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

A new SAR commissioned by Calderdale Safeguarding Adults Board

Following three sexual assaults by the same resident on other residents in a care home, the Calderdale Safeguarding Adult Board (SAB) decided that this series of events, and in particular the final assault, met the statutory criteria for conducting a Safeguarding Adult Review in order to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again' (Care Act 2014).

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

This SAR-In -Rapid-Time was undertaken in collaboration with Manchester City Council, Calderdale Council, West Yorkshire Police, NHS West Yorkshire Integrated Care Board, Calderdale and Huddersfield Foundation Trust, South West Yorkshire NHS Foundation Trust, and a Calderdale Care Home.

What is a SAR In-Rapid-Time?

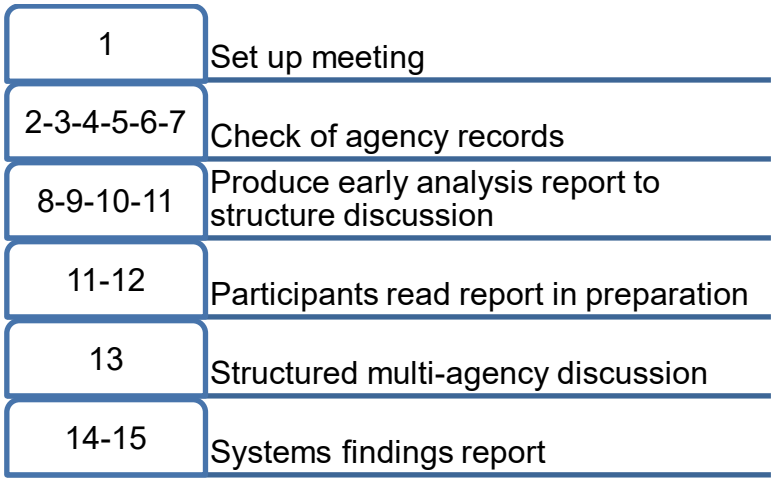
A SAR in Rapid Time aims to turn-around learning within a short time frame, following the Set Up meeting. The Set-Up meeting is held after the decision has been made to progress with a review. An outline of the process is captured below. The numbers refer to days allocated to each stage.

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

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

The process is supported by remote meeting facilities and does not require any face-to-face contact.

Figure 1: Outline of a SAR In-Rapid-Time (in days)



This document

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

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

The facts and focus of this SAR are explained below, followed by the systems findings.

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

Feedback on the findings

In this case we sent a feedback form to the review panel in order to capture feedback on whether the findings in the draft report were systemic, and not only relevant to this one case. We asked for any additional evidence to illustrate how each finding has wider relevance across the safeguarding partnership in Calderdale.

This feedback informed discussion of the draft report on 15th September 2022.

Focus of this SAR In- Rapid -Time

Three residents were sexually assaulted at different times by a fellow resident at the residential care home where they all lived. These assaults were serious and were reported to the police and to adult safeguarding. The victim of the final assault was on end of life care at the time and died shortly afterwards. The death was referred to the coroner. The cause of the resident's death is recorded as natural causes.

To understand how residents came to be exposed to harm we have looked at how Mr E came to be in the residential home. We have looked at how professionals understood and communicated about the risks that Mr E posed to others during his time at the home, and what was known about him prior to admission.

Mr E had been taken to the home by his daughter in April 2019. The home knew nothing about Mr E's history other than his daughter's account and there was no objective assessment of Mr E's needs and risks at the point of admission. There had been an assessment of his need for residential care by his home local authority two months prior to this. He had been assessed as not needing such care and domiciliary care had been provided.

The assault which triggered the referral for a SAR was the third sexual assault on another resident by Mr E to be reported to the Police after he moved into the home in April 2019. There were 16 other incidents of sexualised behaviour recorded on Mr E's care plan dating from May 2019.

The three Police investigations were ended when investigating officers concluded that Mr E was unable to form the intention to commit a criminal act. The incidents were then passed on to the local authority safeguarding teams to complete a Section 42 Care Act enquiry into what further action was needed to protect vulnerable adults in the home. In each case the safeguarding teams concluded that the measures proposed by the home were sufficient to manage the risks posed by Mr E.

