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*Serious Case Reviews in
Adult Safeguarding*

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FINAL REPORT

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This is an independent report commissioned by the Department of Health. The views expressed are not necessarily those of the Department.

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SERIOUS CASE REVIEWS IN ADULT SAFEGUARDING

Executive Summary

This study was commissioned by the Department of Health (DH) to explore specific aspects of adult Serious Case Reviews (SCRs) in England and Wales. The research team conducted a national survey and interviewed 14 people with experiences of commissioning and conducting SCRs. Many examples of local SCR policies and protocols were examined to inform this review and 15 reports were analysed to identify learning about the process of SCRs. Together this evidence reveals the great importance of the anticipated revision of the Association of Directors of Adult Social Services (ADASS) SCR guidance and the potential for DH to collate SCRs to pull together their findings and communicate these more widely to those who have responsibilities to promote adult safeguarding.

The national survey found that in the period 2000-2006 at least 94 Reviews have been conducted, are in progress or are in prospect in England (across 62 authorities), and at least seven Reviews have been conducted in Wales (across five authorities). The maximum number undertaken in any one authority was four. The conclusions and suggested improvements of this study are summarised below and have been passed to the current (2009) consultation being undertaken by the DH on the review of government guidance about adult protection or safeguarding as it is now termed to inform its deliberations:

- There has been an uneven distribution of SCRs across local authorities but they are **widely valued**. This rests on a perception of them as potentially useful learning vehicles, primarily among local agencies in social and health care sectors.
- There is strong support for **greater national guidance** about SCRs. We suggest that a national reporting system be devised by the Department of Health for SCRs. There is a desire for **national collation** of SCRs in order to disseminate lessons learned or points of difficulty. This is a requirement for children's SCRs. However, SCRs are local reports and their commissioning and follow up should continue to be the responsibility of the local Safeguarding Adults Board (SAB). We did not find support for a regulatory or inspection system to be the body to receive and scrutinise SCRs.
- There may be good cause to **formalise the classification** of the various reviews at a local authority's and other agencies' disposal and their

relationship to each other when more than one needs to be undertaken (for example, the move to undertake multi-agency domestic violence homicide reviews). We suggest that the Department of Health refers this matter to the new, integrated Care Quality Commission in 2009 to minimise the gaps and duplications that were identified in this study. The potential for scrutinising 'near misses' might usefully be considered in adult services.

- **Central prescription**—the removal of the voluntary element in SCRs in adult protection—was widely supported by interviewees. They saw this as representing a sign of how important the government sees the practice of safeguarding adults. The current review of *No secrets* has called for responses to this matter and, at the time of writing, there seems to be wider affirmation of this perspective from some sectors.
- **Learning lessons** as the prime rationale of SCRs is well understood and supported. We suggest that this rationale continue. However, agreed review periods should be established by the SAB to monitor if lessons have been taken on board.
- An **independent Chair** was agreed to be important in order for there to be neutrality in relation to all the agencies involved. However, it is not universal practice and it is costly. When establishing/setting up a SCR, the need for an independent Chair should be seriously considered. Statutory organisations in membership of the SAB should share the costs of SCRs.
- As with children's SCRs (Part 8 Reviews), there is a question mark over the **length of time** it is taking to produce some reports in adult safeguarding. Where it is not possible to produce these within three months, we recommend that the reasons for the delay are explicit in the report. The SAB should receive regular progress reports on a commissioned SCR and take action if delay appears unreasonable.
- Reports are often characterised by a failure to expressly consider the issue of threshold (what makes this particular case or incident deserving of a review). This means that the **rationale for a report** is not always clear, nor is its methodology. We recommend that the reasons for the SCR are contained in reports and that the methods of the review are set out, with observations on any lack of co-operation or approaches that seemed to have been particularly fruitful. Decisions about anonymity and confidentiality should be taken at local level by the SAB, informed by legal advice if necessary. A chronology of events and communications is helpful to readers, although these may suggest, with the benefit of hindsight that events were more predictable than they might have been.

