauma that it responded to. One mother felt her son was judged - seen only as a drug user with a criminal history rather than supported to address his mental health and substance misuse and to be a father.

Practitioners frequently experienced challenges of engagement, but assertive outreach was sometimes not used, resulting in a loss of contact. In one case an individual's drug use was not explored with her through a wish to avoid conflict, resulting in a lack of effective challenge. Some cases were quickly closed by substance misuse services, in one case after just one missed appointment. Responses could be narrowly framed:

> "X's care was medicalised, reactive rather than preventative, not personalised or strengths-based and not dynamic in its attention to who he was, his health needs beyond mental health, his previous experiences with the police and his capacity to make decisions about his medication and his use of cannabis."

In some cases, wider risk assessment was missing, for example of the potential effect of substance use on other medication. There was poor understanding of how substance use and mental health were interrelated, and of the impact of long-term alcohol dependency on executive brain function and therefore on mental capacity. Operational understanding of the impact of addiction upon decision-making was lacking.

Drinking became normalised, in that it came to be the individual's expected and accepted behaviour. In one case, while the individual was in hospital there was no discussion about dependent drinking or exploration of the support of substance dependent services. In several other cases there were limited attempts to increase motivation to seek help. Understanding of addiction and responses to alcohol dependency were also limited. One SAR comments that no 'harm reduction' approach was attempted, despite the individual making it clear he did

not intend to stop using drugs.

Another SAR expressed concerns about detoxification at home, which to be safe and effective needs there to be trauma-informed support also in place. Agencies here did not understand the need to support the individual undergoing home detoxification, or the need understand and respond to the impact of detoxification on physical and mental health.

Transition

A number of SARs found shortcomings in the ways in which practitioners supported young people's transition from childhood to adulthood. Sometimes this was through an absence of assessment and planning; one SAR comments that arrangements for ending Education, Health and Care Plans were not robust. Another notes slow responses from the services needing to become involved:

> "X's transition to adult services was poorly managed, in particular the response from the Adults Learning Disabilities Team was slow, leaving X without support for crucial early weeks in adulthood. She was discharged from the service for non-engagement even though difficulties in engaging her should have been known and managed in a more personalised way."

One SAR comments on a lack of awareness of provision for transitions assessments under s.58 of the Care Act 2014. In one case the SAR observes that broader assessment by the local authority's Preparing for Adulthood Team could have identified other ways in which a young person's social needs could be met in ways that made him less vulnerable to 'friendships' and mate crime. Another refers to a lack of coordination in preparing a young person for the transition to adulthood, with significant delays in assessments and missed opportunities to attend to known needs such as compliance with medication, self-harm, vulnerability to exploitation from others and risky sexual behaviour. In another case, a young person had not been looked after by the local authority for long enough to be eligible for enhanced leaving care services under the Children Leaving Care Act 2000, but the SAR comments that under s.24 of the Children Act 1989 he should still have been supported as a care leaver.

Transition sometimes meant a reduction in levels of support and the focus was on practical support and activities of daily living, rather than the need for safer decisions. In one case, the number of visits reduced, working on the basis of standard 'leaving care' practice rather than the individual's needs. As a result they experienced a period of instability unsupported. Another SAR comments:

"Transitional safeguarding approaches recognise the influence that past experiences have on present behaviours and challenge the assumption that just because a young adult is safe they do not need any additional support to help them to adjust to adult life."

In another case there was poor transition from child and adolescent mental health services to mental health services for adults. Transition planning did not start early enough and lacked cohesive planning to ensure she was safeguarded, and adult safeguarding were not involved in post-18 safety planning. A further SAR comments on an apparent absence of clear pathway into mental health and substance misuse service, and a lack of focus on prevention.

One case in particular illustrates the multiple challenges for young people who are moving on having been looked after by the local authority. The SAR followed a young woman's suicide and provided powerful learning about transitional safeguarding in the context of complex and multiple behavioural, mental health and drug dependency needs.

- Looked after since the age of 10, there were no assessments to evaluate whether family reunification (which she desired but her mother opposed) was possible or appropriate, "leaving the predictable cycles of conflict and rejection to play out". "The corporate parent effectively abandons some care-experienced young people to further crises and rejection when they do return home, compounding their trauma and escalating their distressed behaviours, including self-harm."
- Her move to her first adult placement took place without assessment of her needs or sufficient information being shared. There was a mismatch between what the provider could offer (the promotion of independence) and the reality of the young person's situation.
- She left care "with no tangible evidence of her time there, no relationships or life story book".
- Her care leaver pathway plan took no account of her escalating needs.
- She had an ever-changing group of social workers, as well as different care staff, alcohol treatment workers, community mental health practitioners, psychologists, psychiatric staff and psychiatrists, probation staff, ambulance workers and police officers. "It is impossible to work out how many professionals she came into contact with over a four-year period, but it is likely

to be well into the hundreds."

- She left her first adult placement with no transition plan and no continuity of staff. "In placement 2 she had to start again, forming new relationships without any connection to the past."
- When she left, she never saw any of these people again. "There were no photos and no memories, no connecting biographical details, which might have made her feel part of something with relationships and connections."
- In placement three, she had to start yet again, new relationships without any shared collective memory of her last nine years or her family past. "No professional had a picture of that past, nor noticed its absence."
- She experienced deep feelings of rejection and abandonment throughout her young life. She talked of being lonely and alone. "It should have been possible to keep connections, build a story of her life, share memories, maintain relationships, build new relationships and see the routine collection of biographical detail as a critical part of helping her understand her connections."

Hospital discharge

A different form of transition, hospital discharge was clearly a pivotal point at which shortcomings in practice were also identified. One key finding across a number of SARs related to an absence of planning, and an absence of key processes that could affect the outcome of discharge. Examples include:

- failure to assess for care and support needs and safeguarding needs, resulting in no discharge plan supported by Care Act duties
- failure to assess mental capacity in relation to discharge, despite evidence of concerns from both professionals and family members
- failure to consider fire safety needs in the home environment
- absence of assessment by occupational therapy
- no account taken of equipment needs
- discharge to inadequately adapted housing
- discharge to accommodation that had been assessed as unsafe on admission

- discharge to unsuitable accommodation with insufficient oversight and lack of clarity on how compliance with medication would be monitored
- discharge into a severely cluttered home environment
- discharge to family care without consideration of their ability to manage and without carers' assessment
- a Community Treatment Order discharged despite contraindications
- absence of risk management, including contingency planning for failure to attend out-patient follow-up
- poor recognition of how care needs had changed during hospitalisation, resulting in an inadequate care and support package being restarted on discharge
- necessary services in the community not available soon enough, resulting in deterioration
- lack of attention to potential eligibility for continuing care funding
- particular challenges where the patient and family are taking personal responsibility for post-discharge arrangements.

In some cases, the individual was not involved in discussions about discharge and evidence of person-centre planning was missing. In one case, discharge discussions had included people from the individual's network who would not be reliable in terms of risk management. In another, there was a failure to plan for complex needs:

> "X was discharged home from hospital without a multi-disciplinary discharge planning meeting taking place. The hospital was aware that safeguarding referrals made at the time of his admission were subject to a Section 42 enquiry that had not yet been completed. His sisters were not involved in the discharge process, and he arrived without a frame, looking unkempt, and in a hospital gown. There was no communication with them about his needs and no-one came to assess him at home."

In another case lack of risk assessment in relation to the needs of a mother and son, discharged from acute and mental health hospitals respectively, led to unnecessary risks and lack of suitable support.

In other cases follow up care was sometimes not arranged. A patient on leave from mental health hospital as an informal patient was not referred to Adult Social Care for care and support needs assessment, no notification was sent to their GP, no referral made to the community

mental health team and no notification sent to another agency that needed to know about the discharge. In a further case, substance misuse services that were part of the discharge plan did not materialise. In another, safeguarding needs were not addressed:

> "During the final repetitive cycle of self-harm, hospital admission and discharge, good practice would have been for X not to be discharged without a safeguarding referral and multiagency plan to address how to keep her safe from the exploitation."

Another SAR observes that 'fit for discharge' is not the same as 'safe for discharge'. Discharge plans did not work effectively for homeless people without an address to which they could be discharged. One SAR comments that ordinary residence rules should not prevent an individual accessing emergency housing on discharge from hospital. In one case an individual was viewed as 'low priority' for accommodation, despite being discharged from detention under s.3 of the Mental Health Act and eligible for aftercare under s.117 of the Act. Another individual, who prior to admission had been living in temporary supported accommodation and still required this, was discharged to his mother's address, rendering him effectively homeless and without the support he needed to remain independent. He subsequently was moved to an independent flat when nothing had changed to remove the need for supported housing. A further individual was discharged to the street. Although this section is primarily about hospital discharge, one SAR is critical of an absence of discharge planning for discharge from prison also.

Risk management and assessment

Multiple SARs noted shortcomings in relation to risk. Absence of risk assessment was a common theme, with examples across a range of services:

- lack of due diligence in a care home's risk assessment relating to use of a bed rail
- failure to assess suicide risk in hospital, despite evidence that the individual tied ligatures
- risks of pressure ulcers from failed equipment not recognised
- the implications of coercion and control not integrated within risk assessment in practice
- lack of risk assessment in primary care, despite concerns expressed

- lack of attention to gaslighting and vulnerability in an individual's accommodation
- failure to recognise the interface between self-neglect and neglect by family carers
- lack of assurance around infection control and prevention measures resulting in the living environment being unsafe
- no comprehensive risk assessment undertaken when an individual was not eating, refusing support with incontinence and not taking medication
- failure to appreciate the seriousness of the risks being faced
- practitioners' reliance on individuals' self-report when refused access to their property
- failure to seek information from other agencies when undertaking risk assessment
- poor recognition of certain aspects of risk, for example, self-neglect relating to health needs not identified within an overall picture of self-neglect.

Risk assessments were sometimes static rather than dynamic and were not regularly reviewed when an individual's circumstances changed. Examples include:

- lack of reappraisal of risk when a young woman returned to live with her family
- lack of risk review following cancellation of a care and support package
- risk of violence within the family not considered when an individual returned home following prison release
- failure to recognise that in the context of the COVID-19 pandemic, pre-existing risks could be exacerbated by isolation and restrictions.

There were multiple examples of failure to recognise fire risk. In one case, a risk assessment was carried out but did not cover fire, and no referral for a home fire safety visit was made. While fire risk in the housing block as a whole had been assessed by the tenancy management organisation, it had not included fire risk in individual properties. In another case, fire risks were not recognised in the risk assessment, despite the individual presenting a high risk of deliberate or accidental fires, having repeatedly threatened and actually set fires, and repeatedly smuggled smoking materials into wards when in

hospital. In another example:

> “Practitioners were aware that X was a heavy smoker, and of her physical and cognitive decline, but missed opportunities to identify and respond to the risks that this posed to X and others living in the accommodation block.”

Shortcomings in addressing risk of suicide also featured in multiple SARs, with failure to piece together multiple indicators common:

> “The risk of suicide was not fully understood in either case. Both said they had no suicidal intent but risk factors were present: they both struggled with emotional control; they had been looked after children who had survived adverse childhood experiences, perhaps as a result they used drugs and alcohol, lived nomadic lives with few fixed points and had little stability, economically, socially, or of accommodation. Both had experienced recent and ongoing trauma through loss of loved ones and friends, relationship breakups, homelessness and physical and sexual assaults. Both had made previous suicide attempts. These factors could have been fully appreciated through history taking and information gathering.”

In some cases, there was a failure to appreciate cumulative risk, where combinations of risk features that in themselves were not acute but together added up to a much higher-level risk. Where responses to risk were episodic in times of crisis, the disjointed nature of involvement could hide the totality of the risk picture. Incidents of different kinds, such as Emergency Department attendance, hospital admission, refusal to allow carers in, declining medical appointments, could fail to be seen as part of an overall picture. In cases involving multiple types of abuse and neglect, one form could overshadow another, as in a case where domestic abuse was overlooked because the focus was on other safeguarding needs. In other cases, risk was downplayed on the grounds that the individual had made previous threats but never acted upon them.

There was some evidence that risk could become normalised:

> “X was in frequent contact with a number of agencies, making 41 999 calls in the eleven months prior to his death. This, combined with his alcohol use, appeared to result in the normalisation of risk, missed opportunities to identify self-neglect and the risk of harm from others and the inability to see him as a whole person or to recognise how vulnerable and isolated he was.”

Some SARs noted that risk assessment had taken place but no action

had been taken to mitigate it. In one case it was unclear what risk mitigation action had followed the MARAC process.

In some cases, risk that was recognised as serious should have been escalated but was not: “The carers did not take responsibility to escalate the deterioration in her condition over the hospital admission/discharge process to a field supervisor.” In another case where there was believed to be a high risk of suicide but assessment under the Mental Health Act had not resulted in hospital admission, the SAR observes that escalation to a high-risk panel should have taken place.

In a further case involving delay in the provision of appropriate mental health care, there was no consideration to how risks were to be managed in the meantime.

One SAR outlined shortcomings in how police welfare checks were used. Two requests for checks were declined and a decision that he be recorded as a missing person was cancelled. Uncertainty existed amongst the professionals requesting the welfare check as to its purpose, including when it would be appropriate to request one and the information that should be presented to make the case that the risk of immediate harm existed.

Staff within the police contact centre only conducted a cursory risk assessment of the information initially provided and did not fully explore the nature of the individual’s vulnerability.

The caller’s concerns were not fully explored and the police information systems were not researched to review what was already known about the individual. The method of police contact was through the ‘Live Chat’ service, an instant messaging forum; the SAR observes that the absence of a professional conversation hindered the ability to ask questions and to fully investigate the concerns.

A different focus on risk was observed between Children’s Services and the service supporting a young person post-18. The SAR notes a significant change in professionals’ perception of the level of risk once the latter became involved, with no references to the possibility that the individual was a victim of sexual exploitation, or at any risk from her domestic arrangements.

Finally one thematic SAR reviewing multiple cases of modern slavery calls for better exploration of individuals’ own views of the risks they face, and of their ability to protect their own safety: "There is insufficient evidence that an adult’s capacity or, separately, their ability to keep themselves safe is routinely considered and recorded."

Safeguarding

Shortcomings in how individuals were safeguarded fall into a number of themes: (i) identification of safeguarding need, (ii) responses to safeguarding referrals, (iii) conduct of safeguarding enquiries, (iv) intervention to safeguard and (v) the impact of abuse and neglect

Identification of safeguarding need

This is essentially about failure to recognise levels of risk. A thematic review of modern slavery involving multiple victims, many of whom had routine contacts with agencies yet were not identified, notes poor levels of vigilance and lack of purposeful questioning that would have given opportunities for disclosure. Police investigations of rogue trading, seeing the workers as potential criminals, did not recognise them as victims, despite their neglected presentation.

In another case, agencies showed no concern when an individual disappeared from contact, despite it being out of character, and made no attempt to locate her or her family member and her uncollected medication was merely stored by the pharmacy. Another individual alleged twice that he had been abused by a staff member in hospital but no investigation or safeguarding process ensued as staff were unclear what the next steps should be. There were other examples in which SARs commented on a lack of practitioner understanding about safeguarding policies and criteria. In another case where the family raised safeguarding concerns with a health trust, the trust did not pass this into safeguarding as they judged the concern not warranted. In a further SAR, a young woman attended sexual health clinic when raped and disclosed she was a victim of trafficking, had suicidal intent and felt unsafe, yet the clinic made no safeguarding referral. Several SARs refer to mate crime and abuse within peer relationships with friends being poorly recognised.

Sometimes there was failure to act in relation to both adult and child safeguarding. A Domestic Violence Disclosure Panel that knew of potential risk to a young woman and her expected baby (from her partner's HIV+ status and a previous history of domestic abuse) did not refer to children's services or take active steps to safeguard the mother.

Sometimes the need for a safeguarding response cumulative risk was not recognised:

> "There were three incidents that should have been subject to advice regarding the potential for a safeguarding referral to be made, and also four incidents where there were direct threats to

> X's safety. Each incident was treated individually and was not seen as connected, or analysed in a holistic way."

Even extreme self-neglect had often not been referred into safeguarding, sometimes through lack of recognition that it was a form of abuse and neglect covered by safeguarding duties. Alcohol dependency, neglect of healthcare and self-harm were sometimes not recognised as forms of self-neglect that warranted safeguarding referral. Sex work was regarded as a choice and not the outcome of coercion and control, and domestic abuse taking place on the street was not seen as a safeguarding issue. One individual self-harmed 100 times in a 9-month period, with a steady and substantial increase across the period, yet no safeguarding referrals were made by providers, the mental health trust, the ambulance service or Emergency Department. A private hospital took the view that "this is what complex patients do", failing to recognise the need for a safeguarding referral in the face of continual and high impact self-harm.

Safeguarding was sometimes not seen as the appropriate onward referral route for risks that were known but where existing risk management strategies had not been effective.

Responses to safeguarding referrals

There were many examples of circumstances in which referrals did not result in safeguarding enquiries. Some cases were triaged out of the safeguarding pathway and referred on to case management, with its focus on need rather than risk. The same could happen if an individual was already known to Adult Social Care, resulting in the safeguarding focus being lost.

> "The safeguarding referral merged into the ongoing plan for support, and the lack of a multiagency safeguarding meeting meant that there was no discussion or analysis of the ongoing risk that Y might pose to X."

> "When they were unable to make contact, they referred her into safeguarding but the case was then transferred to the older people's team, graded level 2, which could involve a wait of up to six months."

One SAR found evidence a lack of parity of esteem given to the source of the referral, with safeguarding concerns raised by supported living staff given insufficient weight. Other referrals were merely closed as the individual was thought not to meet the criteria in s.42 of the Care Act (for example being mistakenly believed to lack care and support needs), or because it was assumed they were now in a safe place. In some cases, it was mistakenly believed that a safeguarding enquiry

could not take place without the individual's consent.

> "Safeguarding procedures were closed each time X 'refused consent'. No strategy meetings were held as those involved with X at the time felt that her lack of consent prevented safeguarding action."

In one case referrals made over a number of years were either closed due to there being insufficient evidence or because it was believed current support arrangements were sufficient. The alleged withholding of medication by her family carer was not recognised as abuse and neglect. In another case, of multiple safeguarding referrals for self-neglect none were progressed; the concerns were either seen as a health problem or arising from use of alcohol, which the individual would not address: "all safeguarding requests were declined without any prior additional information gathering about the concerns, nor whether the concern was in fact formally assessed against the 3-stage test prior to it being declined." In other cases, the response given was not timely:

> "Although neglect was noted and formed part of the rationale for raising a safeguarding alert, this did not result in any immediate escalation of concerns or immediate action to mitigate the neglect that was clearly evident. (This was) a significant missed opportunity."

SARs were also critical of the lack of feedback to referrers of safeguarding concerns, commenting that this acted as a deterrent to future referrals and a lack of confidence in the safeguarding system. Equally they were critical of failures by referrers to follow up on a lack of feedback: "it was not sufficient to identify risk and to make referrals and then not follow-up".

The conduct of safeguarding enquiries

Safeguarding enquiries were criticised for lacking clarity and depth, or for falling short of reasonable expectations in addressing risk. There were examples in which family members were not informed or consulted. In some cases agencies failed to respond with requested information or held no records from which to give response. Some alleged providers of poor care were not interviewed. Enquiries sometimes failed to make safeguarding personal for the victim. SARs noted that information-gathering was sometimes not robust, resulting in insufficient evidence to understand the whole picture. In some cases the enquiry was prematurely closed before all features had been considered. One enquiry was noted as being unable to determine neglect, resulting in allegations being unsubstantiated. The SAR

comments that practitioners lacked understanding of how neglect might present; here there were unexplained injuries, nutritional concerns and a lack of access unless family were present but these were not recorded as neglect. In another case, skills fell short:

> "When social workers asked X about the allegations of abuse by an agency worker, he was asked a number of leading questions rather than being asked to describe what had happened in his own words."

In one case, multiple failures were in evidence:

> "The delay to the safeguarding enquiry was not acceptable. There was no clear plan or scope of the enquiry and clarity as to what actions needed to be undertaken by whom or which organisation. There was no evidence of the risk assessment and interim safety planning. There was no consideration of follow up actions that may be needed regarding the organisation or individuals responsible for the alleged neglect."

In some cases parallel processes posed challenges. A care home had to be asked to stop taking evidence from staff, as this was potential prejudicial to the police investigation. In another case, when a police investigation did commence safeguarding processes were put on hold through misunderstanding of how and when aspects of investigations/enquiries and processes could run in parallel.

Intervention to safeguard

Safeguarding enquiries did not always result in effective safeguarding plans:

> "Although safeguarding concerns were repeatedly expressed about Adult G, there does not appear to have been any formal action taken to protect her wellbeing."

In one case there was no community safety plan around an individual who was known to be subject to cuckooing. In another, a young woman was supported in a private foster care arrangement as a result of safeguarding concerns in respect of her father, but the exploitation that she experienced in fact escalated. The review attributes this to the absence of a clear framework of assessment and visiting, which limited opportunities to mitigate some of the identified risks. In another case an individual was subject to domestic abuse from both his parents, who threatened to kill him rather than allow him to be looked after by services or move to residential care. Neither parent was challenged about these threats and what they meant for the individual's safety, and the abuse was never sufficiently addressed.

In some cases, the safeguarding response addressed one form of abuse and neglect that was being experienced but not others, for example responses to self-neglect not taking account of cuckooing and criminal exploitation. Physical threats may be addressed but response to the psychological or emotional impacts of the abuse or neglect were less effective.

> "The impact of living within a violent relationship does not appear to have been explored or considered and it appears that physical symptoms were treated in isolation from the context of X's lived experience."

Other poor interventions included unsatisfactory action to attend to an individual's animals through a delayed RSPCA response and Police failure to follow up potential criminal exploitation.

The impact of abuse and neglect

In some cases, the longer-term impacts of abuse and neglect were not recognised or managed. In one case, it was thought that because the individual was moved out of area, the risks he faced were historical. The reports notes that

> "This approach fails to recognise the complexities of financial exploitation and the longer-term impacts – not only on a person's financial circumstances, but on psychological health, and self-esteem, confidence, and formation of future relationships. X may have also experienced associated risks from destitution, poor nutrition and hydration arising from self-neglect. The response failed to address the remedial actions regarding the impact and outcome of exploitation that had already taken place."

In another case, safeguarding did not consider need for recovery in family relationships after allegations and investigations.

'Think family'

SAR reports note multiple instances of practice shortcomings in relation to family involvement. There was sometimes failure to involve families, even where they were close supporters of the individual and very familiar with their needs. In one case, a failure to involve led to family members providing care in a way that caused concern, merely because the correct way had not been explained. In another, there was no communication with the family about an individual's end of life wishes. Families were not always involved in decisions following referral of

safeguarding concerns and informed about outcomes. The failure to involve also meant there was no exploration of whether family members could provide circles of support. There are examples also of concerns raised by family members not being given sufficient weight or attention.

In one SAR, individuals were deliberately isolated from their families, to huge detriment to their care:

> "In deliberately creating distance between residents and their families by mandating or discouraging contact, the possibility of synthesising what is in records with what matters in terms of people's biographies, their personal qualities and resources, social circumstances, interests and 'at home support', for example, is limited."

These and other families felt shut out from the individuals' care, felt they were blamed or their insights ignored. They needed constantly to push for involvement. In another case an individual was separated from his civil partner, who wanted the individual to return home where his care could be met. The SAR observes that practice with the couple was not personalised or creative enough in exploring how care at home could have been delivered.

One case of poor communication was the subject of judgement by the Local Government and Social Care Ombudsman, with the SAR findings consistent with this. The communication was found to lack a person-centred approach, and possibly added to the overall distress they experienced.

In other cases practitioners did not recognise risks from family members:

> "When X's self-funded care package was ended by her partner a decision was made, without any reference to concerns that she was allegedly experiencing coercion and control, that her family member could provide this care instead."

In another case, the impact of control by one family member was not properly understood or analysed because it impeded engagement and assessment of vulnerable family members. A further SAR comments on a lack of robust examination of an informal carer's suitability to act as the individual's appointee before delegating money management to them.

> "There was no consideration of the nature of the relationship between X and his informal carers, specifically whether he was subject to undue influence and/or whether he was a victim of

coercion and control."

In some cases where a family member was providing care and/or making key best interests decisions for the individual, neither their capacity to assume this role nor the impact upon them was evaluated. Family members' assertions were not always tested to establish the facts. One case refers to misplaced professional optimism in placing reliance on a family member carer. Mounting evidence of neglect was not addressed:

> "Insufficient note appeared to be taken of the accumulating evidence of neglect in terms of access to medication and medical appointments, isolation from birth family, cancellation of the commissioned care package, preventing X making the decisions she had capacity to make, failing to ensure privacy and dignity and failing to ensure that X was clothed and groomed appropriately."