A striking feature of this case is that Mr E's history of sexual offences, for which he had not been convicted, were not known to the home or the safeguarding team until Mr E had committed his third and most serious assault on a resident at the home. It is equally striking that the only referral to mental health services in Calderdale was made after this assault had taken place, and that until that point there had been no referral for an assessment or psychiatric opinion on any link between Mr E's sexualised behaviour and dementia. There was no recorded diagnosis of the type of dementia in Mr E's case.

Looking beyond this case

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

Systems findings

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

FINDING 1. There is no agreed process between agencies in Calderdale to assist identification and escalation of serious sexual safety incidents to multi-agency risk assessment where groups of vulnerable people may be at risk.

Systems finding

In safe practice there is clarity and agreement across agencies on thresholds for inclusion of individuals in multi-agency risk assessment processes. Examples of such processes include MARAC, MAPPA and Prevent, where risk is assessed and mitigated through effective information sharing between health, social care, and the police. In the complex and difficult area of assessing risks in relation to past behaviour, current behaviour, and the impact of dementia such information sharing is essential

In discussion with practitioners, it became evident that in practice the safeguarding adults team relies on individual residential care providers to evaluate risk and develop effective care plans to protect extremely vulnerable people in their care. The Calderdale safeguarding process is not, in practice, a multi-agency response in the same sense that MARAC, MAPPA and others are. In a difficult operational environment, with unfilled vacancies and high levels of referrals from care homes, the Calderdale safeguarding team did not use an agreed framework to assist practitioners in identifying indicators for escalation to multi-agency assessment and management.

Equally, there was no partnership agreement around where, other than the safeguarding process, multi-agency assessment of vulnerable people who also present a high risk to other vulnerable people could happen.

Each incident reported showed escalating risks, but this did not lead to multi-agency evaluation of risk involving the safeguarding partners. Important information from the police was not shared until after the third incident. The involvement of mental health services was not sought until this point. In the absence of expert advice, unsafe assumptions were made about Mr E's dangerousness in a setting with extremely vulnerable people.

Questions for the SAB and partners

- Is there currently an adequate level of agreement across agencies about indicators that must trigger an urgent multi-agency safeguarding meeting to develop and review risk assessments and mitigations?
- If so, how can the SAB be assured that escalation arrangements are understood and implemented?

- Is there clear agreement about how, in which forum, such multi-agency assessments of risk should happen? Are there options other than, or in addition to, local authority safeguarding processes?

FINDING 2. There is no agreed and consistently used language to describe types of sexualised behaviour in residential care homes which would more readily enable identification of high risk situations for both residents and staff.

Systems finding

In safe practice there is a shared and consistent language used by all agencies to communicate about what has happened in high risk cases of sexualised behaviour, including sexual assault committed by someone with dementia. In such situations psychiatric expertise is likely to be needed and police checks around past behaviour required. Without such language, it is more likely that unjustified assumptions about the impact of dementia on men's behaviour in particular go unchallenged, a person's history goes unchecked, and safety for all involved is compromised**.**

In the workshop it was clear that terms such as 'disinhibition', 'inappropriate' and 'lacking capacity' were routinely used by agencies without clear and shared definitions. This hampered partners in reaching shared and consistent professional agreement around the risks posed to others by Mr E.

The SAR showed that a range of descriptive phrases were used by different agencies concerning incidents involving Mr E. We found that the same incident was described as a 'serious sexual assault' and also as 'inappropriate sexual behaviour'. When the latter description was used to refer Mr E to mental health services it obscured the seriousness of the risk posed by Mr E. In the discussion with practitioners, it became clear that the use of euphemistic and inaccurate language hampered mental health services in making their response. In consequence the home did not have a useful professional assessment of Mr E's dementia in relation to his high risk behaviour.

Questions for the SAB and partners

- How can the workforce across Calderdale be enabled to engage with the definitions available in recent CQC guidance on sexual safety for social care and mental health? Can other definitions for example, those used in the criminal justice system, be better understood across all agencies?