- In relation to procedural guidance, we heard that this is in the process of being expanded and improved in many areas (for example, in relation to media strategy, staff support and the involvement of family members). We note the effectiveness of the **championing** of these issues by the Association of Directors of Adult Social Services (ADASS) network and recommend that this network further engages with other sectors to devise further guidance to cover all sectors, particularly the NHS.

Introduction

This study outlines the current position in England and Wales with regard to Serious Case Reviews (SCRs) in adult safeguarding or adult protection. It was commissioned by the Department of Health in light of a number of high profile inquiries on the subject of adult safeguarding. While it is not a review of SCR findings, because so few are available in full format that have not been widely reported, it is timely because the document providing foundational guidance for SCRs and adult protection in England, *No secrets* (2000), is being reviewed and re-drafted¹, with specific questions about SCRs. So too is national guidance published by the Association of Directors of Adult Social Services (2006) (see below). *No secrets* was issued by the Department of Health and the Home Office (under section 7 of the Local Authority Social Services Act 1970). It encouraged the development and implementation of multi-agency policies and procedures to protect vulnerable adults from abuse. SCRs in adult protection have also grown up in the light of longer-established reviews conducted in the children's sector (part 8 of *Working Together to Safeguard Children* 1999; HM Government (2006), and in the context of public inquiries into health and social care failures or high profile cases (Stanley and Manthorpe 2004) and statutory inquiries into homicides in mental health services (Reith 1998).

Unlike those carried out under part 8 relating to children, SCRs in adult protection are voluntary and non-statutory, but recent years have seen the release of two publications putting them on a firmer footing. *Safeguarding Adults* (2005) provided a National Framework of Standards for good practice and outcomes in Adult Protection work. One of the standards states that a SCR protocol should be set in place by the local multi-agency management committee in each local authority known as Safeguarding Adults Boards² (SABs). This was joined, in 2006, by *Vulnerable Adult Serious Case Review*

¹ See excerpt from Department of Health consultation (2008) in Appendix II.

² For clarity and simplicity, in this report we use the term Safeguarding Adults Boards to refer also to Adult Protection Committees, although on occasion interviewees use the old term, sometimes in its abbreviated form (APC).

Guidance – developing a local protocol. Published by Association of Directors of Adult Social Services (ADASS), this seven-page document seeks to encourage consistency in the execution of SCRs. This document has been of great use, as evidenced by its influence on so many of the local policies and protocols we reviewed.

Nonetheless, there are concerns that SCRs are not used as effectively as they might be because they are not considered as a whole, as the extract below illustrates:

‘Jim Cousins: To ask the Secretary of State for Health how many serious case reviews for vulnerable adults have been carried out; and in how many cases the serious case review involved the murder of a vulnerable adult. [69218]

Mr. Ivan Lewis: The information requested is not collected centrally. There is no statutory requirement for statutory agencies to carry out serious case reviews for vulnerable adults. This is a matter for local decision’ (Extract from Hansard. 9 May 2006 : Column 242W)

These same concerns arose in the course of this study. This research falls into three parts. First, in the absence of a central register, a survey sought to establish an estimate of the number of SCRs conducted in England and Wales since 2000. Secondly, 15 reports were retrieved from SABs covering a wide range of incidents. These were considered in conjunction with the results of the third element of the study, namely interviews with professionals with experience of SCRs, both members of SABs and independent Chairs of SCRs.

Methods

Survey

Between December 2006 and July 2007, researchers contacted the Adult Protection Co-ordinators, or personnel with equivalent responsibility, in 148 English and 22 Welsh local authorities. This was done initially by letter, with follow-up by email and telephone as necessary. The Co-ordinators were asked whether or not any SCRs had been conducted or commissioned or were currently in prospect in the period 2000-2006, that is since the publication of *No secrets* (2000) in the case of England and *In Safe Hands* (2000) in that of Wales. This was a very basic question, in order to get a full answer. We sought a ‘yes’ or ‘no’ answer and gave assurances of confidentiality. We recorded responses on an Excel spreadsheet. It was notable that few of the positive responses were in a position, when asked, to send us the full report

or even the summary. In many areas those responding to the survey could give no details of the SCR they were aware of as they had not been in post when the SCR was carried out. One possible explanation of this is that there has been limited resourcing of adult safeguarding in some areas and personnel turnover may mean that earlier records have been lost. Currently there is much greater intelligence about SCRs, possibly as a result of the much higher profile of adult safeguarding and greater organizational capacity.