There was some evidence of avoidance of difficult discussions. For example, no discussions took place with a wife who held power of attorney for health and welfare, nor was consideration given to raising concerns with the Office of the Public Guardian. In another case there was confusion over whether a family member held lasting power of attorney and reluctance to enquire about this with family.

In another case, an individual's denials of receiving abuse were taken at face value, possibly because of fear of her daughter experienced by staff. In another, the impact on an individual of domestic abuse between his parents could not be assessed due to one parent's becoming aggrieved and withdrawing from discussions.

Sometimes there was a strong sense of longstanding family dysfunction with present day repercussions, but this was not addressed.

Relationships with family members could be fractious and needed careful management.

> "All family members could be challenging, threatening and aggressive, for example towards home care staff, social workers and hospital staff. Their behaviour could be calmed through discussion. Clear expectations were not laid out by care home and commissioners regarding family involvement."

In another case, professionals were concerned that if they challenged parents about their decisions, the individual would experience detriment such as day centre attendance stopped or healthcare declined. One family member's request for anonymity when referring a

safeguarding concern about their son was breached, fuelling family tensions still further and raising levels of distrust of the local authority.

In other cases, strongly argued disputes within the family about the individual's care created challenges, one SAR noting that offers of mediation would have been helpful.

Family members' needs were sometimes not recognised and carers' assessments were not in place. In one case, this was not offered as practitioners thought the carer would decline. In another, the need for it appears not to have been identified.

> "The support X's mother was factored in as a risk mitigator in risk assessments and plans, but no carers assessment was undertaken as to how this could be sustained in the community, and no advice was given under the wellbeing duty (Care Act 2014 s2) as to who would support her and her family in this endeavour."

In one case where a carer's assessment had taken place, it was insufficiently detailed and did not take account of the parents' age and health. Nor was it reviewed annually so it did not take account of the emerging issues about domestic abuse, fractious family relationships, safeguarding concerns, ill-health, stress and depression. In another case, no support was provided to a family after an individual was found deceased.

The interrelationship between adult and child safeguarding was not well managed in some cases where children were removed from the care of a parent who had complex needs and remained very vulnerable. One SAR addresses this explicitly:

> "Approaches and options for risk management and therapeutic support are inadequate for women whose children the local authority is proposing to remove/not to return to their care, even when those women have known long-standing mental health issues, and a known history of self-harm and attempts to take their own life. This increases the risk that potential tragedies are not averted, and intra-familial cycles of trauma are exacerbated. In circumstances where children's services are initiating court proceedings, a think family approach is not adequately embedded. This means there is little chance that input from a range of adult services who know the mother feeds into planning at this stage of child protection processes. It decreases the chances of adequate compassion being shown to mothers or vital information being shared about risks of self-harm or suicide linked to their despair, so support can be provided."

Records and recording

Some SARs gave examples of poor records or recording practices. In one case, the assessment form that the assessor must complete did not contain prompts for important questions such as the individual's mental capacity and their consent to the process. Health records (both GP and hospital contexts) did not contain a flag for learning disability. Over and above these shortcoming in the recording forms themselves, shortcomings in how they were used in practice included:

- missing records on food and fluid intake
- records organised in a way that made it difficult to spot patterns an history
- minutes that are merely a verbatim collection of statements by individuals, lacking analysis
- missing reasons for case closure decisions
- brief and inaccurate records
- failure to record the individual' wishes and feelings
- recording error that resulted in an individual being placed on a non-intensive support pathway instead of Enhanced Care Programme Approach
- poor recording about risk, which resulted in a crisis team refusing to see the individual out of hours due to the level of risk being underestimated
- assessments outdated, with no mention of current circumstances
- missing records on some attempted contacts and work undertaken
- unsettling and disturbing or controlling behaviour to staff not recorded
- recording insufficiently clear or detailed, impacting on what could be shared with others
- little recording of history
- missing care plans.

Some records focused solely on negative aspects of the individual's presentation:

> "No recorded consideration of the impact on X of being in the

treatment unit, no record of consideration given to the risks patients can pose to each other in terms of emotional distress, a specific area X was struggling to manage. Instead the focus is on recording the aggression she demonstrated and the restraint required to keep her and others safe."

In other cases, risk assessments were not included in records – circumstances and behaviours were described but no assessment outcomes. Similarly, mental capacity assessments were sometimes missing despite it being recorded that the individual lacked capacity.

Domain two: Interagency working

Good practice in domain two

Detailed examples of good interagency practice could be identified in 55 per cent of the 229 SARs selected for qualitative analysis. The most common positive aspects of how agencies worked together were in communicating and sharing information across agency boundaries (found in 24 per cent of cases) and the cross-agency coordination of interagency action (23 per cent). The use of multiagency risk management panels was commended in 10 per cent of cases and good interagency safeguarding action in 8 per cent. Other aspects of interagency working drew very limited commendations, The full picture is found in the table below:

Interagency work feature	% of SARs with positive comments
Communication and information-sharing across agency boundaries	24%
Cross-agency case coordination and working together	23%
Use of multiagency risk management panel	9%
Interagency use of safeguarding/action under s.42	8%
Working across geographical boundaries	3%
Use of interagency procedures/protocols	3%
Cross-agency understanding of role/function, incl. of legal powers/duties	2%
Working with non-statutory/VCS partners	1%
Record sharing	1%
Leadership of interagency strategy	<1%
Other	1%

* Other includes good practice in cooperation between adults and children's services, establishment of a multiagency reception centre to receive and support victims of modern slavery.

It is perhaps telling that good practice was far less likely to be identified in the domain of interagency practice than in the domain of direct practice, indicating that the challenge of bringing agencies together in safeguarding remains significant. However, the examples given do

show the degree of tenacity and commitment that agencies brought to ensuring a sound multiagency safeguarding response in some cases. Turning to the in-depth thematic analysis, a number of themes emerged.

Communication and information sharing

SARs commended some good information-sharing, and other forms of communication, between agencies.

Specific examples included:

- good communication by GPs with a wide range of health providers, including mental health and specialist intervention services and pharmacies
- regular and effective communication between commissioned outreach and 'crashpad'/night shelter services and the local authority rough sleeping lead
- liaison between environmental health and social care/community prevention services
- DWP contacting key agencies to advise of an individual's benefits being stopped
- shared risk information between a social care assessor and a care home
- high level of shared information regarding health risks arising from self-neglect
- community matron's liaison with a home care provider and GP when financial abuse emerged
- a local authority finance team advising the mental health team that an individual was distressed and unhappy in the placement they had arranged
- timely advice from the MASH to a care home
- information shared between housing providers when a perpetrator was moved
- good communication between an Independent Domestic Abuse Adviser and an early help hub
- community nurses reporting a care provider's failure to deliver components of a care plan
- close communications between a hospital and community agencies during discharge planning

- good liaison between the looked after children nurse and the child sexual abuse team in relation to sexual health issues
- good liaison between hospital and community substance misuse practitioners, and between them and pharmacists and GP
- maternity, health visiting and community midwifery shared information in relation to a mother and her baby.

The examples above concern broadly routine communications that occurred as part of day-to-day practice.

One example showed good practice in more unusual circumstances, with the police commended for sharing their records with a local authority that had lost data due to a cyber attack. Good communication across local authority boundaries was noted. In one case most services collaborated in the transfers when an individual moved across local authority boundaries. In another, a housing service contacted services in different local authorities to explore an individual's eligibility for housing. A further SAR notes that a good, consistent approach was established across geographical boundaries.

Interagency referrals

SARs found evidence of good practice in how agencies made onward referrals. At times this involved identifying and referring to specialist services, as for example when individuals attended hospital following suicide attempts or self-harm with overdoses and timely referrals were made to psychiatric liaison teams. Agencies raising concerns about self-neglect, for example during ambulance attendance at properties, was noted as good practice. Other good practice examples included housing officers' annual home visits leading to referrals for home fire safety visits, energy companies raising concerns about the state of individuals' homes and a GP making considerable effort to highlight risk of domestic abuse,

In some cases SARs commended agencies for showing a clear understanding of when professional duty of care must override confidentiality. An art therapist made a referral to the police and the local authority following an individual's disclosure about an attempted sexual assault. The police were commended in a further SAR for making onward referrals having concluded that it was necessary to share the information without the individual's consent.

SARs saw the quality of some safeguarding referrals as evidencing good legal literacy on the part of the referrer in giving appropriate

information to support their concern and linking it appropriately to the criteria set out in s.42 of the Care Act. Responses to referrals were also commended. In one example, Adult Social Care gave a comprehensive response to safeguarding concerns raised by community nurses and care agencies, appropriately considering the complexity of potential familial abuse and the family's ambivalence to the input of agencies. In other cases, GPs were noted to have responded promptly to requests for visits.

Joint working

In contrast to silo-working (noted later in this report as a common shortcoming in interagency work) SARs commended agencies for working closely together, and at times jointly.

Joint visits were seen as good practice, for example between Adult Social Care and community mental health teams, a hospital social worker and an occupational therapist, a social worker and police officers, a GP and Adult Social Care. Joint decision-making on actions was also noted.

Other examples of joint working involved:

- co-chairing of a transitions panel by Children's Social Care and Adult Social Care
- evidence of good communication between the police and a local authority housing service with swift decisions and problem solving facilitated by email exchanges, meetings and joint home visits to resolve problems
- joint work by an acute trust's safeguarding team and the emergency department to identify frequent attenders and potential safeguarding issues

SARs also commended co-location as a means of working together. In one case, a local authority had co-located homelessness officers in services such as mental health teams, drug and alcohol agencies, and the Multiagency Safeguarding Hub. In another:

> "The steps taken to locate X when she went missing reflected the robust approach that is adopted when young people go missing here. A particular strength of the multi-agency arrangements is that two specialist police officers are co-located with the child sexual exploitation team. This ensures close liaison, consistency of involvement, and practitioners getting to know the children through the direct contact they have."

Multiagency risk management meetings

Multiagency meetings (MARAC) were seen as one key aspect of good practice in interagency work, with SARs commending situations in which “the right people were round the table at the right time”. The meetings were referred to by a range of different names – safeguarding strategy meetings, high risk panels, complex case meetings, community protection group meetings, transitions to adulthood panel – but all were essentially examples of agencies coming together to discuss needs, risks and risk management, with the aim of developing shared understandings and shared intervention strategies.

In one case the SAR notes that the multiagency approach to sharing information about missing persons through a Long-Term Missing Panel was innovative and commendable.

A number of SARs mention MARAC meetings as facilitating identification of domestic abuse, completion of risk assessments and referrals for early help.

Routine multidisciplinary team meetings in GP surgeries were commended particularly for their value to care home staff, reducing their time taken in contacting different teams for different residents, and enabling timely healthcare interventions for residents.

One safeguarding team held daily huddles, with an increasingly multiagency attendance, to discuss safeguarding action. In another case, strategy meetings were seen as key to the network’s ability to respond to new information and adjust safeguarding actions appropriately.

> “The high frequency and consistency of attendance at strategy meetings reflected the strength of the partnership working in considering quickly the implications of new developments in X’s situation and agree changes to the safety plan.”

A review concerning abuse and neglect in care homes notes a series of meetings (provider engagement, professionals’ meetings, and strategy meetings) to review care across the homes with both provider concerns and safeguarding meetings continuing.

It reports that the meetings had a positive effect for those attending: healthcare staff felt they became more vigilant on visits after participation in strategy meetings, encouraged to look at broader issues across the homes, not just the individual patients on their clinical caseloads.

Case coordination

Meetings were one way, but not the only way, of ensuring a further key aspect of good interagency practice, case coordination – the degree to which agencies could coordinate their respective involvements.

Multiple examples were given of good practice here, in a variety of contexts: the coordination needed to achieve safe hospital discharge; the dovetailing of primary, community and acute healthcare to meet complex health needs; a prison service coordinating a multi-agency response to homelessness, mental health and substance misuse; coordination between in-patient mental health and housing needs teams; a coordinated approach by Children's Services and Adult Services to the provision of accommodation; effective work between the police, Adult Social Care and a community matron to coordinate responses to health, social care and safety needs.

One SAR comments on "exemplary practice" between a GP, hospital trust, ambulance crew and fire and rescue services to ensure an individual's safety. Another charts "exceptional multi-agency work, led by the Police, to bring the perpetrators to justice."

One SAR found evidence of agencies working together to anticipate risks and identify responses and solutions, including across geographical boundaries.

It notes that cross-border working, for example by police forces, was timely and targeted. Another commended coordinated action in relation to a missing person:

> "The wider professionals network worked closely and collaboratively in respect of the increasing length and duration of X's missing episodes. Both X's family and the practitioners at the learning events commented positively on the strong teamwork between agencies."

A further example is of strongly coordinated safeguarding responses relating to an individual discharged from hospital into poor living conditions and domestic conflicts with another individual, in which alcohol was a factor.

A rapidly arranged MARAC meeting facilitated wider multi-agency information-sharing and information from another local authority about the individual's experience of domestic abuse led to a joint visit by an Independent Domestic Abuse Adviser service and the Domestic Abuse Investigation Unit, as well as a domestic violence protection order.

The order provided a window of opportunity for adult social care to

carry out a care and support needs assessment, with a later referral to mental health services as part of a criminal justice liaison and diversion response.

Structures to support interagency collaboration

An infrastructure to support interagency collaboration can take multiple forms, for example procedures, protocols, IT systems, team structures. A few SARs commented on the positive presence of such features, noting that clear multi-agency policy and procedures were available and had been applied.

Uses made of a learning disability support protocol, domestic abuse policies, high intensity emergency services protocol and a transitions protocol between a leaving care service and housing were all commended.

In one SAR a health information exchange (HIE) had brought together patient information from acute hospitals, primary care and adult social care, and was due to be extended to mental health providers also. In the case in question, it resulted in the individual being diagnosed with a previously undiagnosed learning disability. The HIE was one example of how interagency infrastructure can facilitate collaboration. Another commended example was a framework to manage the interface between safeguarding and care quality concerns:

> "The interface and developed framework between safeguarding and care governance within the locality was effective and facilitated clear lines of communication, information sharing, clear lines of accountability and directed the correct resource support at the right time to drive improvement and embed protection and prevention principles within the partnership. Good partnership working was evident throughout the review of this case."

Challenge and escalation

Finally, SARs gave positive examples of when agencies had given each other appropriate challenge and/or had escalated concerns about decisions or actions. In some cases, escalation was through formal channels, which proved effective in resolving matters of dispute. In others, individuals had escalated concerns outside of formal processes, resulting in positive responses. One SAR describes:

> "Robust but healthy exchange of professional perspectives

> within the strategy meetings about the rationale for the type and location of placements being considered, given that each brought risks as well as potential advantages."

A Relevant Person's Representative and a Deprivation of Liberty Safeguards Best Interest Assessor had worked jointly in challenging end-of-life decision-making by other professionals. A care home was proactive in challenging decisions on behalf of an individual, such as their involvement in consultation over Do Not Attempt CPR decision. In a case in which there had been earlier difficulties in bringing agencies together, better coordination was eventually achieved through agencies coming together in a crisis, leading to a stronger partnership in which appropriate challenge could take place.

> "Eventually there was a multi-agency response to a crisis, with an agreed lead professional, use of the safeguarding framework and MDTs, and consideration of MCA and MHA, and coordinated risk management. There followed some effective partnership working and appropriate challenge of each other."

Practice shortcomings in domain two

Despite the examples of good interagency practice noted, negative observations on how agencies worked together outnumbered positive observations by some measure in all aspects of practice. Of the 229 SARs included in the stage 2 analysis, 95 per cent identified aspects of interagency and interprofessional practice that could or should have been improved. So although interagency communication and information-sharing, and cross-agency case coordination both drew positive comment in almost a quarter of the reports, they were also the most commonly occurring shortcomings, with poor practice featuring in almost three-quarters of the SARs.

Other aspects of practice that were poorly rated include interagency use of safeguarding actions under s.42 of the Care Act 2014 (noted in 38 per cent of the reports) and the use of multiagency risk panels (in 37 per cent). In almost a quarter of cases there were shortcomings in the use of interagency procedures and protocols (24 per cent), in cross-agency understanding of each other's role, function and legal powers (21 per cent) and record sharing (21 per cent). The full list is given in the table below.

Interagency work feature	% of SARs with negative comments
Cross-agency case coordination and working together	72%
Communication / information-sharing across agency boundaries	70%

Interagency work feature	% of SARs with negative comments
Interagency use of safeguarding / action under s.42	38%
Use of multi-agency risk management panel	37%
Use of interagency procedures / protocols	24%
Cross-agency understanding of role / function, incl. of legal powers / duties	21%
Record sharing	21%
Leadership of interagency strategy	19%
Working across geographical boundaries	10%
Working with non-statutory / VCS partners	4%
Other	7%

* 'Other' includes limitations experienced in carrying out joint visits with the police (noted to be oriented towards immediate responses rather than planned ones) and social workers, for whom the wait was often long; concern that statutory and voluntary organisations did not hold parity of esteem; a lack of understanding of multiagency escalation routes; systemic interagency bias and discrimination in relation to race; cross agency failures to respond to families' concerns; failure between CQC, the local authority and the provider to coordinate whistle-blowing investigation; siloed and inconsistent governance of safeguarding across agencies - duplication, multiple IT systems; risk of a lack of objectivity in multiagency discussions when chaired by an agency very involved in the case.

How agencies and practitioners work together is an important element in the checks and balances that can keep the safeguarding system safe. Shortcomings here make it less likely that failures in single agency practice will be picked up. The SARs provided important learning about how the absence of cohesive case planning and multi-agency working, with clear engagement from all involved, affected outcomes in relation to how individuals' needs were met and influenced how effectively they were safeguarded. Turning to the in-depth thematic analysis, the detailed learning on poor practice is reported here thematically, presented in broadly the same order as used in relation to good practice above, with one or two additional themes that emerged.

Communication and information sharing

SARs found multiple examples of poor communication and information-sharing between agencies. Failures communicate and/or share information included:

- health information routinely not given to supported living staff
- information about sources of risk not shared with others by Adult Social Care

- a housing association failing to inform Adult Social Care of their intention to initiate breach of tenancy proceedings
- mental health services failing to inform Adult Social Care that they were closing an individual's case, despite Adult Social Care being the referring agency
- a memory assessment service failing to inform a GP of missed appointments
- agencies not sharing written communications from the individual with other agencies involved
- poor information sharing between agencies on domestic abuse matters
- lack of information-sharing by mental health liaison
- information about an individual's mental health history not shared between their GP, A&E, midwifery and mental health services
- evidence of unsafe smoking not shared with the fire and rescue service
- hostel staff at the hostel in which an individual subsequently committed suicide not being informed that she was known to be at risk of suicide
- poor information sharing in the transfer of information about an individual's needs from one placement to another and its ongoing availability in the system during the placement
- information about the state of an individual's house not shared across agencies
- despite multiple police alerts mentioning poor mental health, no reports were passed by Adult Social Care to mental health services
- missed opportunities to share information between agencies in the context of s.117 aftercare and care programme approach involvement
- lack of information-sharing about development of pressure ulcers
- care plans not provided in full to care providers
- the probation service not receiving submitted police alerts about an individual's safety
- a hospital social work team unaware at times an individual was

homeless, leading to decisions being made without all relevant information

- a GP unaware for three months that an individual had been discharged from hospital
- housing staff with lengthy records evidencing an individual's deterioration not raising these in a timely manner with his care coordinator, on one occasion waiting several weeks
- information from a care home to a GP raising only presenting acute health problems without focus on holistic health.

Sometimes information that was known to some was partially shared without clarifying a complete picture, or communications omitted a key agency. Adult Social Care, for example, advised a GP that an individual's mental health might need review but did not indicate that she was at risk of abuse/neglect. Information about risks posed by an individual were not shared with a housing needs team, leading to an inappropriate placement. Information was not shared with the police regarding an allegation that a woman with no capacity to consent to sexual activity was thought to be pregnant. A probation officer was not included in risk assessments following a domestic abuse incident. A GP was not invited to a key meeting and no active attempt made to engage them.

Sometimes information was not fully shared because it was thought to be highly sensitive. In a hospital's discharge letters, for example, little information was shared about concerns and risks because it was believed letters would be seen by the individual's wife. In another case, the SAR notes significant missed opportunities for better communication between commissioning CCGs, a private hospital and the local authority; in particular this related to safeguarding concerns both raised and not raised, the normalisation of very high levels of concerns and the CQC not following up on the provider's failure to make changes.

Several SARs highlighted uncertainty amongst practitioners about whether and when information could be shared without the individual's consent. This seemed to arise from misunderstanding of data protection law and a failure to recognise that lack of consent can be overridden in certain circumstances.

One case, in particular, illustrates how multiple failings can accumulate. A family with a severely learning disabled adult daughter moved to a new location, but no information regarding the daughter's care and support needs was transferred, nor was any information shared about the mother's historic and continual inability to meet her daughter's

needs. The new GP surgery did not receive whole life medical records, despite chasing them on multiple occasions, so were not aware that she was learning disabled or had been neglected. No education records were provided. When the daughter did come to the attention of the new local authority (through police information about her being bullied) they were told she'd had a social worker in another local authority area. They could have made enquiries at this point but did not. Children's services in the new area were already involved in the family due to concerns about the children of another family member. They invited adult social care to a meeting, but adult social care did not attend. Nor did they respond to a referral from children's services, which contained information that would have lent more urgency to their eventual visit and also have led to a more proactive response when they were later denied entry.

The consequences of these failures were often damaging to work being undertaken with the individual. With no information-sharing, no agency had a holistic picture; individuals' history was not known to those taking action, significant increases in levels of risk were not fully understood, risk assessment and management plans were not updated. The level of complexity in individuals' circumstances was not recognised, thresholds were assumed not to be met, and opportunities were missed to complete accurate assessments or to make appropriate referrals elsewhere.

In one case where the family had reported care quality concerns to a best interests assessor during the Deprivation of Liberty Safeguards process, the failure to pass this on meant a missed opportunity to take preventive action:

> "If this information had of been effectively shared from the DOLS framework to the safeguarding or commissioning service, this may have acted in some degree as a preventative measure to safeguard X."

Failure to share information prior to hospital discharge in another case meant that concerns about the son as carer were not evaluated. Another SAR found that absence of information-sharing meant there was no primary care involvement, a key omission in the context of the individual's needs.

In another case, agencies lacked significant information about the condition of the adult's property, limiting consideration of intervention options. A housing officer had little information about how risks were perceived and was dependent on information from the individual. In another case Adult Social Care's response to alerts from care workers

concerned about a mother's perceived threats to her son was affected by not having police information about a previous criminal charge (subsequently dropped) of attempted murder on his life.

Sometimes the poor information-sharing and communication were between different branches of the same organisation. Commonly named here were adult and children's services, both within the local authority but noted as failing to communicate effectively together or to ensure that information was passed from one to the other.

In mental health services, care coordinator handovers were noted to lack detail. Similarly in the hospital context:

> "When X was transferred to another ward, information was not shared about the stress of the recent abuse that she had suffered. This meant that a clinical judgement was made to place her on a low level of observation without having the full information about her situation."

Communication is a two-way process and in some cases shortcomings related to a failure to proactively seek information from other agencies. In one case Adult Social Care had consistently failed to gather information from other agencies to inform their own involvement. In another, the SAR is critical of the commissioning agency's failure to work with a service provider to ensure that a care package was meeting the individual's needs. There was limited communication between hospital-based and community-based occupational therapists.

Geographical boundaries also inhibited good communication. One SAR describes how discharge planning was impacted by cross border issues; another observes that little liaison took place once an individual had moved across local authority boundaries. Another details the challenges for some agencies, for example in prescribing medication and navigating across substance misuse teams, when an individual moved between local authorities. In another case the SAR records lack of reciprocity and cooperation in the context of a cross-boundary placement. Whatever the cause and whichever agencies were involved, it was clear that poor information-sharing and communication led to a lack of openness, transparency and trust that could severely affect onward collaboration.

Interagency referrals

A more specific element of information-sharing and communication relates to how agencies made referrals to each other in the cases under review. Referrals between agencies were common, but there

were shortcomings in how these were made. Sometimes they were simply not made:

> “There was a poor hospital discharge compounded by disjointed discharge planning between health and social care. The acute trust did not refer X as a safeguarding concern despite pressure areas, alcohol use, falls and signs of self-neglect. No referrals were made for a section 9 Care Act assessment.”

There were missed opportunities to refer for secondary mental health support, and failures to escalate concerns to specialist agencies (such as Fire and Rescue Services) when risk limitation measures did not work. In one case there was no referral for County Lines to the National Crime Agency where this would have been warranted.

In relation to one case where the police identified an individual as suffering from mental illness during an episode in which she reported theft from her home and caused damage to a car parked outside her house, they did not raise an alert to Adult Social Care. The SAR observes: "If a situation does not reach the section 42 threshold then agencies struggle".