- Is there a role for the SAB to support understanding and adoption of the guidance?

FINDING 3. Calderdale safeguarding policies and procedures recognise sexual abuse as a category however there is no local guidance about how sexual safety can be maintained specifically in residential care settings. This is despite recognition of the extreme vulnerability of residents and problematic sexualised behaviour of some residents being acknowledged as common.

Systems finding

Sexual safety in health and social care settings has come into focus in recent years as CQC reviews of data on sexual safety incidents have shown that there are continuing high levels of these, and improvements are needed both in prevention and in professional responses. In safe practice recommendations from these reports and from professional bodies in response are included in improvement work.

In this case, the care home reported the most serious incidents to the police, the local authority and the Care Quality Commission, which was good practice. However, the SAR found that the incidents did not lead to the development of local policy and procedural guidance to support providers with the maintenance of sexual safety for other vulnerable residents, staff or visitors, including child visitors. The SAR review

panel surfaced more recent developments on sexual safety in the care home in this case, but it was not known how widespread this was across the sector.

In this case, the lack of awareness of sexual safety strategies led to responses based on the view that a series of incidents involving residents and staff were 'one offs' always explicable by physical health problems. Other possible explanations were unexplored. A wider understanding of the issue of sexual safety in a setting where as well as residents, staff and visitors need reassurance that they are in a safe environment was needed.

Questions for the SAB and partners

- How can providers across Calderdale be encouraged to develop policies on sexual safety based on recent CQC guidance on sexual safety in social care and in mental health?

- Given the apparent applicability of the mental health guidance to the sexual safety issues in residential care, is there a role for the board in furthering the work on sexual safety in development by the mental health trust, across the partnership?

- Do, or should, local authority and health contracts with care home providers include a requirement for sexual safety policies to be in place?

FINDING 4. The assessment of needs and risks undergone by a person seeking admission to residential care differs greatly depending on if they are funding their own care or not. This creates a disparity that sees full person centred assessments only conducted for people funded by the local authority, increasing the likelihood that self-funders' needs and risks are inadequately understood and shared.

Systems finding

Where an individual seeks the financial assistance of the local authority to fund residential care, the local authority must carry out a financial assessment but must also assess the person's needs and risks to determine, first if residential care is the appropriate option, and second if the proposed placement is able to meet them. In an effective system all adults receive an objective assessment of needs and risks, regardless of how their care is funded. This gives some assurance that people will find themselves in the right places to meet their needs and manage their risks, where these can be known.

Where this system is bypassed, as in this case, there is a risk that information about individuals that could affect safety for other residents goes undisclosed. There is currently no requirement to conduct basic 'disclosure' checks on individuals as part of admission procedures to residential care, as there are for staff who work in such congregate settings. However, without any such checks at all at the front door, providers are more likely to admit people despite knowing little to nothing about the risks they may pose to others.

We have learnt in this case that this can expose other residents to abuse by other residents, including serious sexual abuse. In the workshop we learnt that there was a culture such that, if a relative asks for admission, despite a local authority assessment

that residential care was not needed, and the relative claims that the resident can self-fund, no further questions are asked.

Questions for the SAB and partners

- How can the Board be assured of the robustness of providers' assessments of need and risk, and that assessments consider sexual safety issues?
- Is there a role for the SAB to develop and promote quality standards around this issue?
- What potential is there for the Board to address the disparity between assessments for self -funders and local authority funded residents by encouraging higher standards in risk assessments across the board?

References

- **Joint Multi-Agency Safeguarding Adults Policies and Procedures**
- **Section 42 guidance: https://www.adass.org.uk/media/7326/adass-advice-note.pdf**
- **Resident-to-resident harm in care homes and residential settings | SCIE**
- **Loss of inhibitions and dementia | Alzheimer's Society (alzheimers.org.uk)**
- **Microsoft Word - 20190110 Sexuality in Care V0.09 Clean for approval_PUBLICATION.docx (cqc.org.uk)**
- **Older People Relationships | Publications | Royal College of Nursing (rcn.org.uk)**