Interviews & Reports

In order to find out more about the workings of SCRs we sought the views of people who had been involved in their commissioning or execution. Fourteen confidential telephone interviews were conducted, four of which were with independent SCR Chairs, the other 10 with members of SABs, many of whom commissioned or undertook SCRs or similar or were responsible for devising the local policy. Alongside general discussion, interviewees were asked:

1. In what ways were you involved in SCRs?
2. Why do think an independent role was wanted?
3. Was there any follow-up to the SCR?
4. What are your views on the use or purpose of SCRs?
5. What advice would you give to anyone receiving a request to be an independent Chair of a SCR?

The research team received 15 Reports of SCRs. These were requested during the survey detailed above. Nine were full and final, the remainder were summary or draft reports. We gave assurances of anonymity to those local authorities that had not made their full reports public. The sample also sought SCRs that had not been 'high profile' in order to acquire a range of evidence. An electronic search for relevant documents was also undertaken, this revealed a large number of SCR protocols or procedures, some of which were very detailed; others were more brief.

Findings are based on a restricted evidence base and are therefore indicative rather than absolute and there may be a case for further research.

Findings

Survey

Responses indicate that in the period 2000-2006 at least 94 Reviews have been conducted, are in progress or are in prospect in England (across 62 authorities), and at least seven Reviews have been conducted in Wales (across five authorities). The maximum number undertaken in any one authority was

four—this being the case according to three Adult Protection/Safeguarding Co-ordinators in separate areas. Of those who had not conducted any, it was a common response that no protocol for such Reviews was yet in place.

Interviews & Reports

Summary of Reports

The following table outlines the anonymised details of the SCR reports we received (ages have been reported in age bands to maintain anonymity). Further comment on their content is then contained in the body of this report under the relevant headings.

Report	Alleged Victim/s	Alleged Abuse	Alleged perpetrator	Setting
#1	20+ year old woman; night staff	Sexual; physical; financial	Former volunteer	Care home
#2	<i>Summary of personnel involved and recommendations only</i>			
#3	90+ year old woman	Neglect (death)	Family member	At home
#4	90+ year old woman	Neglect (death)	None specified	Care home
#5	50+ year old woman	Physical (death)	Fellow service user	Private hospital
#6	80+ year old man	Physical and psychological (death)	Wife	At home
#7	Several residents	Neglect	Not specified	Care home
#8	70+ year old woman	Neglect; physical (death)	Husband and adult child	At home
#9	20+ year old woman with physical and intellectual/learning disabilities	Neglect (death)	Family	At home

#10	All residents of a care home	Neglect	Not specified	Care home
#11	30+ year old man with cognitive impairment	Neglect (death)	Carer	At home
#12	80+ year old woman	Psychological; physical; neglect (death)	Unclear	At home
#13	Older person with sensory impairment and poor mental health	Neglect (death)	Not specified	Care home
#14	70+ year old woman	Physical; possibly financial (death)	Unknown	At home
#15	30+ year old woman with learning difficulties	Sexual	Agency worker	Hostel

Purpose of Serious Case Reviews

Paragraph three of the Association of Directors of Adult Social Services (ADASS) guidance (2006) states that the purpose of SCRs is 'not to reinvestigate nor to apportion blame', but rather:

- '3.1 to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults
- 3.2 to review the effectiveness of procedures (both multi-agency and those of individual organisations)
- 3.3 to inform and improve local inter-agency practice
- 3.4 to improve practice by acting on learning (developing best practice)
- 3.5 to prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action' (ADASS 2006)

The ethos of learning lessons as against apportioning blame was widely remarked upon by interviewees when asked their views on the purpose of

SCRs. This was 'organisational learning' (§14) in a multi-agency context. One SAB member described the SCR process as having the potential for 'phenomenal learning' (§6). By overcoming duplication and confusion within services, for example, SCRs could 'open people's minds' (§6) leading to clarity as regards roles and responsibilities. 'It is most definitely worth doing to improve good practice' (§7). This was expanded upon by another SAB member in terms both of the SAB's own role and that of the local authority's housing department:

'In adult protection you get two types of activity—strategic and operational and it is hard to join the two up—you tend to do one or the other. The SCR can join up and strengthens the role of the APC [i.e. SAB] and it helps the APC to have a partnership role outside its own workings and beyond separate agencies. It can help with a sort of scrutiny function. But importantly it is about learning, rather than accountability. Our first SCR led to tremendous learning and put us in a position where we were ahead in terms of thinking about issues that have surfaced recently, like sharing information and housing. We found in the SCR that housing had information that they did not share so we addressed this locally and continue to do so.' (§3)

A typical further comment again focused on inter-agency communication:

'In terms of learning lessons a report is a very useful tool. In this situation, one of the issues that emerged was that the vulnerabilities of the person committing the act hadn't been fully recognised and agencies hadn't really put it all together' (§11)

Notwithstanding this consensus as to the rationale behind SCRs, two interviewees commented on a tension that may arise between a no-blame approach and, despite the fact that Reviews are not cast as investigations, cases where professional negligence is uncovered. Chairs of SCRs said that they felt mandated to inform the social services department about such instances. In the view of an experienced independent Chair, it is more common for it not to be possible to apportion blame either because it is difficult to see how things could have been done differently in all the circumstances or because the facts would more appropriately be tested in formal court proceedings. As a result, this Chair had always erred on the side of organisational learning as against 'pillorying' (§14) the agencies concerned. Nevertheless, he/she said that a SAB had recently re-written one of his/her reports—possibly softening it.

Another interviewee, a SAB member, commented on a SCR of a death involving neglect concerning both the local authority and the NHS. It was clearly felt that the no-blame approach evaporated in the process to the extent that he/she was not sure whether they would commission another one:

'This is because the SCR review we did was taken up by CSCI [Commission for Social Care Inspection] as a sign of us not doing things well...Instead of embracing the fact that we wanted to learn, CSCI focussed on the problems. We wanted to be open and honest...we felt "hammered" by the CSCI criticism and perspective...we have not had a SCR since but we would if we had to, although we might just call it an investigation...We have a SCR policy and use this to think about investigations and so on...My advice to others is that SCRs can have a lot of potential to learn useful lessons but as a local authority you have to look at the purpose and outcomes.'

(§7)

By definition, SCRs take place after distressing occurrences where questions of both agency and professional failure are at least implicit. It becomes then only more important to adhere to what is understood to be the main purpose of such Reviews, namely to learn 'organisational' lessons from what has happened while leaving the apportioning of blame to other forums, such as the courts, other internal review and disciplinary processes and professional disciplinary boards.

Purpose of a serious case review (example)

- to learn from past experience
- to improve future practice by acting on the learning
- to improve multi agency working
- to review safeguarding adults procedures

It is not about allocating blame. Any personnel issues which arise as the result of a serious case review will be managed by each agency according to their usual procedures. (extract from Devon County Council's SCR protocol 2005)

Resources

There is little evidence of the costs of SCRs, however, there may be a need to consider these within the funds available to local safeguarding bodies. One recent estimate from Essex County Council, in its Business Plan, suggests that the following sums will be allocated:

2008-09: £10,000 (with a further £15,000 to develop a protocol from the SCR 'action plan')

2009-10: £12,000

2010-11: £14,000.

In another example, a local SAB asserts:

‘The protocol will set out a clear process for commissioning a Serious Case Review and the Peterborough Adult Safeguarding Board will provide each Serious Case Review Steering Group with sufficient resources, both personnel and financial, to carry out its functions’. (Peterborough SAB 2008, p.11)

The Chair of Serious Case Reviews

Paragraph six of the ADASS guidance (2006) deals with the practical initiating steps once the SAB has decided to set a Review in motion. In 6.1 it states that the SAB will be responsible for the appointment of an independent Chair for a multi-agency SCR Panel now being set up. As it is the SAB that is usually the commissioner of SCR processes and reports, the SCR Panel should be accountable to and will report to the SAB.