Where referrals were made, they sometimes lacked key information, including those relating to the individual’s needs, existing risk assessment, safeguarding actions to date, whether advocacy was needed and the referrer’s expectations. Referrals were sometimes declined because they did not meet inflexibly applied thresholds and fell between different services; for example where needs arose from mental ill-health, learning disability and autistic spectrum disorder. Others received delayed responses.

Several SARs comment that some agencies, including healthcare agencies, felt ‘not heard’ when making referrals to adult social care, or that their concerns were not taken sufficiently seriously. In another case, there was evidence that care workers’ and GP’s concerns about an individual’s mental health were not heard by mental health and learning disability services.

Several SARs reported concerns about a lack of feedback to referrers, including but not confined to safeguarding referrals. Referrers were often left unclear about the actions taken and the outcomes.

There were challenges too when cases were transferred from one agency or one section of an agency to another. These could occur within the local authority between Children’s Services and Adult Services, or between a hospital and community social work teams, or between different wards/medical specialisms, or during hospital discharge to a different health placement. In such cases, robust

handover could be lacking, with poor time, poor information transfer and uncertainties over responsibilities.

In addition there were examples of robust handover lacking between different agencies, for example between adult social care and mental health services, with unresolved disagreements about who should lead, and whether further care and support needs assessment should take place.

In some cases referrals and transfers were hampered by the absence of clear pathways that could facilitate involvement and clarify areas of responsibility. This was particularly the case in the context of the complexity of individuals' needs and risks. Examples included the lack of a specific domestic abuse referral pathway and the absence of a cohesive service for comorbidity involving physical and mental health needs (for example, diabetes and mental health needs were addressed separately). One SAR observes there was no locally agreed diagnostic care pathway for complex autistic spectrum disorder. Another reflects on the lack of a specific pathway for people who are alcohol dependent and are continually referred to public services, including a referral point for what are described as 'complex and change resistant' clients in local alcohol services.

Understanding of agencies' roles

The safeguarding system is complex, with diverse roles, powers and duties across agencies. As one SAR comments: "one service cannot address the needs of marginalised groups alone. The role of all organisations involved should be identified and understood in order to create an effective system around the person". Yet there emerged a significant lack of mutual understanding about the roles, powers and duties of individual agencies within the safeguarding network.

> "Cross-agency coordination and working together was also frustrated by practitioners not having a clear understanding of other organisations' role and remit; they could not challenge each other or hold each other accountable for actions."
>
> "Identified barriers to effective partnership working included understanding the remit and responsibilities of partner agencies, how decisions are made and why in different organisations, and the constraints that they work under."

This sometimes affected confidence in making referrals, particularly to Adult Social Care, which was compounded by lack of clarity about what kind of needs constituted 'care and support needs' within the local

authority's Care Act duties. Referrers didn't always know the language of their partner agencies, their thresholds for intervention and action, and what information was needed to meet those thresholds. In one SAR, supported living staff lacked clarity about which statutory agency they could approach for support. Referral routes and key individuals to contact were not widely known. In another, there was a lack of shared understanding across all agencies of the legislative options available to intervene to safeguard a person who is self-neglecting.

A homelessness team were given conflicting messages about who was organising or had approved hospital discharge. In other examples, the roles of care coordinator and of housing officers were not well understood. There was confusion amongst professionals regarding the day-to-day key worker role and management of social care issues for a person that was funded through continuing health care, with the continuing health care team not contacted when concerns were being raised.

In another case, the individual's needs were so complex and varied that the support system was fragmented, the sheer number of providers making communication and understanding of responsibilities difficult. Elsewhere frustration arose when complex needs could not be addressed simultaneously, and disputes about which could be met first.

> "Agencies need to work collaboratively to address trio of domestic abuse, mental health and substance misuse rather than to expect behaviour to cease first."

There could be significant confusion about which agency was playing what role.

> "X was in contact with a large number of organisations. There appeared to be common agreement between those organisations on what Sophie's needs were, and all had identified reoccurring risk factors. However … the lack of an overall agreed plan led organisations to assume that another organisation was working with X and that she was safe, or that it was another organisation's responsibility to ensure her safety."

Agency responsibilities in crisis were also unclear and one SAR noted an over-reliance on the police as the community safety net for managing risk.

Silo-working or absence of collaborative working

One of the most prevalent themes relating to shortcomings in interagency practice was the tendency for agencies to work in silos –

doing the work of their own agency, often well, but not linking it with the work of others. Multiple parallel and simultaneous interventions can be problematic if they are not joined up, and often in cases that have had tragic outcomes they have not been well coordinated.

In some cases, agencies were unaware of each other's interventions, working in isolation. In others, agencies knew of each other's involvement but did not consider its relationship with their own, or try to establish a cohesive, joined-up approach.

> "The police and mental health trust were each aware of the involvement of the other with X during the period of escalating sexual exploitation. However, neither seemed to consider the need to work together to develop a safety plan."

There were multiple examples:

- no integration of domestic abuse, substance misuse and mental health services to provide the individual with intensive support
- lack of contact and collaboration between Adult Social Care and mental health services, with neither holding the full or accurate picture
- a hospital made no links with community nursing on discharge
- poor liaison between children's and adult services regarding children at risk in an adult safeguarding case
- no liaison between the police and substance misuse services regarding county lines
- failures to provide joined up solutions to cuckooing
- single agency care plans, with no mention of other key services involved and addressing only partial risk, and lack of coordination of independent care plans
- a disconnect between mental health, housing and safeguarding services
- police and CQC working separately rather than jointly on investigations into registered providers
- healthcare staff having no contacts outside of health services.

One SAR noted: "lack of clarity on how to deal with complex autistic spectrum disorder needs, which cut across services and agencies, with no one person having access to all that was required, nor the capacity and in some cases authority to ensure they could be met."

Another recognised how silo working had affected awareness of and responses to fire risk:

> “Each partner working with X identified and responded to fire safety risk as they understood it… However there was insufficient collective understanding of the gravity and/or immediacy of the risks identified by the Fire & Rescue Service. His refusal to change his habits ought to have generated safeguarding procedures which would involve bringing partners together formally in a strategy meeting.”

What silo working meant in practice was that "work was fragmented, with a lack of join-up both operationally and strategically, and ‘referral bouncing’ or non-acceptance of roles and responsibility to be ‘part of the solution’." This failure to take shared ownership was described in one SAR (relating to multiple exclusion homelessness) as providing “a history of fragmentation and retrenchment”.

Joint working

One way forward from silo-working is for agencies to work jointly – linking together to perform their own functions, but together. SARs identified a lack of joint approaches in situations where joint involvement would have been appropriate. They noted missed opportunities to carry out joint visits and offers to arrange joint visits being declined by another agency. At times arrangements were made but the visit did not happen jointly.

One SAR noted how differing agency approaches and working practices can interfere with the intention to work jointly by affecting timescales and plans.

> “… the limitations to being able to do joint visits with the police, who are geared up for immediate responses, not planned ones. We have the same problem with social workers – it can be months before we get a response.”

Structures to support interagency collaboration

The infrastructure to support effective interagency working was in some cases missing. One key component noted was how IT systems could bring an additional layer of complication to the process of working together. One example illustrates the systemic challenges:

> “After her discharge from mental health services X’s GP became central in her care but the pressures on GP services/new ways of working to reduce pressures/post pandemic systems meant patients found it hard to access a GP. Communication via emails

between primary and secondary health are more effective, but there are limitations - mental health cannot easily contact the epilepsy service, the rationale being that it is a hosted service that is provided by the acute trust. Email communication, e-forms, etc. in cases with this level of complexity can be ineffectual. GPs have to access other health providers' records via a Graphnet system, and they need extra training to do this. The Multi Agency Safeguarding Hub only have computer access to half of the area's health records."

Historical information was not always easily available in agency records, resulting in poor understanding of an individual's history of involvement. One SAR described "awkward information-sharing systems" across and between agencies, which did not support a smooth-running multi-agency approach. Records were often kept in silos, with key information (such as risk and safeguarding needs) not visible to all concerned. It was noted that NHS record systems do not facilitate information-sharing between primary and secondary acute care, and problems with information-exchange were aggravated by IT system changes. Deterioration could not be recognised across diverse health services as the systems in place did not facilitate a flow of communication regarding an individual's state of mind.

Policies and protocols also form part of the infrastructure for interagency working, yet the SARs uncovered evidence that policies were not well embedded in practice across partnerships, resulting in restricted understanding in some agencies about what multiagency responses were required. This seemed to be particularly the case in self-neglect. Some SARs expressed concerns about adherence to local safeguarding procedures, finding failures to use thresholds guidance or consistency of responses.

Similarly protocols setting out pathways between agencies were found lacking in some circumstances. In one case, the operating arrangements between older people's mental health service and Adult Social Care were unclear. In another a protocol between older people's mental health services and primary care covered only medication. In a further example, the SAR notes problems with the timely execution of a s.135 Mental Health Act warrant due to difficulties coordinating the professionals needed, calling this a failure to abide by a multiagency protocol requiring assistance in s.135 arrangements. Elsewhere, the PiPoT Protocol relating to decision-making on disclosure relating to person in a position of trust was not followed. A final SAR noted the hampering impact of missing guidance: "The absence of agreed guidance to support health, social care, and housing operational staff to

take 'creative solutions' and actions, jointly monitor progress, share challenges etc. hampered any escalation or working together."

Multiagency risk management meetings

A commonly noted feature was the absence of any multi-agency meeting at which information could be shared, risks assessed and shared risk management strategies put in place. Such meetings take multiple forms under diverse names – safeguarding strategy meetings, multiagency risk management meetings, vulnerable adult risk management meetings, high risk panels, MARAC meetings – but essentially they are a means of overcoming silo working and ensuring good coordination between the interventions of all the agencies

Sometimes risk management strategy meetings were not called or were not called in a timely way. At other times they had taken place but without the involvement of key agencies.

In such cases, minutes were not always made available to missing agencies. In one case they ceased when the individual turned 18, despite the fact that she was still being sexually exploited.

Understanding was sometimes muddled about which procedure to follow in which circumstances. Practitioners commented that the different types of meeting could be confusing, and their specific purposes were not always clear. Some areas lacked an agreed pathway or format for such meetings, in others there was no 'custom and practice' around their use:

> "Practitioners have said that neither the infrastructure nor organisational culture yet existed to ensure consistent use of multi-agency meetings, which would include decision-making about lead agency and key worker, and review of the outcomes of agreed plans."

The absence of such meetings meant that there was a lack of shared ownership, lack of challenge between agencies, and the safeguarding process lacked oversight. The complexity of the safeguarding picture was not understood – in one case where self-neglect was seen to be the issue, ongoing exploitation was missed. In another, mental health staff were not invited to a Children's Services strategy meeting, resulting in vital information not being shared and the adult/child safeguarding response remaining fragmented. The lack of shared strategy was evident in multiple SARs.

In a further example, while several key agencies did meet together to share information, one key service was not a part of that meeting or

involved in any updates as the individual's risk factors escalated, so they were not aware of her increasing vulnerabilities and risks. They were not advised that she had been discharged by mental health services due to non-engagement or that she was to be served with an Eviction Notice.

In some cases, a multi-agency meeting had resulted in agreement over ongoing plans, but there was a lack of follow-through. Actions "did not appear to have been driven or owned effectively enough and, as such, there was insufficient rigour and drive to the plan". Recommendations for actions were not consistently adopted by the agencies to whom they were ascribed, and the intended outcomes of the plan were not achieved. In a further case, meetings were convened in response to crises or deteriorating situations, but were generally one-off events to organise a response, and efforts were not maintained. Plans went unmonitored by partners: "the mind set was that one meeting is enough."

Case coordination

Even where risk management strategy meetings have taken place, interventions involving multiple agencies remain complex and dynamic, with an individual's circumstances sometimes changing rapidly. One notable shortcoming identified by SARs was the absence of a coordinating agency with a lead professional who could be relied upon to know how other agencies were involved, and act as a conduit of information and consultation on multi-agency strategy. In many of the cases featured in the SARs, no one agency was familiar with the whole picture.

Shortcomings in this respect were noted in multiple SARs: "no lead agency", "no nominated lead professional", "no coordination". In some cases accountability was blurred, with a lack of clarity about whether the case was being managed under safeguarding procedures or through some other process. Responsibility for coordination could fall by default to agencies who were least well-placed to exercise it:

> "The voluntary sector and particularly housing support workers were often left 'holding the baby' when all the statutory agencies appeared to deny eligibility for services for very vulnerable high-risk individuals... the least qualified and experienced workers were being left to deal with the hardest and most complex individuals."
>
> "Too much responsibility being placed on accommodation

> providers to engage with other services and to coordinate their involvement."

In one case the coordinating role became challenging for reasons of interagency power dynamics:

> “Her care was not appropriately coordinated. Coordination was particularly important given she had ASD and a complex pattern of mental health problems. The voluntary organisation became the de facto coordinator, but other organisations did not respond well or cooperatively - parity of status issues.”

Difficulties were sometimes compounded when work was being carried out across geographical boundaries. One SAR noted that agencies appeared not to want to take the lead, waiting for each other to do so.

Several SARs comment on the complexity of the issues in the lives of people whose needs bring them to the attention of a wide range of agencies, and make the point that these complex challenges require complex responses that need coordination to achieve their objectives:

> “A lead professional … over the long term to work effectively with a wide range of provider services (many from the voluntary sector), to engage and assess X’s needs and develop an informed care plan. (Instead there was) no jointly agreed care plan with each individual agencies’ actions being clearly understood and their interrelationship being co-ordinated and managed by a lead professional.”

Challenge and escalation

Finally some SARs addressed the question of how agencies can themselves avoid the worst outfalls of interagency working. Key to this is the degree of interagency challenge that can be built into the safeguarding system. Yet SARs found little or no challenge in situations where it could have been made: “After the decision that the referrals did not meet the criteria for a s42 enquiry, there could have been a challenge back to the safeguarding team.”

Yet concerns were sometimes not escalated. In one example, a housing association did not escalate concerns when an Adult Social Care assessment came to a radically different conclusion from their own. In some cases it appeared the escalation routes were not clearly understood and in others it appeared they were just not clear:

> “There was no effective provider concerns process. A more integrated approach was needed to respond to concerns and

complaints about a provider. There was confusion about the interface between safeguarding and care quality/provider concerns processes, with no consensus evident on which when."

In one case where differing views arose about an individual's mental capacity relating to housing tenancy, the SAR notes that the views of police officers and housing colleagues were not given equal value to those of health or social care colleagues, who had not in fact themselves carried out any assessment regarding tenancy: "These differences of opinion were also not recorded or escalated."

In conclusion, included below is a description of learning from the breakdown of interagency processes in a case involving multiple safeguarding enquiries in relation to older adults in two care homes, some of whom had died. The process was subsequently escalated to a Large Scale Enquiry with three points of focus: the residents who had died, the 50+ residents about whom safeguarding enquiries had been conducted, and more broadly all residents in the two services. The shortcomings between agencies relate to both the original failures of safeguarding and the process of enquiry, in which many of the familiar themes of poor interagency working are present.

The SAR presents evidence for a catalogue of shortcomings. The roles of safeguarding and quality management processes became muddled; quality management officers identified concerns about quality of care and made recommendations for improvement but took no safeguarding action. So concerns about residents' unmet needs did not lead to any safeguarding action at the time as they were dealt with under other processes. Concerns known to CQC, to the Police and to community nursing were not referred to local authority safeguarding. When concerns were raised, responses were not well coordinated between CQC, the safeguarding team, the care reviewing team, quality management staff, the CCG, GPs & healthcare staff. Safeguarding thresholds appeared not well understood by quality managers and CQC. Incorrect use of the Harm Table guidance was leading care provider staff to screen out incidents that should have been referred to safeguarding; a large number of reportable safeguarding issues went unreported. Nurses did not always raise formal safeguarding alerts believing instead that raising concerns informally whilst at strategy meetings or at provider concerns meetings was sufficient. Some staff reported that the local authority led the meetings and it was difficult to be heard.

The quality management team hosted multi agency meetings where provider quality / performance was shared but concerns about potential Freedom of Information requests and commercial sensitivity led to minimal detail in the meeting minutes, so with inconsistent attendance at meetings the sharing of information was not robust. Different agencies had access to different systems. There was confusion around roles and responsibilities between the different agencies and further confusion about where at senior level in the local authority

decisions were being made when concerns raised by health staff were taken forward under safeguarding procedures or as an issue of quality of care. This along with the volume and variety of concerns made decision making at the range of meetings quite chaotic and confusing.

The later Large Scale Enquiry meetings were hampered by a lack of consistency in attendance and a lack of clarity as to who was the decision maker. The meetings were swamped with the volume of information, which had not been analysed prior to being taken to the meeting; this impacted negatively on the ability to make an informed decision. Healthcare staff focused on clinical care, social workers the wellbeing of the individual and the effectiveness of their care plan, quality management officers focus on the provision of care across the resident group. These different foci caused a degree of conflict when it came to decision-making.

The SAR records learning about the need for better coordination in investigating and monitoring concerns, including clearer delineation between actions that can be taken between police and adult social care services respectively while both criminal and civil safeguarding actions are taking place. It calls for a more coherent interface between health, social care and the police to enable improvements where possible but also enforcement where improvements are not achieved. It notes the challenge of deciding where and how evidence of abuse/neglect is gathered whilst also mitigating the affects to minimise harm to the adult, calling for multiagency investigative time to focus on evidence gathering independently from any professionals providing care and support services.

Domain three: Organisational support

Good practice in domain three

Eighty three per cent of the reviews in the stratified sample (n=191/229) referred to either good practice and/or practice shortcomings in this domain. As in the first national analysis, SARs contained fewer references to good practice than to practice shortcomings. Very few positive commendations were made about the organisational features that supported good practice in the cases under review. Even the most commonly mentioned positives - the use of supervision and the presence of management oversight - were only each highlighted in three per cent of cases. Training, agency policies and procedures, and access to specialist advice each featured in two per cent of SARs, with staff support, records/recording, commissioning and quality assurance each receiving positive comment in just one per cent. This is not to say of course that positive organisational features were not present in the agencies involved, but that the SARs do not recognise specific positive impacts on the cases under review. The full picture is found in the table

below:

Organisational feature	% of SARs with positive comments
Supervision	3%
Management oversight	3%
Training	2%
Agency policy / procedures	2%
Access to specialist advice	2%
Staff support	1%
Records / recording	1%
Commissioning	1%
Quality assurance of commissioned providers	1%
Other*	1%

* Other includes the commissioning of an extensive and comprehensive independent investigation by the hospital where an individual had died; good timely reaction by a hospital to an individual stealing drugs from hospital pharmacy.

Only 27 per cent of the reviews that commented on organisational features (n=51/191) highlighted one or more components of good practice. Positive observations on supervision and staff support described joint visits due to the potential for violence and aggression, the opening of a safeguarding investigation, and the development of risk mitigation plans. The focus on management oversight positively referred to liaison at a senior level between managers in children's social care and adult social care, and to managers declining to sign off closure of a safeguarding investigation. The importance of management oversight is highlighted in the following two observations.

> "Senior leaders must also provide a clear framework for practitioners regarding decision-making and escalation where real and imminent harm persists; this must empower staff to utilise harm reduction approaches and strength-based risk management which are fundamental making safeguarding personal principles. Staff spoke proudly of the significant activity, led by [the SAB], over the last year and the impact this has had on frontline, shared risk management practice."

> "Eventually senior leaders across police, housing and social care acted to move him to safer accommodation as a result of escalation of concerns."

One important support for practitioners and managers is access to specialist advice. Amongst the few references to this were instances when staff had sought advice on specific concerns, such as denied access, and when either GPs, district nurses, police and/or mental health services had acted with timeliness in seeking guidance.

Agency policies and procedures can also support staff by providing a framework within which to situate practice. Here there were references to NHS Trusts using clinical disengagement policies or adults who abscond policies. There were positive references also to guidance on cuckooing and exploitation and responding to people with complex needs.

> "Since 2017, the police capability to recognise and take steps to combat cuckooing has improved exponentially and with these developments has come greater understanding across the safeguarding network. Developing an effective formula for best practice has not been achieved overnight as the problem of cuckooing is complex and change has necessitated testing new processes and modifying them accordingly."

As with supervision and staff support, the focus on training predominantly referred to the subjects that had been covered, such as self-neglect, trauma-informed care and executive functioning. Occasionally evidence was offered of training outcomes, for example greater awareness of self-neglect in referrals to adult social care. Training alone, however, is insufficient to ensure practice development and improvement.

> "Training on executive capacity had taken place but to undertake these more nuanced assessments of mental capacity takes time, skills and expertise that not all professionals have acquired."

There were also occasional positive reflections on commissioning and the quality assurance of providers. Commissioners had led on the debriefing of staff following a serious incident. There were examples also of commissioners and/or providers responding to critical incidents by commissioning an "extensive and comprehensive investigation … which contributed positively to the SAR and future learning." The same good practice was identified in the "police commissioning of a similar investigation into their practice surrounding a specific incident."

> "Council quality assurance teams had worked with the care provider to improve the quality of provision."

> "During the safeguarding investigation … the allocated social worker completed a feedback to commissioner's form, which had been developed locally, to raise concerns in relation to [a care provider]."

Best practice is more likely to flourish and to be evidenced when recording clearly describes what has been done and the rationale for actions and decisions. There were occasional positive references to the

quality of recording, for example of assessments and best interest decisions.

> "The detailed record of the discussions in strategy meetings shows how a structured approach was adopted to risk assessment with each of the specific concerns listed and balanced against possible protective factors. This provided a clear audit trail as to the rationale for the conclusions reached and actions agreed. The notes also show that there was agreement that despite the fact that [the named individual] would soon reach 18 years of age, there could be no "grey areas" and no let up on protective action to be taken because [they were] still a child."

In common with other domains, the commentary in SARs demonstrates how all the components within this domain need to align and it offers illustrations of positive outcomes when this alignment occurs.

> "Significant escalation of concerns at [a care home], which led to investment by CCG of additional staff resources to improve practice and increase visits by range of professionals. Safeguarding enquiries were reviewed at a senior level (eventually). Management of the concerns was taken over by the Director, due to the nature and volume of issues identified. For police involvement expert advice in safeguarding was required (where concerns related to issues of nursing and standards of care, it was good practice to consult with experts in this field to understand the broader context before making threshold decisions, which was usually from health professionals). Where issues and responses to concerns remained unsatisfactory or safeguarding issues remained unresolved, cases were discussed with managers and the Trust safeguarding team. Concerns were also discussed within Trust processes, at meetings including the Clinical Risk Management Group and Pressure Review Forum; plans were agreed, implemented and then reviewed within internal assurance structures, rather than under multi agency safeguarding processes."

Practice shortcomings in domain three

Negative impacts from organisational features were noted much more frequently, with an absence of management oversight topping the list, mentioned in 31 per cent of cases.

Shortcomings in agency policies/procedures (28 per cent) and in staffing levels and workloads (27 per cent) were also common. In 24 per cent of the cases, shortcomings in commissioning were noted, and training was found to be lacking in 23 per cent.

A shortage of resources affected 20 per cent of cases – this could relate to resources of any kind – financial, services, specialist placements, and so on. The nature of records and recording adversely affected 18 per cent of cases, followed by shortcomings in supervision (16 per cent) and poor access to specialist advice (13 per cent).

Other organisational features drew adverse comment in around one tenth of reports – agency culture (12 per cent), eligibility criteria (12 per cent), quality assurance of commissioned providers (10 per cent) and staff support (10 per cent). Absence of support for legal literacy was noted in seven per cent of cases, and workflow expectations (the expected timeline for throughput of cases) adversely affected six per cent. The full picture is given in the table below.

Organisational feature	% of SARs with negative comments
Management oversight	31%
Agency policies / procedures	28%
Staffing levels / workloads	27%
Commissioning	24%
Training	23%
Resources	20%
Records and recording	18%
Supervision	16%
Access to specialist advice	13%
Agency culture	12%
Eligibility criteria for access to services	12%
Quality assurance of commissioned providers	10%
Staff support	10%
Support for legal literacy	7%
Workflow expectations	6%
Other*	14%

*The other category here is diverse. It includes matters relating to safeguarding:

- unclear differentiation between pathways for raising safeguarding concerns (referral to the local authority vs. discussion with an agency safeguarding lead)
- split responsibility across two organisations for safeguarding oversight, creating inconsistency and tensions
- systemic weaknesses in an ambulance service's safeguarding response
- disruption of links between safeguarding services and commissioners, established communication channels being lost,

leading to increased risk and decreased knowledge of what was happening in relation to care settings

- inadequate systems for understanding patterns and accumulation of s42 concerns
- concerns that risk relating to vulnerable adults is deprioritised/normalised.

It also includes matters related to staffing:

- long term difficulties in recruiting staff
- staff inexperience
- agency structures or practices
- absence of allocated worker due to the practice of placing a case ‘on review’
- a shift from accommodation-based support, available for as long as the person needs it, to floating support that works on a time-limited basis, with no services to refer on to
- agency restructure
- impact of a locality restructure in adult social care on the monitoring of issues and concerns as symptoms of more serious underlying concerns
- risk that under section 75 agreements for mental health services eligibility for health and social care may become conflated, decisions about social care needs becoming entwined with decisions about diagnostic eligibility, resulting in failure to recognise social care needs in situations where an individual does not appear eligible for secondary mental health services
- inadequate systems to record nutrition and pressure ulcer care plans.

It includes matters relating to mental capacity

- some agencies seeing mental capacity assessment as beyond their remit
- mental capacity seen as the end of the story, with case closure following.
- compliance with national guidelines or requirements
- provider failure of compliance with CQC requirements on facilities
- failure to apply national guidelines on diagnosis, assessment

and management of harmful drinking and alcohol dependence

- absence of appropriate notifications to a regulatory council.

It includes matters relating to resources:

- lack of specialist therapeutic provision for women who are multiply disadvantaged, including those whose children may be, or have been, removed from their care.

There were many examples where SARs identified shortcomings across several areas of organisational support. Effective safeguarding might be undermined by workloads, increasing demand, lack of management oversight through supervision, challenges of staff retention, and gaps in commissioned service provision.

> “Housing and probation services indicated that supervision practice was poor in the case, in Probation management oversight was also lacking. Alcohol Services were not commissioned to work with the needs of more 'complex drinkers'. Funding needs to be available for residential rehabilitation without 'unreasonable barriers'. Training gaps are noted around alcohol use, adult safeguarding and the law in various organisations.”

> “Concerns were raised about the context in which care was being provided; specifically, that treatment that should have been available was not due to inadequate staffing levels and resourcing, further that staff were not sufficiently trained in key areas and that ward management and culture may have contributed to the desensitisation to risk and the speed of response towards the incident which ultimately led to her death. There were a number of findings relating to the quality assurance and monitoring of commissioned providers, particularly in relation to the quality of assessments.”

Shortcomings in management oversight featured prominently and were associated with delay, drift and criticisms of assessments and decision-making. Identified shortcomings included the absence of systems to identify how referrals had been progressed, and a lack of escalation or scrutiny that could have provided professional challenge, for example of decisions to close cases. Management oversight and supervision must challenge the lens through which issues are understood, or “tunnel vision”, and safeguarding enquiries should not be closed without management sign-off “to ensure “adequate risk assessment and safeguarding plans completed, with a clear closure rationale.”

> “No evidence of supervision or management oversight. No

checks to ensure that practice was compliant with expected standards."

Shortcomings in management oversight often accompanied critiques of supervision and staff support. SARs highlighted the absence of safeguarding supervision, which was linked to deficits in planning and decision-making, and identified the need for multi-agency supervision for complex cases. SARs also referenced the importance of supporting staff to deal with the emotional impact of the work, for example when practitioners encounter hostility when seeking access to an adult at risk.

> "Management oversight and reflective supervision to assist the practitioners to consider living 'in her shoes' may have assisted in prompting some further thinking in terms of her capacity to make this decision."

> "The provider did not provide staff with a safe working environment and the risk of violence they were exposed to was ineffectively managed. Staff were not supported or trained to manage the risks presented and there was a culture of risk normalisation as it pertained to vulnerable adults who were violent towards others."

Staff support is enhanced when training is provided, the use of which can then be picked up in supervision. Identified training needs once again demonstrate the breadth and complexity of adult safeguarding, and included cultural competence and the impact of discrimination, disguised compliance, and transitional safeguarding. Also identified were training needs on self-neglect, tissue viability, alcohol-dependence, fire risk, response to allegations about people in positions of trust (PIPOT) and working with people with emotionally unstable personality disorders. The focus on training spanned practitioners across health, housing, police, children's social care and adult social work.

> "Each individual working with X understood that there was a fire risk, but none had received training on fire risk to vulnerable people in the home and partners did not fully share their understanding of the risks with each other so they could not have gained a comprehensive view of the risks, including an understanding of the accelerant effect of emollients."

> "Police training on safeguarding did not follow Care Act terminology/principles on use of term 'vulnerability', also did not contain sufficient guidance on what information to include in onward referrals about risk."

> “Staff in the supported accommodation - for individuals with complex lives - had no qualifications, training or appropriate support/supervision. They were often lone working.”

Worthy of note is that there were no entries under good practice for organisational support for legal literacy. One identified training need arose from shortcomings in legal literacy. Sometimes this related to a lack of confidence in following the legal rules, for example undertaking mental capacity assessments, or being clear about the rules relating to ordinary residence. Sometimes it related to lack of awareness of specific duties, such as section 11 Care Act 2014, the provision to conduct care and support assessments where the person has not consented and where there is evidence or risk of abuse or neglect, including self-neglect. Another example here was the duty to refer to prevent homelessness (Homelessness Reduction Act 2017). There were concerns also about inequity in the legal rules for adults as opposed to children, and use of particular statutory provision.

> “Inappropriate use of criminal justice interventions to respond to a vulnerable adult (arrests for wasting police time when mental health needs were well known).”

> “Difficulty in finding a psychiatrist with confidence to assess her mental health alongside her learning disability and autism; same also regarding an AMHP.”

> “Some agencies saw capacity assessments as outside their remit.”

> “The local authority had misunderstood its duties under the Care Act for decision making on the s42 duty.”

> “Staff were uncertain about their data protection obligations and how/when to override consent in the event of safeguarding concerns.”

Staff support is also enhanced when policies and procedures offer guidance within which to situate practice. This component of organisational support for practice and the management of practice featured prominently across SARs. Shortcomings focused on both the absence of guidance and also lack of awareness and implementation of policies that did exist, sometimes associated with a perceived lack of clarity, for example about when to refer adult safeguarding concerns.

The absence of multi-agency policies or guidance covered types of abuse, such as self-neglect, financial abuse, sexual exploitation, cuckooing and domestic abuse (coercive control). It also covered practice, for example responding to high frequency users and to cases

requiring complex case management or transfer between service providers. SARs also highlighted the need for stronger dissemination of policies and guidance, for example on out of authority placements, and were critical of the failure to use available procedures.

“Other” comments included references to failure to follow national guidance on alcohol-dependence: diagnosis, assessment and management of harmful drinking, critique of available guidance on allegations against people in positions of trust (PIPOT), and shortcomings in the administration of complaints procedures. These shortcomings could result in a failure to take appropriate action to safeguard individuals at risk.

> “A number of the agencies did not have any policy or procedure for the disengagement or loss of contact with the vulnerable people using their services. One of the agencies did have a missed visit policy, however this was not followed as it was no longer included during induction training and staff were not aware of its existence.”

> “Whilst practitioners recognised and understood the impact of life trauma on their clients, this does not appear to have influenced organisational policy responses. The practice of discharge following missed appointments, for example, does not fit well with people who are disorganised because of their traumatic life experiences.”

One potential source of support for staff is access to specialist advice, for example from lawyers and named professionals for safeguarding or mental capacity. SARs were critical when advice from specialists had not been sought sufficiently early, if at all, and occasionally when the advice given had been poor. Where there is the potential to access specialist advice, for example on safeguarding, from different organisations, this split responsibility might lead to inconsistency that should not be left unresolved.

> “Local authority does not have an Immigration and Asylum Team to lead and provide advice on assessing and support asylum seekers.”

> “No use made of specialist practitioners to consider impact of learning disability on parenting and links with poverty, social isolation, self-neglect, communication difficulties and mental health.”

> “Community district nurses sought advice from senior nurses but were not advised to complete a capacity assessment or obtain service user rather than carer views.”

The third most frequently referenced critique of organisational support focused on workloads – the lived experience of practitioners and managers. Included here were references to the impact of staff shortages and recruitment/retention challenges, vacancies, and resulting workload pressures. Examples highlighted lack of responses to referrals for care and support assessments or of safeguarding concerns, cases being transferred for review without an allocated worker, delayed mental capacity assessments, and the absence of a system for reprioritising cases on waiting lists. Also illustrated was the impact on relationship-based practice and understanding of risk of changes in allocated workers, and the risks associated with inexperienced health and social care practitioners and managers. Workloads and demand management often involved pressure to close cases and meant a lack of time for critical reflection.

> "Adult social care was very dependent upon a care management model where there was not always a distinction between qualified and non-qualified staff, this model cannot meet the challenges of complex case work where individuals may present with multiple risk. Whilst there had been an attempt to move back to senior social work responses the practitioners reported at the learning event that they were working under increased pressures."

> "MARAC - on average there were 30 cases allocated to each Conference and this often results in time pressures and restrictions on the time that could be allocated to each case."

> "Influences such as a heavy workload could unconsciously sway a professional's decision to accept that they cannot engage a person, rather than work to understand and achieve."

The focus on workloads and increasing demand also led to some focus on eligibility for assessments and/or provision of support. SARs referenced increasingly high thresholds for mental health support and for care and support assessments or enquiries into adult safeguarding concerns.

> "Clinicians did not have time to build on the rapport they had developed with [named individual]. Reported uncertainty within organisations about eligibility criteria and out of area arrangements (between two London authorities)."

> "Eligibility criteria - use by safeguarding decision makers (has capacity to make unwise choices), housing (inability to sustain tenancy) and mental health (not treatable) shut [named individual] out from support. Further training for primary care on

> people in complex circumstances who are self-neglecting/have capacity is needed. People deemed ineligible still carry great risks, commissioning needs to address these gaps."

Alongside the critique of workloads was a focus on commissioning, highlighting lack of resources to keep people safe and to address their needs. For instance, SARs highlighted the lack of commissioned therapeutic support for bereaved families and also for women who experience multiple disadvantages, the insufficiency of care packages, and the lack of provision to respond to people with entrenched alcohol-dependence.

A second feature of shortcomings in commissioning related to practice. Examples here included challenges in transferring responsibility from a local authority to continuing healthcare funding (CHC), inadequate monitoring of how placement funding was being spent, and advice to only commission services that had safeguarding standards embedded in contracts. The challenges of finding providers in particular geographical (rural) areas, and of clarifying responsibilities between placing and host commissioners were also highlighted.

> "Care package after CHC assessment delayed because of lack of appropriate equipment that the family would accept, lack of costings being submitted by a care providers, inability to commission a care provider for that location, and lack of continuity in CHC team."

> "The commissioning of alcohol services is inconsistent. A provider can be changed as a result of a procurement exercise, and this can destabilise established work with individuals. The incidence of alcohol dependency and associated problems is increasing and so the resource of this type of service is very stretched. A dual diagnosis care pathway is needed. The provision and strategy around alcohol services merits a formal audit as this factor of risk alone can make an individual high risk."

Additional to the specific focus on commissioning was a commentary on lack of resources more generally, whether for prevention, outreach or for responding to mental ill-health or substance misuse. There was evidence of services feeling overwhelmed and of prioritising only the most pressing cases. Identified shortcomings once again highlight both the breadth and complexity of safeguarding.

> "There were difficulties encountered in securing access to mental health support for young people who are involved in substance misuse. There should be further exploration of the

> opportunities for formalising joint working between CAMHS and substance misuse services to put in place “scaffolding” to help the young person stabilise their drug use sufficiently, to make it safe for them to engage with therapeutic support. The review identified limited specialist service provision for children involved in high levels of substance misuse. A gap in specialist provision of temporary accommodation for young people (18 or more) who are using substances was also identified; however, this is being addressed through the development of two supported housing schemes.”
>
> “Shortage of housing for vulnerable women with multiple and complex needs, including underlying trauma.”

Where services were commissioned, shortcomings in quality assurance were highlighted. This usually focused on the lack of effective systems for responding to organisational abuse and concerns about service providers. There was evidence of providers failing to comply with CQC regulations.

> “Preventative measures such as regular a programme of contract monitoring and proactive quality assurance visits by the commissioners were not at that time in practice within the locality.”
>
> “The provider lacked understanding of dysphagia, the seriousness of the risks associated with it, and the importance of adherence to care plans. Internal governance systems failed and quality concerns about practice were not reported.”

The majority of “other” comments focused on quality assurance of commissioned providers. In one SAR there was a failure to refer concerns about fitness to practise to the appropriate regulatory council. In another, systemic weakness had been identified in responses to safeguarding by an Ambulance Trust, which had been highlighted by the CQC and prompted an action plan to implement improvements. There were concerns about significant non-compliance with CQC regulations. Best practice and accountability for decision-making are sustained by accurate record keeping. One standard within administrative law requires that practitioners and services record the reasons for decisions – this is central to meaningful accountability. Shortcomings in recording were focused on:

- inconsistencies in what was recorded
- the failure to record key conversations and/or the rationale behind decision-making in assessments or safeguarding strategy meetings. T

- lack of access to records, which meant that practitioners and managers did not have all the available information on which to reach judgements on risk and safeguarding
- some recording systems, for example in primary care, were judged inadequate in terms of enabling easy identification of adults at risk.

"Records were not searched when information was received, so previous contacts with her family were missed and it was assumed she had none. Inaccuracies in records (stating she was in hospital when she had been discharged months earlier) and failure to record outcomes of meetings in contravention of GMC guidance."

"A previous SAR identified a pattern in GP practices whereby no one notices if vulnerable patients with serious health concerns do not request repeat prescriptions for their long term health conditions; meaning some patients' health is not followed up or reviewed by the GP. Recommendations for changes to systems and processes were made. Although in this case the practice manager did pick up the non-collection, there remains no formal process in place."

The organisational context within which practitioners and managers were working was itself identified as impacting negatively on best practice. Across health and social care, there were references to the impact of organisational changes or restructuring. There were also references to missed opportunities to create an organisational culture where reflection and professional challenge were encouraged.

"A consistent view expressed by all the professionals interviewed and by providers was that the locality restructure in adult social care had undermined confidence in safeguarding practice. The move from a centralised team of 'experts' to a generic locality model had a significant impact initially. It was widely seen as leading to inconsistency in terms of the knowledge and skills of social workers, their expertise in safeguarding practice, the quality of assessments, decision-making, recording and communication."

"The locality restructure in adult social care had a significant initial impact on intelligence gathering and the aggregation of small issues and concerns which together signify more serious underlying concerns. In addition, the restructure disrupted clear links between safeguarding services and commissioners, and established communication processes were lost, leading to increased risk and decreased knowledge of what was happening

in relation to care settings."

In "other" comments about organisational shortcomings were references to inadequate systems for understanding patterns of safeguarding concerns raised about individuals, the lack of complex case planning to support transition to adulthood, and inadequate assessment and oversight of 'high impact decisions' such as eviction or disconnection.

Specific policy priorities

This national analysis was asked to document evidence on specific policy priorities. Insofar as they were mentioned within commentaries on organisational support, examples are given here. They demonstrate again the breadth and complexity of adult safeguarding across this domain.

Denied access or difficulties with access

Focus here fell on the importance of supervision and support when practitioners are having to deploy skills of relationship building to ensure access to an adult at risk, and also challenge relatives when they are obstructing assessments and treatment/support plans .

> "The number of complaints and the fear of them had an adverse impact on staff, for example social workers, with a lack of management oversight and support. Social workers also had to contend with the son not allowing them in, and with abuse. Workload demands restricted social worker time to read records to appreciate the history. Staff, for example social workers and hospital staff, were insufficiently protected - zero tolerance policies not activated. No lead senior manager to coordinate local authority's response to complaints."

Homelessness

One focus here was shortcomings in legal literacy, for example not complying with the duty to refer in the Homelessness Reduction Act 2017 or not understanding the need for human rights assessments with respect to people with no recourse to public funds. Demand on statutory services had led to higher eligibility thresholds. Practitioners working for third sector organisations did not have consistent access to training or to specialist advice.

"It was suggested that the county council had pulled back from being the principal commissioner of supported housing, and from its statutory responsibilities regarding homelessness, and that a joint pooled budget

was. Access to dual diagnosis provision and to mental health services for people in the homeless pathway were described as ‘very difficult’. Although a homeless pathway exists, it was unclear whether there was agreement about which agencies were responsible for commissioning aspects of the provision. It was suggested that the focus had been on service provision at the point of crisis and that there was a need to focus more on services to achieve and maintain recovery. Further there were concerns regarding the way in which services were commissioned, which was that they were often time limited. Staff in some sectors lacked confidence in presenting assessments of need to statutory services and did not necessarily understand the criteria for accessing provision and triggering statutory duties. There was reference to a design fault in the system, namely front-line staff often being the least experienced and lowest paid members of the workforce.”

Safe care at home

System pressures also contributed to unsafe hospital discharge when care and support packages, or follow-up health care in the community, were not in place. This could impact on health and wellbeing in an unsuitable home environment and place undue pressure on family carers.

> “Agency culture that family carers will care leading to missed opportunities to assess, lack of challenge and lack of risk management. Pressure on resources and need to manage demands on services leading to multi-agency meetings being seen as resource intensive, with potential also to increase bed pressures as meetings need to happen before discharge. Resource and time pressures resulting in safeguarding partnership being slow to respond to changes in risk. Lack of management support and reflection regarding reliance on family carers. Practitioners not feeling supported to raise concerns with family/relative carers. Competing priorities and stretched resources, together with lack of understanding of agency roles resulting in lack of collaborative working. Time management a barrier to working together, so too stretched resources. Management support necessary.”

Transitional safeguarding

There were occasional examples of positive practice, for example when a social worker supported a young adult to attend meetings with DWP, housing staff and psychologists, although they had been assessed as not having eligible needs for care and support. However, the focus

more often fell on the failure to comply with statutory guidance on preparing young people for adulthood, on gaps in service provision that commissioners were struggling to remedy, on increasingly high eligibility thresholds as a result of workload and demand pressures, and on shortcomings in accessing specialist advice and guidance.

> “Cases were quickly closed by ASC when other agencies became involved on the grounds of 'no further role.' ASC social workers had no access to local authority children's services records which impeded and understanding of the young person's history. [Two young people/young adults] had to cope with several transitions- different providers for child/adult substance misuse services, for mental health and social care. The Youth Offending Service undertook regular risk assessments and, as risks increased, escalated these to senior managers. However even with this escalating risk picture a case was closed without further review as he reached 18. Although the need for legal advice was recognised it was not actively sought. The transitions panel had no attending legal advice.
> “Practitioners who worked with [one young person] were deeply affected by his death, no de-brief for staff. Practitioners would benefit from access to systemic thinking and support, including training, in order to manage complex cases. Commissioning gaps - dual diagnosis services, outreach services. Those working in substance misuse services commented on the need for greater emphasis on outreach.
>
> “Those working in mental health settings commented on limited rehabilitation facilities for young people, both outpatient and inpatient. They commented on the challenges involved in seeking to protect young people from becoming addicted to drugs and/or alcohol, and of the shortage of specialist facilities for young people who are drug or alcohol dependent. Concerns about insufficiency of placements and about the quality of some available placements, noting high cost and low quality.”

“Transition planning can be inconsistent and delayed, in particular where young people’s cases are held outside the learning disabilities service in children’s social care. The quality of transitions depends on the knowledge of individual staff members, without systemic oversight from managers to promote consistency.

The concept of transitional safeguarding is starting to become understood by specialist services but not embedded in mainstream services, resulting in a lack of joined-up planning.

Adults' services (particularly mental health and social care) too often apply rigid referral criteria; this requires young people to quickly adapt to the new legal framework that surrounds them as adults, leaving them bewildered by the complex network of health and care services."

Closed environments

The same critical features of the organisational context surface in SARs that feature closed environments and organisational abuse. Shortcomings in quality assurance and oversight of improvement plans by commissioners and by CQC feature here. There were also concerns about the lack of information exchange between placing and host commissioners, and between different commissioners using the same facility. Staff turnover in care settings, and the paucity of training for staff having to care for people with complex needs, were also highlighted.

> "The service was described as 'inward looking…a closed culture resistant to external advice.' Visitors were not invited to see the [rooms]in which it was alleged that residents were unlawfully deprived of their liberty. The limited training received by staff was in-house. Commissioners accepted that the absence of 'local options' for some adults with learning disabilities and autism resulted in the necessity of out of area placements. These relied on contracts with the providers. Each commissioning body undertook their own scrutiny processes without the benefit of a repository of 'intelligence' about providers. The dispersal of [the provider's] homes lessened the possibility of multiple commissioning bodies collectively assessing the adequacy and quality of individual placements.
>
> "The reviews of some residents did not occur because of 'workload pressures.' People placed out of area were disadvantaged because their circumstances did not feature in commissioning strategies; there was no guarantee that the host authority would be informed of their arrival; and because reviewing processes were underdeveloped there was no agreed means of determining the quality of specialist services. There appeared to be nothing in place, neither commissioning processes nor questioning shareholders, to apply brakes to what appeared to be an increasingly autocratic business which was resistant to change."
>
> "Leadership and oversight gaps within ASC which could have ensured and assured that vulnerable adults were being properly supported and safeguarded from abuse/neglect. Although

> concerns were raised and opportunities were available to understand what was happening with [named individual's] money, and who had access to it, these were missed. There were significant delays in the safeguarding investigation which did take place. All of this is understood in the review to be related to a 'problematic culture' within ASC where safeguarding standards were consistently not met, and leadership lacked confidence and assertiveness."

Discriminatory abuse

SARs sometimes highlighted the impact on decision-making of prejudice related to race and gender. Also found were negative attitudes towards people with 'personality disorders' and assumptions that individuals were "'a problem' rather than vulnerable." The outcome could be inflexibility in how services responded to need.

> "DWP recognised that X needed additional support but its own policy would not allow help for her to fill in forms. The DWP assumed that she received support from other agencies. The Coroner did not accept that failings by DWP and Capita were individual human errors but found systemic problems in their conduct. Capita believed that she posed a risk to its staff who therefore did not visit her, but she posed a risk to herself not to others. The Coroner identified the institutional assumption at the DWP that documents which are not on the claimant's file are missing because the claimant failed to send them in."

Exploitation

There were some positive commendations on how organisations were developing their response to exploitation.

> "There is a clear commitment across senior safeguarding leaders and frontline practice to develop locally mechanisms to improve the recognition and respond to adults at risk of exploitation. It is understood that this requires a trauma informed approach that embodies MSP principles."

However, senior leadership commitment alongside improved training and guidance, and changes in organisational culture, multi-agency working practices and commissioning were seen as necessary.

> "Any multi-agency framework for responding to safeguarding adults at risk of sexual or criminal exploitation requires organisational structures to support practitioners work differently, including developing mechanism for recognising significant changes will happen slowly and giving practitioners time to build

trusted relationships with those at high risk of harm. Without senior leadership addressing the current gaps, skilled practitioners working to improve practice will likely experience fatigue. Many frontline workers wanted to address the 'revolving door' nature of the current system offer by working closely with adults who had experienced neglect and trauma before they became parents to stop the cycle, others too wanted clearer steps on how criminal justice agencies would work more proactively to prosecute perpetrators. Lack of placements for young people with complex needs and experience of exploitation, resulting in out of authority placements and disruption to support networks and continuity of work/relationships. Services under pressure to withdraw due to workload demands."

Domain four: SAB governance

Good practice in domain four

The first national analysis found that there were fewer comments on good practice in this domain than observations about practice shortcomings. This trend has continued in this second national analysis, where only 64 SARs made any reference to governance (27.94 per cent), continuing the decreasing focus the further exploration moves away from direct practice.

Of all the domains, SAB governance was commented on the least frequently. On the positive side, SABs' commissioning and management of SARs were commended, but in only 5 and 6 cases respectively, accounting for only two per cent and three per cent of the SARs. Policies, procedures and guidance were commended in five cases (two per cent) and the SAB's role in quality assurance of safeguarding was commended in three cases (one per cent). Beyond that (in the other category in the table below) one SAR commented positively on the SAB's dissemination of SAR learning, another commended the SAB for securing advice from a specialist community advisor with knowledge of the individual's home country, and another commended the SAB's support and endorsement of a local homelessness fatality review process on which it receives outcome reports. The full picture is found in the table below:

SAB governance feature	% of SARs with positive comments
Management of SARs	3%

SAR commissioning	2%
Policies, procedures, guidance for practitioners	2%
Exercise of quality assurance	1%
Dissemination of SAR learning	<1%
Other	<1%

Management of SARs drew the most positive reflections from SAR authors. There were references here to the involvement of an advocate in co-facilitating a learning event, and to excellent cooperation across two geographical areas. One SAR noted that it had been completed on time; another commented positively on attendance and engagement at a learning event. One SAR also referenced advocacy, this time to enable engagement of family members that enhanced the understanding of the person whose human story was being reviewed, which had not been found in agency records.

One aspect of the management of SARs is the commissioning of reviews. Here there were positive comments of timely commissioning and that a SAB had accepted ownership of a transitional safeguarding review even though it had not held legal responsibility for the person. One SAR observed that the approach taken, a rapid review, had been adopted to build on a previous thematic review of self-neglect rather than simply to replicate findings. Another SAR commented that the pandemic had not affected practitioner and agency participation in a review and that the approach adopted had worked well.

> "The methodology of using narrative chronologies, supplemented by interviews and a learning event, worked well. SAR took place during COVID-19 pandemic, but this did not affect participation. The role of housing was recognised through the SAR process."