Example of setting up a first SCR

‘The Safeguarding Adults Committee has commissioned X to conduct a serious case review. Funding for this review has been provided by Adult Social Services, Children’s Services & the Mental Health Trust. Recommendations from the review are due to be reported to the October Safeguarding Adults Committee meeting.... We are in the process of undertaking our first serious case review, and need to be prepared to take on the recommendations from this’. (extract from London Borough of ‘Z’ Safeguarding Adults Committee Annual Report 2007/8)

Independence

An independent Chair was thought by interviewees to improve the quality of SCRs, to encourage better responses from the agencies involved, and to result in a report more likely to command public (and family) confidence.

The matter of quality arose for one independent SCR Chair in relation to a case involving more than one kind of assault at a care home: questions of inter-agency communication—information sharing and the corollary concern of data protection—were found to be at stake at both strategic and operational level. As this respondent said:

‘I think they wanted an independent report writer because the case covered so many agencies and authorities and was very complex...Having an external person doing the report was extremely useful in terms of analysing the situation and making recommendations for a number of the different agencies involved.’
(§11)

The independent Chair's objectivity is viewed as allowing for greater clarity in the face of the inter-agency matrix. By the same token, being independent meant this Chair felt unrestricted in what he/she could raise in the course of the Review:

'My independent role in writing up was very useful because it meant that during meetings and in the report I could ask questions with a free rein. I wasn't investigating but could ask how things came about. They were clear that they wanted me to sign off the report as an independent report writer.' (§11)

Plainly, where one agency may have more to learn than another and where this may—withstanding the no-blame ethos—imply criticism, the neutrality of the independent Chair is useful in making the parties feel more at ease in contributing to the success of the project. In the words of such a Chair:

'What was important about having an independent role was that I was independent of all the agencies and all the different professional bases, there was potential for it to be quite high profile and I think they were quite concerned about this and they were worried about some of the agencies' behaviour, we needed to be able to address the politics with a small "p" especially about the Inspector's behaviour which was under sharp view. Social services couldn't do this—they needed somebody independent because it was so sensitive.' (§12)

By extension, respondents saw impartiality as an important element in how the SCR would be viewed beyond those agencies whose practice was under scrutiny. Insofar as the appointment of independent Chairs is not the universal norm (discussed below) one of the explanations for this was presented in terms of just how 'high profile' (§12) the case was. Where the case was of 'limited local interest' (§10) then it was less of a priority. But, in cases with wider ramifications and attracting broader interest from media and public, then there was a question of commanding public confidence—'justice being seen to be done' (§10). Moreover, this was described as being of value not just at press conferences, but also when the time came to communicate findings to any family involved.

Independence was described as 'absolutely vital' (§5) by one SAB member for the reasons already given here, and by another as a means of giving the SCR more 'clout', as was perceived to be the case in children's SCRs (§6). And this is achieved through the use of academics, independent consultants, or personnel from other authorities. Indeed, one recent SCR chaired independently was described as enjoying an even 'further level of independence' by virtue of the fact that it had a member of a national advocacy organisation on board (§13). But, as remarked upon above, in

England and Wales at present, SCRs in adult protection are not always conducted by an independent Chair. Interviews revealed that some have been conducted by a member of the SAB, that there is a notion of 'degrees' of independence, and that cost concerns are pertinent here.

For two interviewees the fact that SAB members were being used in this capacity was not a concern. For others it was clearly a live issue, but some justification could be sought from the fact, for example, that the member concerned was from the independent sector rather than the statutory services, which is where most scrutiny of inter-agency communication takes place. Another pointed out that using a manager in Older People's Services for a Learning Disability Service SCR meant there was no line-management relationship. The same respondent remarked, however, on the 'raised eyebrows' (§10) on the part of the Mental Health Trust that had made the application when the decision not to go fully external (independent Chair) was made. Cost is clearly one concern: adult protection is the 'poor relation of child protection' (§6) in the literal pecuniary sense as well as in the matter of its relative profile in the social care sector as a whole. One SAB member remarked on the fact that his/her authority had been unable to afford bringing in an independent Chair. For another, finance was an obvious element in the decision to make the shift:

'Our policy does not presume external input but it might be needed. It has been flagged up as a possible expense.' (§2)