Another component of the SAR process is the difference that reviews make in terms of practice development and service improvement through dissemination of learning. Only one SAR commented positively on dissemination and impact of learning. It observed that there had been awareness of previous SAR findings across health, housing and social care, and that early learning had ensured that findings from a Local Government and Social Care Ombudsman decision had been progressed, with the consequence that the SAR could focus on lessons learned across the partnership.

Overall, SARs provide limited insight into good practice regarding the commissioning and management of reviews, and how lessons from previously completed reviews have informed key lines of enquiry or terms of reference, and of how newly commissioned SARs have been used to build on earlier work.

SAB governance also extends to its role in seeking assurance about the effectiveness of adult safeguarding, and in publishing and disseminating policies and procedures as guidance for practice. There are only limited references to positive practice here, namely the use of audits of practice to seek assurance, and the availability of guidance on a diverse range of topics, including cuckooing, information-sharing, exploitation and escalation of concerns. Occasionally, it was noted that policy development had been a direct response to SAR findings.

Finally, the following positive examples of governance emerged. One endorsed the process of homelessness fatality reviews and annual reporting to the SAB of the acquired learning. Another commented positively on the guidance from a community adviser with knowledge of effective cultural working and of the individual's home country. Given the concern reported in the quantitative analysis regarding the lack of focus on issues of equality and diversity, this is a welcome but sadly rare example of positive practice. SARs often take place in parallel with, or subsequent to, other review processes. The following example highlights the importance of alignment between parallel processes and how SARs might build upon learning from other investigations and enquiries. A thematic review refers to a complex abuse investigation in a care home as "exemplary" because:

> "As well as timely, well managed, well attended and clear multi-agency meetings at regular intervals, the various strands of the investigation were constantly pulled together and coordinated. The process was exemplary in its focus on the welfare, well-being, voice and needs of the victims of the abuse, and uncompromising in seeking to pursue legal justice for them. The dismissal of staff and the pending legal proceedings are an indicator of the thoroughness and tenacity of those involved to ensure the alleged perpetrators are properly brought to justice."

Practice shortcomings in domain four

The only frequently noted negative impact of SAB governance was from SABs' policies, procedures and guidance for practitioners, commented on in 31 cases (14 per cent), with some shortcomings noted also in SAR commissioning (six cases, three per cent) and management (nine cases, four per cent). Training and SABs' quality assurance actions (eight cases, three per cent, each) were also both occasionally subject to criticism.

In the 'other' category, one review raised a question about whether the

SAB's SAR procedure was fit for purpose in addressing large scale organisational abuse concerns; another questioned a SAB's failure to respond to a suggestion of seeking SAR panel membership from an organisation representing older people, in order to mitigate risk of age-related unconscious bias in the SAR process. The full picture is given in the table below.

	% of SARs with negative comments
Policies, procedures and guidance for practitioners	14%
Management of SARs	4%
SAR commissioning	3%
Training provision	3%
Exercise of quality assurance	3%
Links between SAB and other governance structures (CSP/HWB/LSCB)	1%
SAB membership	<1%
SAB leadership	<1%
Dissemination of SAR learning	<1%
Other	2%

Most negative findings in the domain of SAB governance related to policies, procedures and guidance. One theme here was the absence of policies or guidance to provide a framework for multi-agency risk management. Two SARs identified the absence of a protocol for escalation of concerns regarding high-risk cases and resolution of professional disagreements, which had negative consequences for mental capacity and best interest decisions. Other SARs commented on the absence of specific guidance, for example on self-neglect, executive capacity, sexual exploitation or culturally competent practice. Several highlighted the absence of procedures for responding to cases of abuse or neglect, especially where there was evidence of lack of consent, self-neglect, or coercive and controlling behaviour, that were regarded as falling outside the criteria for enquiries under section 42 Care Act 2014.

If one theme focused on policy and procedural gaps, another was lack of awareness of policies and procedures, resulting in missed opportunities to identify and address adult safeguarding concerns, such as self-neglect, working with risk, exploitation and transitions. There were examples of staff not knowing about self-neglect procedures and pathways to access and use high-risk panels.

However, even if policies and guidance were known, they were not always referred to in practice, either because they were perceived to be unclear or because they were not embedded across all agencies. For example, several SARs highlighted confusion about whether to use adult safeguarding or self-neglect procedures, and about whether to refer domestic abuse concerns to MARAC and/or adult safeguarding. One particular site of confusion was responsibility for convening multi-

agency risk management meetings; another acknowledged confusion for staff in services that crossed local authority boundaries when policies diverged rather than aligned.

A final theme on policies and guidance was the need to review procedures either to ensure that they were compliant with expectations in the Care Act 2024 statutory guidance or to strengthen their effectiveness in the light of experience, for example of large-scale organisational abuse enquiries or outcomes of multi-agency risk management. Examples where policy review was recommended included clarifying arrangements for information-sharing, strengthening multi-agency partnership working in response to multiple exclusion homelessness, and promoting the need for specialist input in cases involving acquired brain injury, alcohol-dependence and disruption of perpetrators of abuse and exploitation.

> “Providers and some managers highlighted the need for the development of a simple guide to raising safeguarding concerns, to help them make judgements about when, where, who and how to make safeguarding referrals to social workers. They noted that [the local authority] does not have a professionals’ helpline for them to use in arriving at judgements nor does it have a clear levels of concern, or a simple local safeguarding matrix tool.”

Practice shortcomings were also identified in relation to the commissioning and management of reviews, and dissemination of their findings. On SAR commissioning, one review observed that a SAR referral recommendation in a section 42 enquiry had not been actioned; two others commented on the absence of guidance about commissioning, including how to accurately interpret the criteria for review in section 44 Care Act 2014, which had disrupted and delayed decision-making. One SAR reflected that there was limited understanding of the purpose of and criteria for reviews, resulting in missed opportunities to refer cases, for example those involving substance misuse or homelessness. Another observed the absence of information for service users and their families on standards of good care and available pathways to raise concerns, which include SAR referrals.

> “SAR forms to be amended to include date of SAR referral.”

On SAR management, some key statutory or third sector services were not included in panel membership and/or in learning events, with a consequent impact on the identification and evidence to inform key lines of enquiry. Age UK and probation were examples. Some services,

such as police, were said to be unclear about what was expected.

Different elements within the SAR process were also highlighted. There was some criticism of the poor quality of independent management reviews (IMRs) and recommendations for guidance for IMR authors. There were examples of delays in receiving information pertinent to the review, and uncertainty, confusion and/or delay about how to manage parallel processes, such as coronial inquests, Local Government and Social Care Ombudsman inquiries, or investigations by the Independent Office for Police Conduct. There was some reflection on how best to inform families of a SAR and to seek their involvement. Letters being sent without prior communication had been experienced as distressing. Also upsetting were delays that were not explained.

On dissemination and learning, one review found a lack of awareness of findings from previously completed SARs.

> "There was no immediate referral under section 44 (Care Act 2014) for consideration of whether the Safeguarding Adults Board should undertake a Safeguarding Adults Review even though the section 42 investigations indicated the criteria for such a review were met. If it had been, there may have been a more effective process of learning from what had happened, as well as a multi-agency approach to the case."

There were few references to SAB membership and leadership. However, one review highlighted gaps in the inclusion of housing and environment health, with additionally some agencies being unaware of the Board and its roles and responsibilities. Three reviews criticised insufficient leadership regarding self-neglect, domestic abuse or adult safeguarding. A perceived lack of leadership was sometimes linked to identified gaps in multi-agency training, the objectives for which include raising awareness and understanding of risks and pathways for intervention. The subject areas identified here illustrate the breadth and complexity of adult safeguarding – domestic abuse, self-neglect, alcohol-dependence, legal literacy and complex enquiries.

> "Practitioners and managers should be offered training to develop their knowledge of and skills for transitional safeguarding. This includes understanding the developmental needs of young people, proportionate risk-taking, legal literacy, mental capacity (16 up) trauma-informed practice, and development of skills of professional curiosity and enquiry into young people's lived experiences."

Where training had been provided, this had not necessarily been followed with outcome evaluation, which is one aspect of the SAB's

responsibility for quality assuring the effectiveness of adult safeguarding. Of particular concern here was the SAB's role locally for assuring that providers can meet local needs for safe care at home or for appropriate placements in health or social care settings.

Finally, three SARs explicitly highlighted the need for all-age governance and for oversight of practice and the management of practice across partnerships. This included an all-age focus on exploitation and on domestic abuse, involving safeguarding children partnerships and community safety partnerships, and the need for clarity about where the governance for homelessness sits.

Domain five: The national legal, policy and financial context

The first national analysis of SARs reported that just under a quarter of reviews commented on the national context within which adult safeguarding is situated. It referenced concerns that SARs had given insufficient consideration to this context and observed that the quality markers had advised SABs to consider which findings and recommendations would be addressed more effectively in regional and national forums.

In the stratified sample for this second national analysis of SARs, 96 reviews (42 per cent) contained observations about the national context, representing an increase from the earlier study. However, 40 per cent of references to the national context focused on the pandemic. Seen in this light, there remains insufficient focus on the national legal, policy and financial context within which safeguarding is situated.

Positive features of the national context

There was very little of positive note in the national context domain. Among the 229 SARs included in the analysis, only six commended features of the national context, five of them (two percent) noting the COVID-19 pandemic, and one (<1 per cent) about national health and social care policy.

National context features having a positive impact on the case under review	% of SARs with positive comments
COVID-19 pandemic	2%
National health and social care policy	<1%

A few SARs did mention the positive impact of the "*everyone in*"

response to the pandemic with respect to people experiencing homelessness, highlighting what can be achieved when there is a national policy initiative supported with funding. Other SARs commented positively that health, uniform and social care practitioners had continued to meet people's needs, with face-to-face visits continuing.

> "Despite the pandemic putting the NHS under extreme pressure, the GP remained open and was available to [named individual] throughout. It is reassuring that the pandemic had no impact upon the GP practice's ability to arrange an out of hours home visiting service healthcare professional to attend the home address in January 2021 when he was poorly. Similarly, it is commendable that the community nurse attended to him at home. It is particularly commendable that despite the pandemic, he was still able to have his annual health check in October 2020."

> "It is important to acknowledge what has been achieved with respect to people experiencing homelessness as a result of the response to the COVID-19 pandemic. Derogation of legal rules and the injection of financial resources has made a marked difference for people previously homeless. It has demonstrated what can be achieved when the financial, legal and policy context changes, and supports good practice locally. It has demonstrated what recent research has advised when outlining five principles – find and engage people, build and support the workforce to go beyond existing service limitations, prioritise relationships, tailor local responses to people sleeping rough and, finally, use the full power of commissioning to meet people's health, housing and social care needs."

Negative features of the national context

Conversely, 22 per cent of the SARs commented on shortcomings arising from the COVID-19 pandemic. Negative impact from the economic context was noted in eight per cent of cases, and from legal powers and duties in seven per cent.

National health and social care policy drew criticism in five per cent of cases, and national commissioning strategy was seen as having a negative impact in three per cent. The statutory guidance on safeguarding drew negative comment in two per cent of cases, with under one per cent of cases featuring negative impacts from

immigration policy (two cases) and regulation of services (one case). The full picture is given in this table.

National context feature having a negative impact on the case under review	% of SARs with negative comments
COVID-19 pandemic	22%
National economic context	8%
Legal powers and duties	7%
National health and social care policy	5%
National commissioning strategy	3%
Statutory guidance on safeguarding	2%
Immigration policy	<1%
Regulation of services	<1%
Other*	8%

*Aspects of the national context featuring in the 'other' category include safeguarding:

- a national shortage of staff experienced in safeguarding
- absence of safeguarding policy in Royal Mail
- some regional or national organisations (the water company, the postal service and utility companies) not responding to invitations to participate in the SAR, causing the review to question how these organisations engage with safeguarding
- risk assessments not undertaken with people who are self-funding their care, resulting in less information passed on to providers
- gaps in information sharing due to asylum processes
- telescopic bed rails, against local guidance and Health and Safety Executive advice
- national guidance lacking on adult sexual exploitation and the transition to adulthood whilst being sexually exploited as a child and limited case law in the use of inherent jurisdiction in this area of work
- the Disclosure and Barring Service operating in a way that can leave home care providers unsighted on historic information that might impact on risk assessment and employment decisions.

Inequalities:

- poverty and inequalities faced by black and minority ethnic groups
- use of the label Acute Behavioural Disorder/Disturbance as it relates to Black people, specifically how it is understood across national and local agencies
- lack of parity of esteem for people with learning disabilities in the

context of their healthcare.

Legal powers:

- absence of any power to compel actions to reduce fire risk in private dwellings
- actions of DWP and Capita
- actions of CQC.

Several reviews demonstrated the impact of interconnected features: responses to the pandemic alongside the impact of austerity and available legal powers; NHS or social care policy in the context of austerity.

> “The changing nature of the legal framework when young people attain 18-years of age led to different approaches from agencies. Suddenly an 18-year-old is expected to be fully accountable for their decisions, there is little long-term work. There had been a significant rise in the number and complexity of cases involving young people leaving care, placing considerable pressure on available resources. Young people are entering the care system later than previously and that renewed emphasis needed to be placed on early transition planning.
>
> “The COVID-19 pandemic has had an impact on staff, increasingly working from home, making it more difficult to access peer support to help with processing the emotions triggered by the work. The impact of more than a decade of financial austerity and its impact on the availability and quality of placements. Practitioners and operational managers also drew attention to the difficulty of finding appropriate placements, such as mental health beds, and of commissioning within the available funding envelope. As a result, young people/young adults could be “pigeon-holed” into an existing service. It has been suggested that consideration be given to further development of services for 18–24-year-olds.”
>
> “Communication issues between provider (host health area) and commissioner (placing health area) were exacerbated by the role that is played by NHS England in sourcing a placement; NHS England communicated directly with [the person’s] family, but not with provider or commissioner. This lack of consistency and the informal communications that followed made it difficult for the provider to respond to [the person’s] understandable queries about discharge from PICU and into low secure accommodation, and also difficult for commissioners to provide

similar progress updates.

> “Long waiting times nationally for talking therapies. National shortage for provision for people with EUPD. Her transfer from the out of area PICU to a low secure environment was delayed by months because of the low availability of a suitable long-term placement which felt they could meet her needs. Her stay on PICU was no longer supporting her. This delay is more likely to happen to women (Women in Crisis: How women and girls are being failed by the Mental health Act 2018: MIND) There is a national underfunding of mental health resources.”

Turning to specific features within the national context, there was some criticism of the government’s response to the pandemic. For example, a lack of planning and preparation in recognition of the needs of the residential sector.

> “Shortage of PPE for supported living providers. Lack of guidance initially for supported living providers regarding shielding and confusion about whether someone needing to shield could go out for exercise (he was taken out despite being advised that he should shield). Critique of government guidance - delays in issuing for supported living providers, frequency of change sin guidance, virtual working systems patchy and not fully developed, uncertainty for providers about DOLs and shielding. Family not told when they could visit during pandemic to hospital despite NHS England guidance.”

More numerous were references to the impact of the pandemic on adults at risk from domestic abuse or substance misuse, and on those living in supported settings, on learning disabled people and those living with other forms of neurodiversity.

> “The COVID pandemic caused a traumatic loss of routine. It was hard for [him] to understand the loss of activities such as holidays and trips out. It must be acknowledged how his stress and anxiety would have intensified the demands of his care and although this review is unable to ask his parents for clarification, it undoubtedly must have had an effect on them as his carers. The biggest challenges arising from the COVID pandemic for professionals was that it hindered the ability to undertake home visits. In the absence of face-to-face contact with X, professionals found it harder to monitor his care needs and support. As other services were not undertaking home visits there was an unavoidable reliance on the Day Centre to communicate any change in need and it is good practice that

> when staff became concerned for him, they referred immediately for support. However, there was an unavoidable closure of the day service in January 2021 due to a COVID outbreak, and hence a period of time when no professional saw him."
>
> "X was supported via telephone only services during the lockdown just prior to her death. She felt isolated and requested face to face but was thought to not have a high enough risk to warrant the COVID infection risk. The coroner's verdict specifically identified that her suicidal intent was aggravated by the restrictions imposed in response to the COVID-19 pandemic. Her Hepatitis C care was also affected by the pandemic, and she struggled to comply with restrictions, she was hospitalised twice with COVID infection."

Some reviews noted the impact of the pandemic on available services, for example residential rehabilitation, deep cleans, or accessing secondary mental health services for people needing urgent and emergency mental health care. Others observed the impact on monitoring adults at risk by practitioners and by relatives, the limitations of virtual communication, and the loss of the individual's voice. One SAR commented that safeguarding supervision had been suspended alongside delays in assessment and staff shortage due to illness. Staff redeployment reduced the availability of advice from specialist practitioners.

> "Whilst face to face meetings with X were maintained, their frequency was reduced, and a significant amount of contact was conducted by text messaging. This made it difficult for professionals to identify that some of the information provided to them was not true and that he was providing conflicting information to those working with him. Due to the national 'lockdown' and the government's 'work from home' guidance, mobile and remote working practices had to be implemented rapidly. Whilst professionals quickly adapted to this new way of working, it reduced the opportunity to receive support and guidance from colleagues and supervisors, that had previously been provided through everyday contact in the workplace. Not only would this have reduced the quality of case supervision, but it understandably led to professionals feeling a sense of isolation and a general feeling of nervousness whilst delivering services during 'lockdown' periods."

The pandemic also impacted on SAR management, with staff being redirected to other priorities, with adaptations to intended methodologies in acknowledgement of pressures on practitioners,

managers and services, and delays in completing and implementing learning from SARs.

SARs provide evidence of the profound effects on individuals and on care settings, and of the challenges experienced by health and social care staff in particular.

> "Whilst [two named young women] continued to receive services during the COVID pandemic the lockdown may have impacted negatively on their mental health, increasing risks to them. The research evidence supports this and identified that the negative impact had been greater for younger people. This appears to have been the case for [one of the young women], who was reported by her PA to have found isolation very difficult emotionally. She had said in June 2020 that she was part of a suicide pact and took her own life in July 2020, after the first national lockdown had ended. Similarly, [the second young woman] appears to have been grieving the loss of her partner to suicide. These are factors that can increase the risk of suicide. She was living with a friend when she took her own life in May 2020, whilst the first lockdown was still in force."

Despite austerity being a feature of public services for over a decade, only 19 SARs referred to its impact. In relation to homelessness, a SAR referred to the lack of supported housing and the demise of the Supporting People programme, concluding that there had been a loss of provision, an increase in silo working and reduced tenancy support. This SAR also suggested that changes to housing benefit were linked to homelessness. More generally, small numbers of SARs referred to the impact of austerity on people's lived experience - the impact of welfare benefit rules, for instance the bedroom tax, the impact of poverty and inequality on disabled people and on people from minority groups. Other SARs referenced the impact of austerity on services in a context of rising demand – lack of funding for specialist provision, of substance misuse services for example, or lack of consistent substance misuse staff available in emergency departments, or mental health bed pressures leading to premature hospital discharge and section 17 Mental Health Act 1983 leave decisions. One review suggested that austerity had resulted in demand management and reduced professional curiosity. Another that a shortage of dual diagnosis placements meant that there was very little choice of provision on discharge from hospital.

> "The review found that housing options are limited since there is no funding available for care leavers outside of the statutory temporary accommodation for all people based on priority need

and vulnerability criteria."

> "The impact of austerity locally had resulted in a lack of investment in community substance misuse and mental health services, particularly those that enable early intervention or preventative approaches. A national shortage of specialist residential placements - this has worsened significantly since 2019."

The focus on legal powers sometimes identified specific gaps in law, for example the consequences of the absence of an adult safeguarding power of entry in England, unlike in Wales and in Scotland, or the lack of any power to enforce action to reduce fire risk in a person's own home. One SAR was critical of the law relating to disclosure of criminal convictions, concluding that this had left a home care provider unsighted on historic information and therefore unable to complete a thorough risk assessment prior to an employment decision. More generally, there were criticisms of the level of legal literacy amongst health, social care and other practitioners. Critique of the legal rules was sometimes linked with the impact of austerity on individuals and on services, and to the policy environment.

> "The legal framework does not provide rigorous enough requirements to ensure the host authority is both aware of and able to monitor the well-being of those individuals placed in learning disability, autism or mental health settings in particular. It is clear that the situation in [a care home] reflects a broader national set of issues in relation to how well a local authority area can safeguard and protect its citizens properly if it does not know where the most vulnerable are living or what degree of need there might be for specific forms of service (such as specialist autism support). The argument for mandatory reporting has been made before but it remains valid. ... Placing authorities are frequently a distance away, and staff do not always perform sufficient due diligence when making placements especially when spot purchasing in a crisis. This ongoing situation is not acceptable. Whether mandatory placement reporting is a requirement laid on the placing authority or on the provider of the care setting is less important than the expectation all placements are reported to the host authority."

> "Government policy with respect to 'no recourse to public funds' undeniably presents challenges to those working with people who are homeless with care and support needs ... The processes to secure settled status and habitual residency are

slow and complex. Vulnerable people can find it difficult to apply for settled status, especially if they have limited ability to speak and understand English, limited access to online technology, and difficulty in obtaining documentary evidence from High Commissions and/or Embassies. The financial context, noting the impact of financial austerity on the capacity of all agencies (not just Adult Social Care) to absorb the workload arising from recognition of the care and support needs, and safeguarding concerns of people sleeping on the streets. The documentation provided for this thematic review includes the observation that the closure of a day centre hit [named individual] hard since it meant that he lost friendships, care and solace. The Homelessness Reduction Act 2017 is silent with respect to two of the main contributing factors towards homelessness, namely the lack of supply of affordable housing and affordability of available accommodation. Welfare reforms have had a negative impact by creating landlord mistrust of Universal Credit and by failing to assist people into the private sector due to the rise in rents not being matched by the level of assistance available. Reducing support for people to help them maintain tenancies and changes in Housing Benefit have rendered some people homeless. It is not unusual to remark that the achievement of one government policy, namely here the prevention of homelessness, is undermined by another, namely here welfare benefit changes."

References to NHS and social care policy focused on specific concerns, for example the limited attention given to alcohol-dependence in Care Act 2014 statutory guidance, practice guidance for the Mental Capacity Act 2005, and code of practice for the Mental Health Act 1983. One SAR suggested that either improved guidance or new law was needed with respect to treating alcohol-dependence. Others identified policy gaps included:

- lack of quality standards for inpatient settings and for safe staffing levels, including management and leadership roles alongside clinicians and practitioners
- absence of a statutory requirement for a named doctor for adult safeguarding (unlike for safeguarding children)
- lack of a statutory requirement on visiting frequency which limits assessment and review of the needs of people with learning disabilities
- lack of national guidance on adult sexual exploitation, including

for transitional safeguarding

- absence of national policy on information-sharing for responding to violent or sex offenders who develop dementia
- absence of a nationwide approach to checking if a person is missing
- lack of an evaluated tool for assessing levels and seriousness of self-neglect, contrasted with the Graded Care Profile.

Occasionally, SARs referred to problems with current policies, including lack of awareness of the modern slavery National Referral Mechanism and delays in the transfer of primary care records,

Finally, under this heading, there were references to national training needs, for example for working with people with learning disabilities and autism, and to ensure enquiry into domestic abuse when callers contact emergency services.

> "Gap in national policy identified regarding responsibility to disclose information when people on the violent and sex offender register experience declining mental capacity (dementia). This was referred to the National Police Chiefs Council."

> "Broad concerns were raised about the effect of racism on police decision making, in relation to [named individual] and to black men in general. Concerns that this has not been addressed despite the numerous inquiries and reports into the issue in the last 30 years. Concerns about accountability processes of the IOPC being insufficient to address race and racism."

> "No national policy, or statutory framework, for responding to adult victims of sexual exploitation because their plight has in the past not attracted sufficient attention. A key issue is the lack of robustness in the transition pathways for child victims unless they are "looked after" children where there are statutory responsibilities entitling them to continued support up to the age of 25 from the local authority. For other young people, who may have experienced high levels of trauma and harm, their circumstances and needs do not readily fall into the existing transition arrangements and referral routes into adult services – those provided by all agencies not just the local authority. This is despite research findings that have shown that access to ongoing mental health and therapeutic support for victims moving into adulthood is crucial to aid their recovery."

There were specific comments on the Care Act 2014 statutory

guidance provisions with respect to adult safeguarding. Some SARs highlighted the need for adult safeguarding to include such services as postal delivery, utility company provision and refuse collection, and for such services to have policies on adult safeguarding. There were some criticisms of the provisions relating to the duty to enquire (section 42).

> "Although all agencies should be using the 3 stage criteria, as set out in the Care Act 2014 (section 42.1) in practice this is difficult, due to both subjectivity on the part of staff and the lack of clarity in the statutory guidance. This causes confusion about the threshold for identifying an issue as 'a safeguarding issue.' A key issue was when the catalogue of supposed minor issues reach the threshold for a criminal standard of proof for gross negligence, requiring police action. Concerns raised by health professionals to local authority thresholds were not necessarily agreed between the agencies for involvement duties under section 42.2 If the concern was considered to not meet the threshold, by the safeguarding adult team, a single agency plan was implemented and overseen by the health practitioner involved."

There were occasional comments on the impact of immigration policy on individuals, with SAR authors concluding that uncertainty about an individual's status affected their physical and mental wellbeing and delayed decisions about their eligibility for services to meet accommodation and care and support needs.

A few SARs comment on the regulation of services, for example the absence of regulation at the time of accommodation housing vulnerable individuals, or perceived shortcomings in inspection.

> "There was no credible monitoring or inspection. The CQC did not seek out the families' experience of visiting (or being discouraged from doing so) and did not 'hold the ring' in terms of having an overview of the complaints, the safeguarding referrals and contract compliance monitoring for example. It was unaware of the existence and use of the 'Garden Room' and the 'Quiet Room.' The CQC stated that its pre-October 2014 inspection methodology was heavily weighted towards seeking people's views and making observations, with inspectors focusing less on the documentation relating to people's care – which is where the strongest evidence of noncompliance was eventually found."

The challenges of recruitment and retention of staff were mentioned in a few cases when linking local findings to the national context. There were also reflections about inequality of health care for learning

disabled people, and concern about the use of a diagnosis of acute behavioural disorder or disturbance being applied to Black British, Black Caribbean and Black African men, often in a context of contact with the police.

Finally, returning to policy on welfare benefits, there were concerns about Department for Work and Pensions' recognition of adult safeguarding responsibilities and conduct when processing benefit claims.

Learning from the two reviews quoted below has resulted in the development of a memorandum of understanding between DWP and the National Network for SAB Chairs in respect of information-sharing, referrals under section 42 and section 44, and collaboration on SARs.

> "His family wanted it to be made clear that his death should not be characterised as arising solely from self-neglect. They feel the welfare system failed him as it has/does many others in similar situations. It is evident from the review that the combined impact of policy and practice around DWP decisions (and the actions of the council arising from them) had an impact, although not causal, on his death."
>
> "The coroner was highly critical of the DWP and Capita and issued a Regulation 28 report to prevent future deaths. The coroner referenced twenty-eight problems in processing her PIP claim and detailed the impact that this had upon her mental health. The coroner did not accept that these were individual human errors but found systemic problems in the conduct of the DWP and Capita."

Sources of evidence

The SAR quality markers advise that SAR reports should be clear where wider knowledge about adult safeguarding is drawn from when interrogating individual cases. In the first national analysis, 23 per cent of SARs did not reference wider sources of learning. That figure has fallen to 20 per cent here but is nonetheless of concern that many SARs are not explicitly supporting their analysis by drawing on law, guidance, research and other sources of knowledge about adult safeguarding.

Seventy seven percent of the 229 SAR reports drew on wider sources of learning to provide context for the learning emerging from the specific cases under review. Many of the sources quoted were either

from statute or statutory guidance - the former being quoted in 50 per cent of all SARs and the latter in 38 per cent. Research findings were also commonly quoted, appearing in 50 per cent of all SARs.

Reports also drew on non-statutory guidance: national guidance documents (such as those produced by NICE) (mentioned in 41 per cent of SARs) and practice guidance/codes of practice (mentioned in 34 per cent). Local policies, procedures and protocols appeared in 39 per cent. Learning from other SARs also made an appearance, with 21 per cent referring to other SARs published by the SAB and 19 per cent to other SARs conducted elsewhere, while seven per cent referred to the first national analysis of SARs.

Finally, four per cent made mention of inspection reports. Case law, local DHRs, journal articles each received two or three mentions. There were also a number of single mentions, including of the 2017 London thematic review of SARs, an ADASS practice note, CQC guidance on medication, GMC ethical guidance, a LeDeR report, journal articles, NHS England guidance, a government report on COVID, serious incident review findings, an Asian mental health helpline, a children's commissioner report and a chief social worker briefing on transitional safeguarding.

Source of learning	Number of mentions	% of SARs in which the sources appear
Research findings	115	50%
Statute	114	50%
National guidance documents (e.g. NICE)	95	41%
Local policies / procedures / protocols	90	39%
National statutory guidance	87	38%
National codes of practice	78	34%
Other SARs conducted by the SAB	47	21%
Other SARs conducted by other SABs	43	19%
First national analysis of SARs 2020	17	7%
Inspection reports	9	4%
Other	17	7%

In some other SARs there was a limited use of wider learning and evidence through oblique references to sources of knowledge without further detail. This raises a question, first highlighted in the first national analysis, about how SABs are assuring the quality of final reports.

> "This SAR would have benefitted from a greater focus on evidence related to cultural competency and relationships between marginalised communities and statutory agencies. It would also have benefitted from drawing in evidence about familial abuse and self-neglect, which although unconfirmed in relation to X provide useful evidence about positive practice

which may have been helpful in understanding the care and support offered to X and her family."

However, other SARs made extensive use of wider sources of learning, as noted during the stage 2 analysis.

> "Good use (and not over-use) of evidence and wider learning. In particular, really good use of previous SARs commissioned by this SAB and good connections made between findings and recommendations that avoided duplication of effort but also highlighted ongoing systemic issues arising even after other reviews have noted such issues."

> "The report makes good use of a range of evidence, policy and learning at local and national levels. Interestingly it also indicates opportunities to influence national change in relevant areas, which is unusual in a SAR and gives it a stronger systems-focus."

> "A very evidence-led review, making mention of a wide range of relevant legislation, guidance and how it applies to the safeguarding of the three subjects of the thematic review."

In the first national analysis, 58 per cent of SARs referenced primary legislation. This figure has fallen slightly to 51 per cent but law remains the primary source of wider evidence. The range of legislation once again demonstrates the breadth of adult safeguarding, covering care and support (Care Act 2014), health (Mental Health Act 1983 and Mental Capacity Act 2005), accommodation (Homelessness Reduction Act 2017 and Housing Act 1996), domestic abuse (Domestic Abuse Act 2021 and the domestic violence disclosure scheme or Clare's law), offending (Serious Crime Act 2015, Offender Rehabilitation Act 2014, and anti-social legislation), child care and transitional safeguarding (Children and Families Act 2014 and Children Leaving Care Act 2000), and social justice (Human Rights Act 1998 and Equality Act 2010). There were occasional references to the law mandating CQC inspections and deprivation of liberty.

There were occasional observations, when quoting statute, that the provisions were not well understood, highlighting the importance of legal literacy. One example, relevant to counteracting organisational abuse, is section 44 Mental Capacity Act 2005. Forty one percent of reviews in the first national analysis used research findings. That figure has risen to 52 per cent here. Once again, the span of utilised research findings demonstrates the breadth of adult safeguarding. Some drew attention to the national context, to enhance commentary on domain five – the impact of the pandemic on adult safeguarding and the

consequences of austerity. Other research was used to reinforce the findings of particular types of abuse/neglect, such as domestic homicide involving older people, child neglect, ageing and neglect, or self-neglect. Other research reinforced findings on particular issues encountered by practitioners, for example diabetes, adverse childhood experiences, links between autism and suicide, alcohol-dependence, dual diagnosis, and people diagnosed with emotionally unstable personality disorder.

> "Research studies on learning disability - health issues, premature mortality, use of services, reasonable adjustments, and use of Mental Capacity Act."

> "This report gives an excellent overview and critique of safeguarding in the context of sexual exploitation."

Other research focused on practice itself – trauma-aware and trauma-informed practice, professional curiosity, and services working together. The breadth of adult safeguarding and of the knowledge required by SAR authors is also illustrated by an increasing use of national guidance from organisations such as NICE, SCIE, Alcohol Change UK, NHS Digital, the Local Government Association (LGA) and CQC. Further examples included guidance on opiate dependency (Public Health England), clinically assisted nutrition and hydration (British Medical Association), making safeguarding personal and best practice with people experiencing homelessness (LGA), safeguarding across borders (ADASS) and hospital discharge (NICE).

Once again, some of the guidance utilised focused on specific types or abuse/neglect; some on specific concerns encountered in practice, for instance the impact of adverse childhood experiences, alcohol-dependence, suicidal ideation, frailty and dementia, disabled young people with complex needs, continence care, and adults with severe and enduring forms of mental ill-health.

One review specifically highlighted vicarious trauma, a process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents, torture, and material relating to their trauma, is potentially affected, including health and social care professionals. Another review focused on inequality experienced by disabled people.

This second national analysis has seen a rise of five percentage points in the use of local or regional policies to reinforce SAR findings. Examples included guidance on escalation and the resolution of professional disagreements, hospital discharge, pressure ulcer care and responding to tissue viability concerns, and procedures for

convening and using multi-agency risk management meetings. Occasionally, discrepancies were highlighted between regional and local policies, for example on how to navigate divergent wishes expressed by carers and the cared-for person.

Occasionally also, gaps in local policies were recorded, such as sexual safety in residential care, or recommendations were made for policy review. Demonstrating the impact of learning as the SAR process unfolded, there were examples of recent policy development, for example to guide practice in the provision of section 117 Mental Health Act 1983 aftercare.

There was less use made of statutory guidance and codes of practice in this second national analysis. Unsurprisingly, most focus here fell on the statutory guidance accompanying the Care Act 2014 but there were also references to statutory guidance on anti-social behaviour, Home Office guidance on statutory disclosures, and Working Together – guidance for safeguarding children. A wider range of practice guidance or codes of practice was referenced, mainly relating to the Mental Capacity Act 2005 and Mental Health Act 1983. Some use was made of the Department for Levelling Up, Housing and Communities' rough sleeping strategy, the Department of Health and Social Care's guidance on dual diagnosis, and guidance on supported living, the Care Programme Approach and on preventing premature deaths of learning-disabled people.

Very limited use was made of case law, the following example being an exception.

> "Inclusion of case law including Greenwich RLBC v CDM [2019] EWCOP 32 and Cheshire West and Chester Council v PWK [2019] EWCOP 57."

Once again, despite the increasing number of reviews and the availability now of a SAR national library, references to other SARs completed locally were limited (10 per cent in the first national analysis; 21 per cent here) or elsewhere (12 per cent in the first national analysis; 19 per cent here). This runs the risk of duplication of findings and recommendations, rather than evaluating their outcome and building on earlier work. This was acknowledged implicitly on occasions, with references to repetitive themes, for example on transitional safeguarding, homelessness, executive functioning and alcohol-dependence. Little use had been made of the first national analysis in subsequent reviews.

Much less use has been made of inspection reports, a fall from 10 per cent to four per cent. There were occasional references to decisions by

the Ombudsman, to OFSTED commentary on placement shortage, and to annual reports outlining LeDeR findings.

Under the “other” category, were individual references to guidance from NHS England, CQC (medication management) and from the General Medical Council (ethics), LeDeR reports, domestic homicide reviews, and journal articles, for example on self-neglect and on transitional safeguarding. There were single references to ADASS briefing notes, OFSTED findings on serious incidents, government reports on COVID, the Children’s Commissioner report on out of area placements, and the Chief Social Worker’s guidance on transitional safeguarding.

Recommendations made by SARs

The majority of the SAR reports made recommendations for action to be taken as a result of the learning arising from the review. The highest number of recommendations in any one SAR was 36, while ten SARs made no recommendations. The average across all SARs was 9.06. The median (middle value when all numbers were ranked) was 8 and the number appearing most frequently were 5. This compares with the first national analysis where the mean was 10.17 recommendations per review, the median was 8.5 and the most frequently occurring number was seven.

SAR reports usually framed recommendations as specific actions to be taken. Of the 203 SARs doing so, 34 per cent specified action by the SAB, eight per cent by specific agencies, and 58 per cent to a mix of both.

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	Party to whom the recommendation actions are addressed	Response Percent	Response Total
1	to the SAB	34%	69
2	to individual agencies	8%	16
3	to a mix of both	58%	118

Of the agencies named in the recommendations (regardless of to whom the required action was directed) action was most commonly to be taken by the SAB, specified in 74 per cent of the SARs in which the agency to act was named. This mirrored first national analysis. It was also common for action to be addressed to all agencies, without any singled out; this was the case in 55 per cent.

Of the named agencies, the local authority appeared most frequently (51 per cent), with action by mental health trusts (27 per cent) and Integrated Care Boards (23 per cent) required in more than one fifth of the reviews, closely followed by hospital trusts (19 per cent) and the police (18 per cent).

	Agency named in the recommendations	Response Percent	Response Total
1	Adult social care	51%	110
2	Local authority housing	8%	18
3	Local authority other	16%	34
4	Police	18%	38
5	ICB	23%	50
6	GP service	14%	30
7	Hospital trust	19%	40
8	Mental health trust	27%	57
9	Community health trust	11%	24
10	Fire & rescue service	2%	5
11	Ambulance service	3%	7
12	Housing provider(s)	4%	9
13	Social care provider(s)	11%	24
14	Addressed to all agencies	55%	119
15	The SAB	74%	159
16	A national body	13%	28
17	Other	46%	98

National bodies specified included CQC, NHS England, Department of Health and Social Care, Law Commission, Crown Prosecution Service, Home Office, Ministry of Justice, Post Office, Department for Work and Pensions, General Optical Council, National Care Forum, Police and Crime Commissioners Office, Canal and River Trust, the National SAB Chairs Network, Modern Slavery NRM Reform Team and Office of the Anti-Slavery Commissioner.

At local level, additional agencies from which actions were required included the Coroner, Children's Services, Safeguarding Children Board, Multi Agency Safeguarding Hub, Probation Service, Community Safety Partnership, Healthwatch, SABs in other areas, advocacy provider, drug and alcohol services, care home providers, groups of experts by experience and equipment providers.

The actions required in the recommendations fell across all domains of safeguarding, with improvements in direct practice being the most frequently sought; this domain featured in 93 per cent of the 215 SARs in which the domain targeted for recommendations could be identified.

At the other end of the scale, action by agencies operating in the national context was required in 15 per cent.

	Domain of practice in which action was recommended	Response Percent	Response Total
1	Direct practice	93%	201
2	Interagency practice	85%	183
3	Organisational features	70%	150
4	SAB governance	52%	111
5	National context	15%	32

Before reflecting on individual recommendations across the five domains, the breadth and complexity of adult safeguarding can be illustrated by summarising the scope across all domains. By way of illustration, one review recommended all agencies and practitioners to support relationship-based practice and measure its quality and outcomes; to ensure supervision; to develop a culture of curiosity; to ensure awareness of when consent can be overridden because of safeguarding risks (legal literacy); to check on practice standards; to ensure awareness and use of available guidance; to ensure sound consideration when concerns expressed by members of pubic or families; to be aware of organisations that might be able to contribute, and to reflect on practice and decision-making, for instance in

supervision.

Another focused on safeguarding awareness and response to late presentation at emergency departments of injuries and of bruises. It recommended a focus on Adult Social Care responses to repeat referrals of safeguarding concerns, raising awareness and promoting use of strategy meetings, improvements in discharge planning, awareness and response to advance decisions, and documenting best interest meetings, raising awareness of carer assessments and of domestic abuse/coercion and control, and development of a policy for resolving professional disagreements. A further SAR offered improvement recommendations on legal literacy, approaches to working with challenging family members (denied access), responses to safeguarding concerns, strengthening cross-borough working, and development of multi-agency escalation and information-sharing processes.

Recommendations in reviews on self-neglect demonstrate this whole system response, advising review and relaunching of guidance alongside improving knowledge and both direct practice and multi-agency responses to self-neglect with a focus on appropriately assessing mental capacity, and making appropriate referrals of concerns. Questions posed in another review of self-neglect illustrate a similar focus across several domains, namely:

- how to further raise awareness across diverse service providers and local communities that self-neglect is everyone's responsibility and of the pathways for referrals, in order to counteract its invisibility
- how to further enable practitioners to have the time and skills to persist with engagement in the face of refusals where there are significant risks of self-neglect arising from care and support needs and health concerns
- how to improve understanding of the significance of mental capacity, the importance of explicit assessment in conditions of high-risk decision-making, including consideration of executive function, particularly where alcohol dependency is present
- how to promote more consistent awareness across all agencies of fire risk and associated risk management strategies
- how to promote a "think family" approach that sees exploration of familial and social relationships as an important enquiry in order to appreciate signs of safety but also risks of undue influence or coercive and controlling behaviour

- how to ensure referral of safeguarding concerns of self-neglect cases and that repetitive referrals of concerns prompt safeguarding enquiries
- how to build on information-sharing and communication between services, both statutory and third sector, by ensuring that a response to need and risk is coordinated, with a lead agency and nominated key worker, and overseen by regular use of multi-agency meetings;
- how to ensure that supervision promotes and records reflection on the approach being taken, challenges any normalisation or desensitisation of risk, and supports practitioners to manage complex and challenging issues
- how to use the resources that are available to best effect in supporting people who self-neglect, particularly where mental health needs and alcohol dependency are both present.

The focus on learning from fire-related deaths also demonstrates the breadth of action required, including scrutiny of the legal powers available for fire prevention, and the importance of information-sharing. One SAB was advised to seek assurance on fire risk assessments, use of available procedures on self-neglect, training on home fire safety awareness and mental capacity assessments, and provision of carer assessments, as well as to review learning from earlier SARs on fire deaths.

The focus on tissue viability also illustrates the breadth of action required, including quality assurance of available equipment and ensuring awareness of pressure care pathway protocols. Recommendations in one SAR covered identification, referral, assessment and treatment responses; equipment management; risk management and escalation, and personalised care and support.

Similarly, recommendations in a review that focused on acquired brain injury covered several of the domains – commissioning of services, ensuring coverage of comorbidities and co-occurring conditions or needs; development of referral pathways, including for specialist advice; training, for example on how ABI might impact on mental capacity; updating policies and procedures, and ensuring that multi-agency working includes decisions of which agency will lead and which practitioner will act as keyworker.

The breadth and complexity of adult safeguarding can also be illustrated by focusing on some of the recommendations relating to key lines of enquiry on which the second national analysis was explicitly requested to explore.

Denied and difficult access

There is no provision in England, unlike in Wales and in Scotland, for an adult safeguarding power of entry to interview an adult at risk. The recent introduction by the police of 'right care, right person' has brought this into sharper relief with the withdrawal of the police from welfare checks and a focus on their power of entry only when there is an immediate threat to life or limb (section 17 Police and Criminal Evidence Act 1984). Provisions for warrants in the Mental Health Act 1983 will not be relevant to all situations when access might be denied to an adult at risk. One SAR recommended that the absence of an adult safeguarding power of entry be escalated to DHSC. This was done using the escalation protocol developed by the National Network for Safeguarding Adults Board Chairs with DHSC. Another recommended the development of a toolkit detailing ways in which different services can seek authority to access premises.

> "Refusals by family members to allow access to adults identified in need of safeguarding must result in a risk assessment and escalation … Training to develop the skills to work with families who refuse support but who care for an adult who cannot make their own choices."

> "Assurance on the timely execution of warrants with full risk assessment of the impact of any delay and assurance that police will not be asked to undertaken safe and well checks as an interim measure … Assurance on improved cooperation in the execution of s.135 warrants and compliance with the interagency protocol on this."

Organisational abuse and closed cultures

SARs offered recommendations to strengthen large scale enquiry processes and to improve monitoring of providers by commissioners and regulators. One SAR recommended that all patients were immediately removed from the care of the hospital and referred to strengthening processes for commissioning, monitoring and oversight of private hospital facilities, improving accountability processes, closing loopholes that enable failing providers to continue to operate. It also recommended more active reviews of services, to include visits and conversations with patients and raising issues/inviting evidence/seeking assurance at the national level with NHS England,

DHSC and CQC. There were also recommendations related to review of staff training on identifying and reporting organisational abuse, and addressing racism with learning disabled adults.

> "ASC Contracts and Commissioning team to review the focus of provider monitoring visits. ASC to review their contracts team quality improvement board, terms of reference, including accountability and information sharing with other teams within ASC. ASC review the provider concerns and escalation process to include practice guidance and procedure. ASC review mechanisms for sharing both hard and soft information about nursing and care homes. [Care setting] to ensure that care planning meetings with new residents, and where appropriate their families, to take place within 14 days of admission. Responsibility and accountability for implementing the agreed home improvement plan to include the local home management team from the onset. Existing systems to be applied with consistency to 'hear' the residents and their families/representatives voice. {Care setting's] improvement plan to be continually reviewed and critically analysed for effectiveness through considering the experience of the current residents. Community health safeguarding training should stress to all professionals their duty of care and the need to be alert and vigilant to risks of abuse in all settings including care homes, ensuring that the local safeguarding procedure of reporting concerns is embedded in practice."

Exploitation

The adequacy of the definition of sexual exploitation in the Care Act 2014 statutory guidance and the need for more extensive national guidance about safeguarding adults who have experienced sexual exploitation have been escalated as concerns to DHSC by the National Network for Safeguarding Adults Board Chairs.

Recommendations from the stratified sample covered all the domains when addressing the topic of exploitation, including:

- updating and promoting awareness of national and local guidance to ensure roles and responsibilities are "clear and unambiguous"
- provision of support to enable individuals to address the longer term impacts of harm from financial, criminal and sexual exploitation

- assurance regarding transitional safeguarding arrangements for victims of sexual exploitation
- training, for example to recognise the role that alcohol and drug use might play in a person's risk of exploitation and abuse, and their ability to protect themselves from harm
- ensuring contextual risk assessments and proactive risk management plans when placing children or adults with care and support needs who are known to be at risk of sexual or criminal exploitation, or substance misuse
- challenging victim-blaming of young people/young adults
- reviewing commissioning arrangements for complex cases, including a focus on access to suitable and safe care and accommodation
- assurance regarding the effectiveness of PIPOT policies
- provision of guidance on joint investigations, police and ASC
- commissioning of pathways of support for victims and survivors
- SAB to request that the Crown Prosecution Service and Police investigators work to improve the victim's journey through the criminal justice system to create better outcomes for victims of ASE.

Transitional safeguarding

The Care Act 2014 statutory guidance outlines duties across children's services and adult services in relation to transition for care-experienced young people and disabled young people. Recommendations from SARs that feature transitional safeguarding also cover all five domains. They advise improvements to transition planning, to transitional safeguarding, awareness and consideration of exploitation, strengthening the approach to mental capacity in children's services, strengthening the role of care coordinators to act more as lead professionals, responding to autistic young adults with complex needs more holistically and effectively, and improving housing pathways. They emphasised development and alignment of policies across children's social care, community mental health and ASC regarding transitional safeguarding and development of policy for health services regarding transitional safeguarding of physical needs. There were recommendations for multi-agency case file audit regarding the quality of transitional safeguarding, including compliance with statutory

timescales and quality of supervision. Training was highlighted for children's social care and adult social care jointly on Mental Capacity Act 2005 and Care Act 2014, trauma and brain development.

> "SAB to improve policy on managing risk of harm and safeguarding young people transitioning to ensure it is a multi-agency effort. CSC to develop foster placements that provide comprehensive and tenacious care for young people who have experienced trauma. SAB to establish a task and finish group to develop practice, including capacity assessments, when adults at risk have experienced complex trauma. Approaching adulthood procedures to be amended to prioritise young people with complex trauma histories."

Homelessness

Homelessness is an adult safeguarding issue and increasingly has featured in SARs. Once again, recommendations have covered all five domains, demonstrating that practice development and service improvement require corresponding changes at all levels, in effect a whole system response. One SAR made 18 recommendations, which included the following:

- audits of the use of interpreters and advocates, with particular focus on cases involving people who are homeless or threatened with homelessness.
- tracking the impact and effectiveness of recent service enhancements for working with people experiencing homelessness, identifying positive outcomes and any gaps in provision
- SAB reviewing with commissioners and providers where there are gaps to be filled in the availability of holistic, wrap-around support for people experiencing multiple exclusion homelessness
- SAB working with relevant partners to develop guidance on the interface between mental health and mental capacity, with particular reference to the impact of trauma and adverse life experience, substance misuse and the potential for impairment of executive capacity
- SAB convening a summit to review pathways into mental health provision, and to strengthen strategic relationships and operational practice between primary care, social care, third sector agencies working with people experiencing

homelessness and mental health providers.

- assurance from the local authority on how the provisions in the Care Act 2014 relating to care and support are being implemented with respect to people who are homeless
- assurance reports from partner agencies on implementation of the Homelessness Reduction Act 2017, to consider whether further training is required regarding, for example, the duty to refer
- SAB reviewing the use of multi-agency meetings in cases where there are adult safeguarding concerns, including cases involving homelessness and self-neglect, and considering the implications of the findings for revision of policies and procedures, and for the commissioning of multi-agency training.