The appointment

If by independence the Chair garners the confidence of public and personnel alike, then they must also bring other qualities to the role if the Review is to be a success. Of the four independent Chairs we interviewed one was a former criminal justice professional and three were academics, one of whom remarked:

'they wanted somebody independent and they also wanted somebody with a broad background in inter-agency work, not a single professional background, and of course they wanted somebody to be credible across the whole range of agencies involved.' (§12)

One of the academics had been involved in adult protection since the late 1980s and worked on the evaluation of the prototype for *No secrets*. The other said of his/her appointment:

'They wanted someone with knowledge of adult protection, social services and to be a registered social worker. I'm not sure why a registered social worker, perhaps as a mark of good standing...One of the things about me doing it as "independent" but employed by a university was that I was "reputable".' (§11)

The former criminal justice professional was able to cite 30 years' experience, with the investigative skills that come from conducting enquiries and an adult protection background.

Conduct of Serious Case Reviews

This section reports on the current state of guidance for SCRs and then considers current practice as evidenced, in particular, by the 15 Reports that the research team analysed.

Guidance

The publication in 2006 by the Association of Directors of Adult Social Services (ADASS) of *Vulnerable Adult Serious Case Review Guidance – developing a local protocol* was a staging post, if not a watershed, in the formalising of practice in the conduct of SCRs. One SAB respondent characterised his/her board's approach to SCR procedure before then as 'making it up as we went along' (§10). One of the SCR Chairs, recalling the time before the *Guidance's* publication, described circumstances in which 'everything was a bit home-grown...The approach for the Department was up to me and I identified what to do.' (§12). For another, this involved taking protocol directly from part 8 Reviews for children. For others it was a matter of looking to other local authorities for models.

In the wake of publication some interviewees reported their SAB's uptake of the *Guidance*—'Our policy is much the same as the ADASS protocol' (§9). For others it was a matter of fashioning a hybrid policy and procedures document from the ADASS policy and that of a neighbouring authority, or an amalgam of the new guidance and what went before.

The *Guidance* is not without its critics (even amongst those who had a hand in developing it). One Chair, from a county described by him/her as something of a pioneer in SCR protocol, remarked on its lack of detail. A SAB respondent acknowledged that while it has imbued the process with some clarity the document does not see through some of the detail, in particular relating to public, media and budgetary matters. Such weaknesses are compounded by the fact, according to another SAB member, that, 'Although there is the ADASS document no-one outside social services has heard of it.' (§4).

Two observations can be made about these criticisms. First, the *Guidance* is due to be reviewed in 2009. Second, and in advance of that, a recent ADASS conference (July 2008) saw the presentation of new advice which specifically picked up on and expanded elements of the 2006 *Guidance* that had been relegated to brief references in an appendix, in particular regarding media strategy and involving family members. It also considered questions of staff

support in the carrying out of SCRs. In short, the ADASS *Guidance* is more aptly seen as work in progress rather than definitive.

One further development concerns the growing interest in links between domestic violence and adult safeguarding. The lessons from multi-agency domestic violence homicide reviews (Metropolitan Police 2006) are likely to be worth considering individually and when collated. Some local SAB policies give guidance about avoiding duplication:

‘Where there are possible grounds for both a Serious Case Review and a Domestic Homicide Review then a decision should be made at the outset by the decision makers as to which process is to lead and who is to chair with a final joint report being taken to both commissioning bodies’. (Wakefield and District SAB, 2008)

The **Domestic Violence Crime and Victims Act 2004** Section 9(1) states that a serious case review under the Act should be initiated when “the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

- i. a person with whom he/she was related or with whom he/she was or had been in an intimate personal relationship
 - ii. a member of the same household as himself /herself
- with a view to identifying the lessons to be learnt from the death”

Threshold and terms of reference

Most interviewees stated that where there had been a death in combination with evidence or suspicion of neglect or abuse this should lead to the commissioning of a Review. The ADASS *Guidance* makes clear that such circumstances should always give rise to a SCR. It goes on (at para 4.2) to state that where there has been potentially life-threatening injury through possible abuse or neglect and the case gives rise to concerns about the way local services and professionals have worked together then a SCR should be considered. The same principles apply wherever abuse or neglect have taken place, in a person’s home or care and treatment setting, or when multiple ‘abusers’ are possibly involved. Reflecting the ADASS *Guidance*, the SCR protocol for Kent and Medway considers whether there has been a death or life-threatening injury, or a serious sexual assault or an assault of such severity that it has left a permanent impairment. If, in addition to one of these eventualities, there are concerns about the way in which local professionals

and services worked together to safeguard vulnerable adults, then a SCR may be commissioned (Brown 2009).