Another SAR made 15 recommendations, reported here in full to demonstrate the importance of a whole system approach to achieving systemic change. The SAB:

1. engages with other strategic boards to agree roles and responsibilities for people experiencing multiple exclusion homelessness
2. reviews policy and procedure on self-neglect, with reference to people who experience multiple exclusion homelessness, and ensures that all agencies disseminate the requirements and expectations to all staff
3. develops policy and procedures for work with people experiencing multiple exclusion homelessness, to include the adult homelessness pathway
4. engages with other strategic boards and partner agencies to determine the process for future reviews of cases involving the deaths of people experiencing multiple exclusion homelessness
5. maps current service provision for adults who self-neglect and/or have complex needs/or misuse substances and/or are homeless or threatened with homelessness and hold a summit with commissioners and providers to consider further developments
6. maps current service provision for women who experience multiple exclusion homelessness and reviews how children's services and adult services respond individually and together in cases where child protection concerns are engaged
7. reviews multi-agency procedures for working with people who self-neglect to ensure clear pathways for multi-agency panel

meetings and escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice

8. produces guidance and tools for assessing risk in respect of adults who self-neglect and/or experience multiple exclusion homelessness
9. monitors the outcomes of referrals for safeguarding enquiries for those experiencing multiple-exclusion homelessness
10. promotes the development of trauma-informed practice and the assessment of mental capacity, with specific reference to executive decision-making
11. seeks reassurance that discharge arrangements/transitions from prison or hospital settings conform to best practice guidance
12. seeks reassurance that people experiencing multiple exclusion homelessness are benefiting from an integrated approach to meeting their multiple needs
13. ensures the availability of procedures for responding to self-discharge and to patients/ service users who do not engage or attend appointments where risks are significant
14. promotes through the network of SAB independent chairs a “whole system” conversation, including with central government departments, about the learning from this thematic review and other SARs that have considered cases of people experiencing multiple exclusion homelessness
15. audits progress on learning from this SAR after one year from publication and tackle where barriers and obstacles to effective practice and policy or management for practice remain.

Alcohol dependence

A prominent feature when working with people who self-neglect is alcohol-dependence and/or dependence on other drugs, often with a backstory of trauma. Substance misuse is then sometimes explained as a way of managing emotional and mental distress.

In that context, one SAR recommended that all services should be aware of the impact of Hepatitis C on cognitive functioning and mood, and advised all agencies to use the AUDIT tool to identify and record the level of alcohol-related risk. It also recommended that:

"The CCG, Mental Health Trust, Adult Safeguarding, Adult Social Care,

Substance Misuse Services and other relevant agencies should develop a clear approach and pathway to complex clients with emotionally unstable personality disorder, substance use and suicidality. This should identify the need for further service development."

A similar whole-system set of recommendations was contained in another review, as follows:

- joint health and care plans to assess and manage the risks for problem drinkers, including crisis and contingency arrangements to manage the harm arising from alcohol addiction
- guidance on assessing levels of drinking
- assurance on assessment of mental health for people with alcohol dependency when referred
- guidance for practitioners on working with historical trauma affecting a person's mental health
- commissioning of substance misuse services to ensure sufficient provision for assertive outreach
- substance misuse services to define and prioritise clients considered to be at most risk, for example using the Blue Light Approach
- assurance that mental health services have guidance, systems and processes in place to suitably assess mental disorders arising from substance misuse problems, especially where there are symptoms consistent with alcohol related brain damage, such as confabulation, forgetfulness and confusion when the person is not intoxicated
- assurance that thresholds for safeguarding duties are sufficiently understood to apply where self-neglect may arise as a direct or indirect consequence of substance misuse.
- assurance that ASC have sufficient understanding of eligibility criteria following referrals for adults with substance misuse problems
- child carers needs to be assessed and children to be referred to children's services if parental substance use affects their wellbeing
- MCA assessments for people with addictions to take into account of the impact of addictive behaviour on an adult's ability to use and weigh information about the consequences of refusing services, when intoxicated.

Recommendations in one review all centred around direct and multi-agency practice related to domestic abuse and alcohol dependency and included recommendations to implement the findings from the Alcohol Change UK SAR research, audit the effectiveness of the Team Around The Individual (TATI) process and support for domestic abuse perpetrators, to ensure GPs are routinely involved/informed about MARAC cases, to update guidance and improve evidence-based pathways into services.

> "The provision of services for those with alcohol dependency needs to be commissioned in such a way as to provide service users with continuity and flexibility, and be part of a dual care pathway if required with a strong outreach ethos."

> "Mental Health Trust and Substance use service to review the care pathway for people with alcohol dependence and mental health trauma and to provide a co-ordinated response of care and support. ... SAB to raise awareness and understanding of the needs of people who are dependent upon alcohol and the organisations that work with them. This should include mental capacity and that alcohol dependence is not a lifestyle choice."

Domestic abuse

There has been an increase in the number of SARs featuring domestic abuse and a growing recognition of coercive and controlling behaviour.

There were recommendations for an all-age approach to domestic abuse, review of MARAC meetings, multi-agency case audits to provide assurance about routine and direct enquiry about domestic abuse, and an improved training offer for staff around coercion and control, including its impact on people's ability to seek help.

All five domains are again evident in the focus of the recommendations.

> "Domestic abuse training and supervision must cover staff awareness and confidence when there are issues of control, and where people have mental health issues that impact on the safety of others."

> "The board should prioritise further multi-agency focus on the issue of adult family violence between siblings and parents as part of its wider approach to reducing the incidence of Domestic Violence."

Safe care

Some recommendations highlight components of practice to ensure safe care, whether at home or in care settings. One SAR drew attention to several of these components, namely supervision and support to home carers to ensure escalation of deterioration, timely district nurse responses to referrals, timely provision of equipment, and processes for sharing key codes to enable timely access to property.

> “Practice should differentiate between neglect and acts of omission in care relationships, with safeguarding investigations expressing professional curiosity about the underlying causes of care omissions. Annual reviews, medication reviews and specialist reviews should include direct consultation with patients, including home visits.”

> “Where there are concerns about possible financial abuse, or any type of abuse, by a paid carer a referral should be made to the MASH.”

Recommendations by domain

Direct practice

Making Safeguarding Personal (MSP) is a central component of adult safeguarding practice and aligns with two of the six adult safeguarding principles, namely empowerment and partnership. Unsurprisingly, therefore, recommendations on direct practice included the promotion and embedding of MSP, including in risk assessment and management.

> “All agencies to ensure MSP - voice and views of person and their family are captured and recorded, utilizing interpreters and language facilities when appropriate to aid communication.”

> “MSP - work to ensure that a person's views are well informed about risks, and to ensure practitioners ask what life is like for a person rather than think what we as a provider can do.”

Other ingredients that combine to promote empowerment also featured in recommendations, including the promotion of trauma-informed practice.

> “When [the SAB] disseminates the learning from this review, [it]

> emphasises the importance of listening to service users and responding appropriately to their wishes. ... [The SAB] promotes the replacement of the term ‘challenging’ behaviour with a less judgemental term such as distressed behaviour in order to encourage practitioners to explore why the person is behaving as he/she is.”

Advocacy is one means of promoting empowerment and partnership. Embedding advocacy in safeguarding was a focus of some recommendations. Of concern is the apparent need to remind agencies of the importance of the use of advocacy to support the individual.

> “ASC to review how advocates are enabled to fulfil their role and to promote their engagement, especially in situations of control by a third party.”

> “Assurance that all partner agencies ensure that adults who are described as lacking communication should have an advocate in line with their human rights and the Care Act 2014.”

Recommendations on partnership included seeking assurance that practitioners were consulting directly with the adult at risk, for instance speaking with them on their own in a setting of safety when there were concerns about abuse/neglect. There was an emphasis on reviewing communication with individuals and their families, with particular focus on how services respond to ‘did not attend’ or ‘was not brought’. Before drawing conclusions about individuals being unwilling to engage, recommendations encouraged practitioners to review their expectations about contact. One SAR recommended reflection on the concept of ‘non-engagement with services’ and whether sufficient efforts had been made to access ‘hard to reach’ individuals.

> “When an individual like the adult refuses services, it is important to consider why he might be refusing and steps that might be taken to promote his engagement. This will include consideration of mental capacity and safeguarding from the start and to ensure that the individual understands the implications of this and that this is recorded.”

> “SAB should consider the use of outreach and flexible approaches to meet the needs of individuals over the age of 18 years old who find it hard to engage with services and who services consider have multiple complex needs and/ or have had experienced adverse childhood experiences.”

Demonstrating professional curiosity is a central skill. Recommendations addressed the need to promote its use and to support practitioners to challenge what is said and to explore what is

not said, for example in situations of concern about domestic abuse or financial exploitation.

> "The board should immediately pose the question to itself and its partners 'What does a culture of professional curiosity look and feel like?' This work will ensure that all partners are sufficiently confident that their front line staff display professional curiosity in all interactions with their vulnerable clients."

Expressing concerned curiosity is part of prevention and protection, two of the six adult safeguarding principles. On prevention, recommendations encouraged earlier intervention with people experiencing both mental health and physical health needs, and recognition that mental health decline does not always manifest itself as a crisis. Prominent here were recommendations concerned with suicide prevention. Once again, there was also a focus on responses to non-engagement.

> "SAB should consider how to amend procedures and practice guidance in order to specify the nature of vulnerability and potential harm in situations where the adult at risk is also a source of harm to others. All partners must consider how to prevent and respond to such situations, share information with partners, identify themes and cumulative risk, and consider the need to refer an adult safeguarding concern."

> "GP practices to review the use of letters when they have had no contact/response from elderly individuals with a recorded mental health history."

> "SAB should promote learning around inpatient suicide, timely information sharing between agencies, and the risks associated with unmanaged observation levels with all inpatient services. SAB will need to be assured that this has made an impact on practice. ... SAB should be assured that local providers have an agreed protocol in place to identify high risk behaviour incidents and/or patterns of self-harming behaviours, to include thresholds for reporting of safeguarding concerns. ... SAB should promote learning in relation to trauma informed practice. This is to encourage staff to take account of an individual's history of trauma to inform response decisions."

On protection, recommendations aimed to improve safeguarding responses, for example to concerns about domestic abuse, discriminatory abuse or self-neglect, and when individuals find it difficult to disclose abuse. They also addressed safeguarding of individuals with particular disabilities, including learning disabilities and dementia,

through for instance the use of hospital passports. Almost a decade has passed since implementation of the Care Act 2014; it is troubling to read a recommendation that adult social care must improve practitioner confidence in coordination of safeguarding processes and develop thinking on what constitutes a safeguarding concern in individuals whose care and support needs may not be commonly understood, and that all agencies should improve understanding of partnership working in adult safeguarding.

> "Supporting adults living with dementia, particularly those who go missing from their home and who are living in extra care schemes, managing the balance between care and control ... and joint working processes to support high risk individuals, including the use of electronic sensors in extra care, multi-agency risk assessments processes, involvement of landlords and responses to provider concerns."

> "Services to provide assurance that cases have been assessed and plans made to share information when individuals on the violent and sex offender register have declined mental and/or physical health to manage risk. When sex assault in a care setting occurs, police and commissioners should speak as soon as possible to the victim to ascertain their wishes, offer support services and offer alternative accommodation."

> "Police to consider when hate crime involving a person with care and support needs becomes an adult safeguarding issue to be referred. SAB to raise the profile of hate crime as both a criminal offence and a safeguarding issue. SAB to ensure trauma-informed care promoted by Health and Wellbeing Board mental health strategy is embedded across all partners. Police to review victim support services for individuals with learning disability and mental health problems."

The reference above to managing the balance between care and control aligns with the principle of proportionality.

> "[Adult social care] to further enhance and provide assurance of proportionate, personalised and outcome-focused safeguarding adult enquiries."

> The principle of accountability was most often expressed in recommendations focused on legal literacy – reviewing compliance with legislation and ensuring understanding and appropriate implementation of statutory powers and duties.

> "All agencies should take steps to ensure that staff are aware of key elements of the statutory legal framework under the Mental

> Health Act. This includes a knowledge of when compulsory powers under the act may need to be utilised."
>
> "[The local authority] should have a mechanism for ensuring that conditions attached to DOLs authorisations are reviewed and implemented."

However, recommendations also focused on ensuring standards of best practice.

> "[The SAB to] commission audits of the standard of assessments of service users, including those carried out in hospital settings, in respect of whom a residential 24 hour care placement is being considered."
>
> "The Integrated Care Board should write to all GP Practices advising them that when letters are shared with the Practice, either from the patient themselves or by another agency, that they consider it in the context of potential evidence of deteriorating mental health and consider the need for further assessment and/or referral to specialist services."
>
> "Assurance needed on agencies' understanding of safeguarding risk and actions required under safeguarding procedures. ... Test whether coordination and pathways between mental health, housing and adult social care have improved, particularly in the context of adults at risk of suicide and self-harm."

Recommendations on legal literacy inevitably concentrated on practice surrounding mental capacity assessments. Some recommendations focused on practitioners' practice, lack of confidence or ambivalence in conducting mental capacity assessments.

> "Assurance that community nurses have increased knowledge and confidence in mental capacity assessment. Best interests discussions to involve all family members."
>
> "SAB to seek assurance that partner agencies and the services they commission are acting in accordance with the Mental Capacity Act 2005 and its supporting Code of Practice to ensure that: capacity assessments are completed and recorded in accordance with local procedures; there is proper legal scrutiny of long-term decisions re adults who lack capacity in accordance with the judgement of the Court of Protection regarding Steven Neary (2011); appropriate referrals are made to the Court of Protection for the appointment of a Deputy or any relevant Order."

Other recommendations focused on improving practice with respect to

the impact of undue influence on decision-making, fluctuating capacity or executive functioning.

> “Further work to support the importance of understanding the importance of mental capacity, and situational capacity, particularly in the context of an individual living within a toxic relationship where substance dependency, mental health needs and domestic abuse are apparent.”

The Mental Capacity Act 2005 was implemented in 2007. However, there remain concerns about compliance and accurate understanding of the requirements of the legislation.

> “The SAB should seek assurance from the local authority, CCG, health trusts and community health teams that action plans have been developed to address the inconsistencies and potentially unlawful practice identified in this SAR regarding the use of the Mental Capacity Act.”

A further component of legal literacy focuses on duties within the Equality Act 2010 to counteract discrimination and promote equality of opportunity, for instance through the implementation of reasonable adjustments, such as the use of interpreters and referrals for advocacy.

> “Assurance about the level of awareness and related skills of professionals in assessment services for housing and social care in communicating with and understanding how to make reasonable adjustments for people with autism.”

> “[Provision of] guidance around unconscious biases, stigma and perceptions (especially related to perceived around 'lifestyle choices' e.g. sexuality and drug use).”

Best practice is founded on thorough assessments. Unsurprisingly, therefore, SARs included recommendations on assessment, some of which focused on the development of tools.

> “Development a formalised tool to assess self-neglect.”

Other recommendations focused on assessment practice, such as not closing cases until safeguarding assessments and enquiries had been completed, and robustly reviewing assessments and waiting lists for assessment. Assessment practice recommendations also focused on ensuring reasonable adjustments to enable participation of disabled people, and in ensuring timely and thorough reviews of care packages and placements.

> “SAB to seek assurance from ASC that they are offering, completing and reviewing assessments of an adult’s care and

support needs and a carer's support needs in accordance with s9 and s10 respectively and, where appropriate s68, of the Care Act 2014. ... SAB to seek assurance from ASC and the CCG that complex care packages are reviewed regularly and when circumstances change and are managed on a multi-agency basis."

"Where there are differences of opinion about a person's diagnoses, or presentations have changed over time or are no longer consistent with earlier assessments professionals should seek to clarify this through ensuring appropriate reassessments have taken place and are clearly recorded."

"Improvement to the planning and reviewing process by a shared joined planning and reviewing strategy between social care and health in particular closer working with general practitioners. ... Wide promotion and checks on learning disabled people to have annual health checks, Health Action Plans and Hospital Passports. Where people have personal communication needs this should be highlighted in such plans."

Other recommendations focused on types of abuse, the impact of adverse childhood experiences and trauma, and specific practice issues such as home fire safety assessments.

"Need to identify different types of intra-familial domestic abuse - ensure training, supervision, and assessments covering coercion and control."

"ASC to review assessment process to ensure identification and understanding of ACEs. ... SAB and SCB to arrange a multi-disciplinary event to explore impact of ACEs on adults."

"SAB to seek assurance from partner agencies regarding the mechanisms each agency has in place to promote identification and risk reduction of fire safety concerns, including referral routes to [Fire and Rescue] for fire and safety checks. ... Fire & Rescue, local authority and community health trust should review opportunities to develop joint initiatives between Fire and Rescue Services and Occupational Therapists, with a view to combining skills and expertise making most effective use of resources in relation to safe and well checks."

Some recommendations explicitly addressed assessment and support of carers, including carer capacity to provide care and assessment of co-dependence.

There were recommendations that challenged agency culture of

assuming that family members were willing and able to provide care. There are connections here to safe care at home.

> "ASC to assess extent to which carer assessments take account of learning difficulties/disability, and update the carer template on recording systems to encompass carer needs. ASC to reconsider use of term informal carer in context of CA 2014 duties and provide assurance that carer assessments are effective in identifying those who are entitled."

> "Assurance that carers assessments are quality audited. ... Assurance that carer assessments are included in the annual review of an adult with care and support and that these have future planning embedded within them and a risk assessment regarding the sustainability of the caring role."

The focus on carers links with another set of recommendations relating to adopting a think family approach. Included here were recommendations highlighting the importance of understanding cultural and family dynamics, and of working with families as partners in care planning and delivery.

> "Agencies involved in this review should introduce a 'Think Family' approach and support practitioners to consider, for instance, how background information can be obtained from family members or friends that will help to identify risk and approaches to take to increase engagement; how to identify whether family or friends are protective factors or not and how work with family or friends in protection planning and providing ongoing support. This can be achieved through, for example, training, practice development interventions, the use of case and clinical supervision."

> "Assessments must include full involvement of the wider family and social context if this is judged by professionals to be in the individual's best interest or the public interest, even if the individual has not consented."

> "Ensure discussion with family members regarding how to keep an adult at risk safe and well, and consequence of acts of omission/neglect."

One SAR recommended the use of family group conferences to support a think family approach.

> "Council [and NHS Foundation Trust] should assure themselves that staff always consider the possible benefit of offering independent mediation and / or the Family Group conferencing

approach to help resolve entrenched disagreements between relatives which are hampering the agency's ability to deliver the required care and / or treatment."

Hospital discharge is a transitional moment when assessment is especially important. Recommendations advised that hospital discharge assessments and planning comply with NICE guidance, and that discharge processes be reviewed.

A multi-agency and multidisciplinary approach was emphasised, involving information-sharing and use of planning meetings that embodied a whole system response – health, housing and social care.

> "CCG and council are recommended to agree a process to follow in respect of planning and managing very complex discharges. The processes should include discharge plans informed by assessed need, not diagnosis; ensuring that mechanisms are in place to make sure that health and social care specialist and community supports for people with complex needs are identified, are involved in discharge planning and are in place prior to discharge; identification of mechanisms to support transition into the community, including a review of needs, risks, and plans at agreed intervals post discharge."

> "It is recommended that [the foundation trust] amend their discharge planning arrangements to suggest a multi-disciplinary planning meeting where the patient is subject to an ongoing Section 42 Safeguarding Enquiry and there is suitable reason to call an MDT to further protect that person (e.g. in [named individual's] case he was returning home to place of risk."

Best hospital discharge practice includes consideration of risk.

> "Ensure an effective system of multi-agency planning prior to hospital discharge of vulnerable people, including information-exchange and risk assessments."

Recommendations focused on several aspects of risk assessment. Some emphasised the importance of clear pathways and tools, and of a multi-agency approach.

> "Review of risk assessment tools and conventions to improve quality of risk assessment."

> "Implement multi-agency risk framework and tools for all agencies."

Others focused on guidance for, and quality assurance of risk assessments.

> “Assurance from commissioners on flexibility in commissioning to enable return home. ... Guidance on risk assessment that balances self-determination with duty of care.”
>
> “Commission multi-agency audit of risk assessments, for example when section 42 criteria not met, to ensure a joined-up approach; review multi-agency risk assessment policies and provide training in multi-agency risk assessment.”

Interagency practice

Central to effective adult safeguarding is how the ‘team around me’ or the ‘team around the person’ works together. SARs recommended the promotion of professional assertiveness rather than acceptance of professional hierarchies, and called for better liaison between children’s services and adult services in transitional safeguarding.

There were recommendations that sought improved collaboration between adult social care and older persons mental health services, and between substance misuse and mental health services.

> “Strengthen partnership working with adult mental health services and probation and ensure GP registration is part of release from prison plans.”
>
> “A clear dissemination strategy needs to be implemented, including transfer of knowledge to practice at all staffing levels. Where there is mention of a ‘carer’ formal checks with DWP need to be made by the lead agency and information then recorded and shared ... Promotion of collaborative, multi-agency and preventative working across all agencies as a way of moving beyond silo working. Annual audit of this.”
>
> “Test whether coordination and pathways between mental health, housing and adult social care have improved, particularly in the context of adults at risk of suicide and self-harm.”

Collaboration is more effective when all those services either involved or with a potential contribution to make come together in multi-agency (risk management) meetings to share information, and to develop and then review agreed plans to mitigate risk, to prevent and to safeguard individuals from abuse/neglect. Recommendations encouraged the promotion of hoarding and complex case panels, and emphasised the importance of shared and enhanced planning, with roles and responsibilities of participating services clearly outlined.

SARs commented on the need for a clearer focus on use of multi-

agency meetings, ensuring that they are embedded in practice and that procedures for convening, recording and reviewing their outcomes are in place. Where different meetings and panels with an adult safeguarding element were available, SARs recommended clarity about terms of reference and when particular pathways for multi-agency discussion should be used. This was especially the case when the criteria in section 42 Care Act 2014 had not been met.

> "Review VARM guidance to make links with criminal exploitation, risk assessment when self-neglect, impaired executive functioning and fluctuating capacity. Evaluate use of guidance … Ensure clarity of interface between allegations of cuckooing and criminal exploitation in VARM, strategy discussions and section 42 … SAB to raise awareness of not allowing one narrative, here self-neglect, to obscure other forms of abuse, of what to do when VARMs do not achieve change, of considering accumulation of concerns and risk, of co-dependent relationships, of family involvement in VARMs, or escalation processes and threshold guidance."

Information-sharing is also central to counteracting silo working. Recommendations here focused on raising awareness about the importance of sharing information, reviewing information-sharing protocols, and encouraging use of available policies, including on escalation of concerns. One review in particular focused on improving information-sharing across local authority boundaries. A sense emerges of the continuing challenges surrounding information-sharing – uncertainty still regarding whether and when the law permits information-sharing to safeguard a person at risk, and technological barriers that result in no agency having a complete picture of work being undertaken and its outcomes.

> "Requirement for multiagency meetings in any situation of unresolved risk … Improved cross-border practice and information-sharing in relation to adults at risk."

> "Local authority, hospital trust and mental health trust to review information-sharing to reduce silo working … Local authority to strengthen links with housing to promote information-sharing and safeguarding."

Information-sharing is closely linked with the accessibility of records and the adequacy of their contents. Recommendations here included advice that an ICB should consider whether hospital and mental health teams should have access to all health and social are records, and training in their use. There were also recommendations that different

recording systems should be merged.

> "Greater information sharing is required as currently there continues to be complexities due to different recording databases being used across agencies as well as uncertainty around information sharing protocols between them, regarding vulnerable adults."

SARs also focused on counteracting shortcomings in recording practice. They recommended recording of when consent had been given to share information, of plans and outcomes, of assessments and safeguarding concerns. They recommended documentation of mental capacity assessments and flagging in primary care records of safeguarding concerns and identification of patients at risk. Records should capture a person's history, for example of self-neglect and also be more precise regarding whether a person has learning difficulties or learning disability. The focus was on improving the quality of recording.

> "Use of prior records to identify previous contacts/information about an individual … GP Practices to be reminded about the need to accurately record patient information."

Effective multi-agency collaboration depends on standards of referral practice. One focus here was clarity about referral pathways for carer support and for responding to sexual violence and exploitation, modern slavery, dementia and cuckooing. Having clarified pathways, recommendations also advised audits of operational practice and the provision of training and guidance to inform their use.

> "[Ensure] staff are conversant with how to refer to the local Forced Marriage protocols and procedures."

> "Mapping of the multi-agency pathway for reporting and responding to modern slavery concerns and quality assure the multi-agency contribution at each stage … Provision of a place of safety for victims pending decision on entering the NRM, along with casework support during this period … Mechanisms for coordinated, multiagency restorative care from the point of disclosure onwards … Multi-agency operational guidance, including arrangements for emotional and practical support to staff."

A second aspect of recommendations on referrals focused on practice – ensuring that referrers provide full information to highlight what is being requested and why, and services giving feedback to referrers.

> "Provide feedback of referrals and follow-up if none received. Ensure management oversight of rejected referrals … Ensure in

all communication that they key issues stand out in referrals and the steps required."

"Use pertinent points and suitable language in referrals and state what the issue is and what needs to be done; record decisions and the rationale behind them clearly."

The aforementioned quoted recommendation on modern slavery highlights the importance of practitioners and managers having available frameworks within which to locate their practice. Unsurprisingly, therefore, there were recommendations for development and/or review of multi-agency procedures to guide practice and the management of practice, for example in relation to missing persons, service refusal, self-neglect, financial abuse, safeguarding referrals and escalation of concerns, and balancing the competing needs of care-providers and cared-for individuals.

> "The SAB to consider developing multi-agency guidance and develop bespoke training sessions to raise awareness of the national protocol of pressure ulcers referral procedure, specifically regarding risk assessment and application of checklist to ensure that the agreed pathways are followed across the partnership. Awareness raising needs to include a strategic response to ensuring professionals not only have knowledge of the protocol but appropriate skills to implement the protocol in practice."

> "SAB seek assurance that partner agencies have developed, implemented and are monitoring a multi-agency protocol for responding to aggressive and potentially abusive carers/family members and looks to develop a similar joint protocol with the Safeguarding Children Partnership."

Central to effective safeguarding is awareness of and effective use of provisions in section 42 Care Act 2014, the duty to enquire. Recommendations here responded to different findings on shortcomings. Firstly, the need for a shared understanding of the criteria in section 42(1):

> "CCG to remind GP practices that consent is not required for safeguarding referrals."

> "That the board seek assurance from non-statutory agencies that they are confident in relation to the safeguarding procedures contained in the Care Act and how to raise safeguarding concerns under section 42 of the Act."

Secondly, how services should respond when the criteria in section 42(1) are not met but safeguarding concerns and risks remain:

> “Ensure clarity of section 42 criteria and interface with police investigations, and establish a forum or pathway for multi-agency management when section 42 criteria not met but an adult is at risk.”
>
> “SAB to agree and embed across agencies an enhanced risk management framework for high risk cases involving pressure ulcer care, when the safeguarding threshold is not met.”

Thirdly, local authority responsibilities when referred safeguarding concerns are triaged to another service:

> “Safeguarding Adults Board should seek assurance from Adult Social Care that when the latter requests other agencies to carry out elements of Section 42 enquiries, the findings are incorporated into a single overall report, and it satisfies itself that the outcome of all the enquiries, and any further actions proposed, are appropriate as required by the Care Act 2014.”
>
> “That the board seek assurance from the council’s community learning disability service that they have the structure, policies and procedures to undertake safeguarding enquiries under section 42 of the Care Act where safeguarding concerns are received and the threshold is met.”

Fourthly, recommendations on enquiry practice:

> “It is recommended that Adult and Community Services put a system in place to trigger reconsideration of protection planning when a person who is subject to Section 42 Safeguarding Enquiry transfers to a different setting … It is recommended that consideration is given to developing a system for sharing protection plans with all agencies having a legitimate reason to be aware of the protection plan and its contents … It is recommended that [the Foundation Trust] amend their discharge planning arrangements to suggest a multi-disciplinary planning meeting where the patient is subject to an ongoing Section 42 Safeguarding Enquiry and there is suitable reason to call and MDT to further protect that person (e.g. in Nigel’s case he was returning home to place of risk… It is recommended that the process for closing Section 42 Safeguarding Enquiries is enhanced to specifically consider whether a referral for a Safeguarding Adults Review referral is justified.”
>
> “[SAB to seek assurance that] agencies across the safeguarding partnership are aware of, and applying, the SAB guidance on the co-ordination of S42 Safeguarding Adults Enquiries (with other Investigations) [and] the SAB guidance is

> updated to include further detail about the roles of the respective lead officers for the safeguarding and complaints enquiries, and the process through which decisions are made on how these will be progressed and co-ordinated."

Despite the undoubted impact of the COVID-19 pandemic on individuals, families and services, there were few recommendations that directed attention to improvements in how agencies work together in such crises. One SAR did recommend that the Local Resilience Forum be strengthened, with a focus on business continuity for providers, training for staff on managing care during pandemic restrictions, the role of multidisciplinary teams in risk management, and the importance of accessing infection prevention and control expertise.

> "The Community Safety and Safeguarding Partnership requests the commissioners and providers of care homes to identify lessons learned from the manner in which COVID-19 risk to care home residents was managed in the first phase of the pandemic with particular reference to infection control, the extent to which agency staff were used, the extent to which staff – including agency staff – were deployed to more than one establishment and the management of visits by relatives and friends of care home residents during this period."

Organisational features

Recommendations demonstrate considerable faith in procedures – here in the development or revision of single agency policies and guidance, and later the same for multi-agency policies and guidance as part of SAB governance. For example, a mental health service was recommended to develop new guidance on the review of community treatment orders, whilst an adult social care department was recommended to develop guidance on the triage of adult safeguarding concerns. Other examples included recommendations regarding guidance on whistle blowing, on responses to allegations regarding people in positions of trust (PIPOT), clinical disengagement, professional challenge and dispute resolution, risk assessment and hospital discharge.

One SAR recommended that services develop guidance for working with people with learning disabilities and devise a whole life-course neglect and self-neglect strategy that included a formalised assessment tool. Another SAR recommended that the police revise their welfare check policy and missing persons protocol, and that all agencies review their safeguarding policies and develop procedures on

working with people who are reluctant to engage.

> "[Mental Health Trust] to ensure that its discharge policies reflect the most recent NICE guidance."

> "The [local authority] should develop new guidance for family engagement when considering the best interests of adults with care needs. This should be based on a trauma informed approach and also provide guidance for professionals to manage cases where a consensus cannot be reached."

The existence of policies and procedures is no guarantee that they are understood and used. This was occasionally recognised in recommendations addressed to services, including advice that regular case file audits be adopted.

> "Agencies need to assure themselves that practitioners are using the current self-neglect guidance when working with people who self-neglect to support their decision making."

One review made several recommendations regarding policies, procedures and practice for safer recruitment in order to ensure safe care at home and in care settings.

> "Brief care providers on the findings regarding DBS checks, financial abuse, professional curiosity regarding employed staff … SAB to use the SAR to inform safer recruitment practices and guidance when there are criminal convictions disclosed prior to employment … CQC to audit risk assessments where staff have DBS offence disclosures … Risk assessments to ensure that there are risk assessments and mitigations when staff with criminal convictions are employed … Police to review their practice regarding DBS …SAB to point out to Home Office gaps in DBS interpretation … Care providers should not rely on references where there is a strong personal connection/relationship."

Some recommendations focused on ensuring that staff support, supervision and protection were in place, including creating a culture where professional challenge was encouraged and introducing a model of multi-agency supervision when working with complex cases. One SAR recommended that systems should be instituted to support staff with the impact of suicide of a patient/ service user. Another recommended improved management oversight of complex and challenging cases. Another focused on the availability of specialist advice and guidance.

> "[The SAB] may also want to establish whether capacity and

capability are being managed to best effect by the local authority in balancing sufficient specialist expertise alongside a locality based model of service delivery. The merits of a model which provides specific safeguarding practitioners equipped to give locality-based consultancy and advice to practitioners and team managers should be considered by the local authority."

"[The local authority and NHS Foundation Trust] should assure themselves that:-
(i) staff managers are being proactive in considering whether any special arrangements need to be made to protect staff who are being subject to abusive behaviour from service users and / or their relatives, including verbal abuse, harassment or threats;
(ii) staff who are victims of these behaviours have access to appropriate support."

Recommendations on training and staff development provide a menu of topics that illustrates the breadth of knowledge and skills required for effective adult safeguarding practice – legal literacy (application of Care Act 2014 and Mental Capacity Act 2005), advocacy, carer assessments, cuckooing and exploitation, fire risks, trauma-informed care, professional curiosity, cultural competence, professional challenge, brain injury (and its impact on executive functioning), self-neglect, safeguarding, and working with people with learning disabilities, alcohol-dependence, or mental ill-health (emotionally unstable personality disorder).

"The police need to review their training to ensure that it robustly follows the accepted concepts when providing adult safeguarding training to officers. This is to include the preferred terminology in the Care Act 2014 of 'adult at risk' or 'adult with care and support needs'."

"A multi-agency learning event to consider legal literacy and the use of inherent jurisdiction … Further work to support the importance of understanding the importance of mental capacity, and situational capacity, particularly in the context of an individual living within a toxic relationship where substance dependency, mental health needs and domestic abuse are apparent."

"ASC is now checking use of MCA in safeguarding processes but need to increase practitioner confidence and skill in using the Act … Domestic abuse training and supervision must cover staff awareness and confidence when there are issues of control, and where people have mental health issues that impact

> on the safety of others … ASC and MH Trust to discuss how to promote practitioner confidence working with people with mental health problems."

The relative absence of recommendations that address the lived experience of work for practitioners and managers reveals either an assumption that the knowledge and skills acquired in training can be implemented in the workplace, or neglect of the context in which staff are working. Recommendations on workloads were noticeably missing, although one SAR did recommend that a system should be developed to cover worker absence. Another recommended that the local authority and NHS trust should develop an action plan to reduce resource pressures.

> "Seeking assurance from health and social care operational and strategic managers that workloads are manageable and that supervision of cases involving adults at risk ensures that plans are implemented, and their outcomes reviewed."

Recommendations for commissioners featured strongly. Some focused on recommendations for service development, for instance commissioning provision for parents whose children had been removed or for families after bereavement due to suicide. A SAR recommended the commissioning of trauma-informed support.

> "When a suicide occurs, [to ensure] that a system is in place which ensures families are contacted about potential support and are provided with appropriate signposting within primary care services."

> "CCG to support primary healthcare needs of women who are long-term substance users and consider development of trauma-informed practice and how to support women whose children are removed at birth. Commissioning to develop services to provide trauma-informed support."

Some focused on recommendations for engagement with providers. One review explicitly advised work with providers to establish a stronger collaborative partnership rather than engagement that merely concentrated on contractual arrangements.

> "ASC to ensure communication with care providers about risks, and to ensure pathways for information exchange are known."

Other commissioning recommendations focused on responsibilities beyond contracting with providers, for example practice with individuals who are alcohol-dependent.

> "Substance misuse service commissioners should ensure that

> the specific needs and impacts of chronic, change resistant and dependent drinkers are identified in needs assessments and addressed in any future commissioning plans. In particular, investment in assertive outreach capacity for this group of clients is required … Substance misuse service commissioners should consider how to ensure that chronic, change resistant and dependent drinkers can be managed thorough a consistent multi-agency framework …
>
> "Substance misuse service commissioners should ensure training and awareness raising is available to all appropriate frontline professionals (and their managers) on best practice in working with chronic, change resistant and dependent drinkers. This should include on the impact of brain injury on the behaviour and mental capacity of people who are dependent on alcohol …
>
> "Those who commission and plan the development of alcohol treatment services need to ensure that frontline staff consider residential rehabilitation as an option for clients and that it can be accessed without undue barriers. In particular, a path from inpatient detoxification to residential rehabilitation should be possible for complex clients."
>
> "NHS and LA commissioners to undertake market development of dual-diagnosis services to ensure adequate provision is available in the locality for patients with complex mental health needs and drug or alcohol dependence."

There was limited recognition of the challenges facing commissioners as a result of the impact of austerity on public services. One SAR implicitly recognised this challenge when recommending consideration of how the ICB can fulfil its role as commissioner of services in a way that considers patient choice but also scrutinises suitability of accommodation being proposed for highly vulnerable people.

Prominent amongst recommendations for commissioners was a focus on out of authority placements and the roles and responsibilities of placing commissioners and host authorities. SARs on organisational abuse and closed cultures have particularly highlighted the failure to comply with statutory guidance and with practice guidance on roles and responsibilities when seeking and reviewing placements.

> "Key steps and principles set out in Statutory Guidance, the ADASS and LGA Advice Note, and ADASS Guidance on Out-of-Area Safeguarding Arrangements should be incorporated into local policy and procedure and embedded in commissioning

systems to raise awareness and concordance."

"[The SAB should] obtain assurance in respect of the oversight of out of area placements, in particular that responsibilities are not passed from services in the placing to the receiving local authority area until the placement is assessed as stable and meeting the needs of the service user … [The SAB should] obtain assurance that any concerns the host authority may hold about a placement are sought out by the placing authority before a placement is agreed."

"The SAB, in collaboration with NHS England leads, should consider how communication should be improved for cases with out of area placements where NHS England Commissioning Services are involved. This should include designated points for contact, frequency of contacts, expectations for minimum information sharing in relation to safeguarding concerns and nearest relative details."

Also prominent amongst recommendations for commissioners was a focus on quality assurance of providers and on the effectiveness of provider concern investigations. These recommendations arose especially in reviews that featured organisational abuse and closed cultures, and neglect and acts of omission by providers.

"Seek assurance on how training within agencies is given in identifying and responding to provider concerns in both a commissioning/contract monitoring and safeguarding framework … Initiate conversations with commissioners on their resource and capacity requirements to ensure preventative and responsive management of provider concerns."

"The host CCG to lead on work with partners to implement a robust quality assurance, scrutiny, and ongoing monitoring function as part of commissioning arrangements for private mental health providers (to align with that in place for LA commissioned Health and Social Care services) … Assurance from CCG there is robust monitoring of all 'in county placements' and their placing authorities' care worker details. The CCG will maintain a single point of contact for the placing authority. SAB to lobby NHSE for the development of statutory guidance in support of hosting CCGs for Mental Health provision."

"To agree a multi-agency contract review and quality improvement framework, coordinated by [the local authority]; including (i) regular provider monitoring visit outcomes shared with CQC, and (ii) monthly quality improvement meetings for oversight and scrutiny of safeguarding adults and quality

concerns (hard and soft data) processes."

Lastly, commissioners have been reminded about the importance in adult safeguarding of 'nothing about me without me' – the core principle of partnership working with individuals and their families.

> "Clarify how agencies inform families of how to identify and to whom to report arising care quality concerns."

> "Assessment documentation, care and support plans, and referral paperwork for accommodation placement should include evidence on how service users, and families where appropriate, were involved in the process. Documentation should evidence the service user's views and wishes, and involvement that is genuine and influential."

SAB governance

Recommendations on SAB governance fell into two categories. The first relates to the SAR process itself. Here there were recommendations to make reviews "*more efficient, effective and timely*." This covered assurance that recommendations from previously completed reviews had been implemented, clarity about decision-making when there are overlaps with other review procedures (such as DHRs and LeDeR) and action planning to disseminate learning and measure the outcome of recommendations via audits and assurance reporting.

> "The current SAR SAB protocol requires updating and made accessible for all residents [of the local authority]. Guidance on the SAR process might be usefully provided to ensure more consistent quality standards to completing documentation by IMR authors, understanding by agencies, and clarity for adults and their families."

> "SAB should consider amending the SAR request form to enable recording of the date of referral. This will assist with the tracking of the timeliness of subsequent decision-making."

> "Revise SAR procedures to clarify the respective roles of SAR panel and SAR sub-group."

> "The SAB is recommended to share an update with [the person's] family in a year's time on what has changed as a result of the SAR learning and subsequent action plans. This recommendation is a family request."

The second category of recommendations on governance addresses the responsibilities of SABs to seek assurance about, and promote the effectiveness of, multi-agency adult safeguarding practice. Thus, there were recommendations on awareness-raising, for example of fire risks and home fire safety visits.

> "SAB to raise awareness of not allowing one narrative, here self-neglect, to obscure other forms of abuse, of what to do when VARMs (vulnerable adult risk management meetings) do not achieve change, of considering accumulation of concerns and risk, of co-dependent relationships, of family involvement in VARMs, or escalation processes and threshold guidance."
> "SAB to raise the profile of hate crime as both a criminal offence and a safeguarding issue."
> "Raise awareness of adolescent on parent domestic abuse. Raise awareness of mental health triage resource operated by police, and of new dedicated missing person team."
> There were recommendations that focused on development and/or review of policies, procedures and guidance, for example a cuckooing and criminal exploitation harm reduction strategy, or complex case guidance that included risk assessment and pathways for escalation of concerns."
>
> "Review guidance provided across partner agencies regarding risk assessment and risk management. Review policies on information-sharing and self-neglect either as stand-alone policies or included as part of the overarching safeguarding adults policy or both. In this review the SAB must ensure there is a process for risk management that requires a meeting of the professionals involved at an early part of the process. Through its Policy and Procedures subgroup the SAB must ensure the revisions made are agreed and disseminated widely throughout the partnership at all the appropriate levels …Review all relevant policies and procedures in light of learning from this case and, subsequent to any necessary revisions, ensure wide dissemination and subsequent audit of their use and effectiveness."
>
> "SAB to review and develop practice standards to improve outcomes for people with learning disability … SAB to review systems and guidance on care coordination, recording and information-sharing, lead professional and multi-agency approach."
>
> "SAB to develop inter-agency escalation protocol and to review

guidance when conflict between residents, including use of discriminatory language, should be seen as a safeguarding concern. SAB to ensure all services have operational guidance for multi-disciplinary care planning, including involving care providers to facilitate holistic planning and risk management. SAB to promote understanding of role of care coordinator."

There were recommendations that emphasised promotion of best practice, including training and the use of briefings on specific elements of adult safeguarding, such as professional curiosity, roles of different practitioners and resolution of disagreements. Training examples included promoting safeguarding literacy and mental capacity literacy across health, housing and social care staff, working with people who self-neglect, responding to domestic abuse and coercive control, and highlighting trauma-informed practice."

"SAB to share learning with Health and Wellbeing Board and suicide prevention group to inform autism strategy."

"Safeguarding Adults Board should develop a programme of multi-agency training, focusing on how agencies work together to safeguard people who may be difficult to engage with."

"Safeguarding Adults Board should develop a multi-agency training and development programme for professionals involved in complex enquiries."

Finally, there were recommendations that advised SABs to seek assurance, through multi-agency audits, of practice that included the Care Programme Approach, risk assessment, multi-agency meetings, referrals, treatment and support pathways, and responses to self-neglect.

"The SAB should ensure that there are robust escalation pathways which can support agencies to try more creative approaches to managing complex and potentially costly clients. The SAB [should] ensure that local professionals are clear about the national guidance on how ordinary residence is affected by being placed outside of the home local authority. The SAB, and its various partner agencies individually, should ensure that frontline staff are reminded of the importance of the inter-connected issues of smoking risk and fire risk with vulnerable clients."

"SAB to seek assurance about responses to 'was not brought.'"

"SAB partners to audit cases where cases are not referred under section 42 to the local authority and where that local authority

decides not to undertake an enquiry. SAB to seek assurance services, pathways and multi-agency decision forums are clear across services."

Collectively the recommendations demonstrate the span of a Safeguarding Adults Board's roles and responsibilities. The following example provides one further example.

> "The SAB should review and strengthen its membership in terms of links with housing associations, utility companies and trades people. Produce and disseminate multiagency procedures for working with people who self-neglect. Commission multi-agency training on self-neglect. Discuss with partner agencies how additional flexibility can be created within their organisation's standard workflow expectations. Seek assurance from each partner agency that all staff are aware of and able to exercise their responsibility for identifying and if necessary, testing mental capacity. Request that Adult Social Care provides clarification for all partner agencies of referral pathways. Seek reassurance from Adult Social Care that the question of consent is not a barrier to acceptance of referrals where there are safeguarding concerns and how the learning from this review can be embedded in training for Contact Centre staff. Request that police provide for partner agencies clarification on the circumstances in which welfare checks are considered appropriate, consider referral processes to Adult Social Care, and consider how and when information on identified vulnerability is made available to other agencies. Seek agreement with DWP on strengthening information-sharing with GPs and referral pathways to other agencies. Seek assurance that surgeries have their own policy non-attendance for medication reviews. Request that partner agencies consider how recording systems can be modified to enable practitioners and managers to identify patterns of non-engagement (such as missed appointments). Provide regular briefings as a means of disseminating learning from this and other SARs and of raising awareness of its policies and procedures. Audit how learning from this SAR has impacted upon agencies' practice one year on from dissemination of the learning."

National context

Mental health was a prominent feature amongst the recommendations that focused on the national context. Sometimes these

recommendations highlighted what was regarded as a national concern without being addressed to a named organisation or government department. Thus, one SAR explicitly highlighted racism in mental health provision and recommended a national initiative to address disproportionality. Another review highlighted the lack of Tier 4 mental health beds. A third focused on the difficulty of finding specialist placements for young people. There were examples, however, of recommendations on mental health being directed to NHS England, concerned with pressures in the mental health system, or to the Home Office and Ministry of Justice regarding policy and guidance on mental health, probation and offender management. Mental health featured in recommendations within a SAR on transitional safeguarding.

> "The partnership should seek assurance from NHS England in respect of its plans to improve access to Tier 4 beds and NHS intensive therapeutic placement for young people up to the age of 25 that are local to them, to reduce reliance on acute admissions, avoid delays in young people obtaining the treatment they need and improve their experience of mental health services. Clarity should also be sought on how NHS England holds commissioned Tier 4 CAMHS providers to account for effective discharge and transition planning. The Partnership should utilise the national escalation pathway established between the National SAB Chair's Network and Department for Health and Social Care to advocate for the proposed changes to the Mental Health Act to include statutory duties for NHS England and providers of children's and adults' mental health services to improve transition planning so that young people do not experience a gap in service when they turn 18."

Denied access also featured in recommendations directed to the national context, especially the absence of an adult safeguarding power of entry when provisions in the Mental Health Act 1983 did not apply and when police officers did not believe the criteria for immediate risk or threat to 'life and limb' had been met (section 17, Police and Criminal Evidence Act 1984).

One SAB was recommended to raise with DHSC the case of a learning-disabled young women who had been admitted to hospital malnourished and neglected, when she had not been seen for months and when the family had not responded to efforts by practitioners to make contact and had cancelled respite care.

SARs occasionally referenced the national context on provision of substance misuse services. One drew attention to the resources

published by Alcohol Change UK. Another highlighted concerns about limitations in law and guidance:

> "Those who commission and plan the development of alcohol treatment services may wish to consider lobbying national government for either improved guidance on using the Care Act, Mental Capacity Act and the Mental Health Act with this complex client group, or new legislation to better meet their needs."

Concerns about perceived limitations in national policy and guidance also prompted recommendations to DHSC about strengthening the definition of, and guidance for responding to adult sexual exploitation, and to DWP about improving its response to claimants with care and support needs and/or at risk of abuse or neglect, and its engagement with adult safeguarding pathways. DWP is currently engaged with the National Network for SAB Chairs in developing a memorandum of understanding in response to the two SARs that explicitly highlighted shortcomings in meeting the needs of claimants at risk. Again, with a focus on law and policy, one SAR reviewed actions implemented since an earlier 2013 serious case review in relation to organisational abuse and closed cultures and made further recommendations on transforming care. It recommended DHSC, NHS England and the Local Government Association to:

- incentivise commissioning bodies to engage in "close to home" commissioning for adults with learning disabilities, autism and mental health needs
- make mandatory the notification by commissioning authorities of prospective placements to the host authority
- assert the requirement for specific funding for essential monitoring, reviewing and safeguarding and for residents' access to local health services
- commend the replacement of episodic/once a year reviews with continuing, complex case management with a strong advocacy role
- incentivise the creation of a repository of "intelligence" about providers which is accessible to commissioning bodies [to] include a company's response to complaints, inspections and compliance matters
- ensure that people receiving specialist care must include their health, wellbeing and need to be protected from harm and danger is explicit in enforceable, individual contracts and support plans

- review impact on corporate governance of the care of large numbers of adult residents and the public sponsorship involved
- promote that proceedings under the Company Directors Disqualification Act 1986 are considered when residents are harmed and a company's inattention to outcomes for them is recurrent.

One SAR specifically drew attention to policy inequity between safeguarding children and safeguarding adults, namely the absence of a statutory requirement for named and designated adult safeguarding professionals in ICBs and NHS Trusts.

One SAR recommended escalation to lobby for evaluation of the Building Better Relationships Programme to seek assurance that it is delivering the intended outcomes of reducing offending by male perpetrators of domestic abuse within heterosexual intimate relationships. Another addressed a recommendation to CQC, namely:

> "The chair of the SAB should write to the CQC highlighting the apparent gap in the inspection of primary (and possibly other health care settings) checking on the understanding and use of the GP learning disability register."

One SAR recommended discussion with the Fire and Rescue Service about the need to advise the Home Office that, where there are safeguarding concerns, there is a gap in law, and advocate for Fire and Rescue Services to be given powers to enter private dwellings.

Recording early actions taken

Agencies have often already made changes to their agency practices, either prior to the SAR taking place or during the review process. In 59 per cent of the SAR reports, this was acknowledged, with detail given about the improvement actions taken. One SAR explicitly recommended that the SAB should monitor implementation by individual agencies of the changes that they had identified as necessary.

Were improvement actions taken following the SAR?			Response Percent	Response Total
1	Yes		59.29%	134
2	No		40.71%	92

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