Example: Introduction to a Serious Case Review (SCR)

‘(The) Police recommended this case for a SCR. They described allegations made against a care worker working in an NHS Trust care home for adults with a learning disability, as protracted and worrying. The allegations included physical, psychological abuse and neglect which taken together could rightly be described and institutional abuse. The police voiced concerns that alleged practices did not appear to have been addressed appropriately by the management.’

Of the 15 Reports analysed for this study, ten involved a fatality and evidence of neglect or abuse (whether or not such neglect or abuse was clearly causative of death). The remainder involved allegations of either sexual assault, or in two cases what one report described as institutional abuse: events, in one instance, leading to the closure of a care home and in the other forming a regime that had residents being bathed on occasion before six in the morning. Seven of the cases involved allegations of neglect or abuse taking place at the service user’s home at the hands of a relative or carer. It was striking that amongst the reports it was unusual for them to expressly consider the issue of threshold, thereby making it impossible to know the explicit rationale for their execution. A clearly perceived threshold would be of value not only for SCRs, but would also give better definition to those investigations of so-called ‘near misses’ that occur beneath the threshold and where, notwithstanding the fact that nothing serious has occurred on this occasion, lessons may still need to be learned (Bostock *et al.* 2005). The matter of threshold, of what should trigger a SCR, is one of the questions raised in the Department of Health consultation on the review of *No secrets* (Department of Health 2008, See Appendix II). One example of a SCR (not among the 15 analysed in detail), undertaken into an incident where death or major injury did not occur, appeared to result in some very useful learning for a wide range of agencies:

‘The remit of the Review was to investigate and report on the circumstances that led to the failure of service delivery which resulted in a woman with learning difficulties being left overnight on a transport bus in the X Depot on the night of x 2006’. (extract from SCR summary report, London Borough 2006).

An abiding difficulty faced by commissioners of SCRs is, according to the independent chair of one SCR panel, that the single incident trigger approach to SCR commissioning carries with it the risk that scenarios in which there is an 'ongoing accumulation of concern tends not to trigger a timely response.' (Brown 2009). In other words, effective safeguarding calls for ongoing service level quality assurance as well as SCRs that are necessitated by events that 'test adult protection work and the system beyond its capabilities' (Brown 2009).

Example of threshold in operation (Halton Borough Council, 2007)

'When should a Serious Case Review be undertaken?

The Safeguarding Vulnerable Adults Partnership Board (SVAPB) should conduct a serious case review in the following circumstances:

- When a vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in the vulnerable adult's death.
- Consideration should always be given to whether to undertake a serious case review:
 - a) When a vulnerable adult has sustained a potentially life- threatening injury through abuse or neglect and
 - b) The case gives rise to concerns about the way in which professionals and services work together.

Where a case is referred to the SVAPB for consideration for Serious Case Review and is found not to meet the necessary criteria...but the case has raised concerns about the way in which professionals or services worked together, the SVAPB should make recommendation(s) for its consideration through another, appropriate reviewing mechanism. Should such a review be necessary, its findings and any actions agreed should feed into the Scrutiny/Quality sub-group of the SVAPB'.

A checklist approach – Leeds Adult Safeguarding Board

'The following checklist of questions may help in deciding whether or not a case should be the subject of a Serious Case Review in circumstances, other than when an adult dies. A 'yes' answer to several of these questions is likely to indicate that a review will yield useful lessons: -

- The abuse was not recognised by agencies or professionals in contact with the adult;
- The abuse was not shared with others;
- Was not acted upon appropriately;

- The abuse happened in an institutional setting;
- Does one or more of the agencies or professionals consider that its concerns were not taken sufficiently seriously or acted upon appropriately by another?
- Does the case indicate that there may be a failing in one or more aspects of the local operation of Safeguarding Adult procedures which go beyond the handling of this case?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the Safeguarding Adults Board may need to change its local protocols or procedures or that protocols or procedures are not effectively used or acted upon?'

Methods and timescales

As with threshold, it was the exception, amongst the reports received, for the methodology to be clearly laid out, detailing the activities of the Review. One where this had been done involved questions being raised of a care home provider. Here, the independent Chair and the seven panel members met three times to review and analyse the evidence. This included:

- Adult protection strategy meeting reports and minutes
- Inter-agency case chronology
- Commission for Social Care Inspection (CSCI) reports
- Current adult protection procedures and practice guidelines
- Adult protection referrals
- Relevant legislation.

During the course of this SCR, the investigator interviewed: six adult and community services staff; three NHS staff; four other professionals; five residents; 11 relatives; two counsellors; and, one registered care home manager.

One SCR (2008) notes that the local authority had difficulty in its investigations of allegations of abuse by staff in a care home in obtaining information about the care provider from CSCI. It had to resort to taking action under the Freedom of Information regulations to obtain this information. Consideration of this course of action might usefully be drawn to the attention of the new Care Quality Commission.

While, as here, relatives were typically interviewed by SCR investigators none of this study's respondents remarked on the possibility of making the Review a fully collaborative process, that is involving family members, as well as the other interested parties, at every step of the way. Drawing on one SCR,

Hitchen recommends this if circumstances are non-conflictual with family members (Hitchen 2007). In the case she reports, following the death of a person with serious mental illness, family members of the deceased were involved from initial drafting to final draft of the SCR report. Hitchen argues that, while the collaborative approach is time-consuming in the short term, it has the virtue of reducing the likelihood of post-publication complaints and delays. She suggests that this approach has the following advantages: the promotion of transparent processes, increased and more effective organisational learning and subsequent change, a more explicit and understandable story, an evidence-based and validated report, and the acknowledgement from the organisation of the grief borne by the family members.

Data about timescales may be problematic because legal and disciplinary proceedings may intervene and stay a SCR's progress. This is not always detailed in the reports. One exception is the SCR protocol from the Pan Dorset authorities which outlines the liaison steps necessary with HM Coroners, as below:

'When a death of a vulnerable adult occurs, where either abuse or wilful neglect are known or suspected to be a contributory factor in the death, before the APC commissions a SCR, the following action must be taken in respect of the Coroner:

- The Police representative on the APC Sub-committee will cause enquiries to be made with the Coroner to identify whether an inquest will be or has been held.
- If an Inquest is to be held, the Chair of the APC will notify (in writing) the Coroner in whose area the death occurs that a review under these guidelines is being undertaken.
- When the terms of reference of the case review have been agreed by the APC, the Chair of the APC will forward them to the Coroner in whose area the death occurred and invite comments from the Coroner to avoid any conflicts between the two separate processes.
- Should a conflict be identified, then a meeting may be held between the Chair of the APC and the Coroner in an attempt to resolve the issues.
- The Police representative on the CRP will liaise between the Coroner and the APC with a view to identifying the time-scales for the Inquest'. (Pan Dorset agreement, guidance on conducting inter-agency reviews, 2008).

Not all SCR procedures and protocols include the Coroner as a signatory to them – one exception is that of Leicester City, Leicestershire and Rutland (2007).

An Ofsted report (Ofsted 2008b;) into children's SCRs suggests that a period of four months between the decision to conduct a Review and completion should be aimed for (and long delays in children's Part 8 Reviews are highlighted and criticized in Ofsted's annual report: Ofsted 2008a). Amongst reports analysed in the present study, where the data were available, timescales of between 10 and 15 months were recorded between first meeting of SCR panel or decision to conduct a SCR and report completion. In the case of the closure of a care home by a magistrate, this was followed by 13 months before the SCR report appeared, and, in another instance, where a care home was de-registered the time lag was 15 months.

Extract from the SCR summary in respect of HL, Surrey Safeguarding Adults Board, September 2008, outlining the complexity of the methodology

'The Methodology used by the Serious Case Review Group (SCRG):

An initial meeting was held to: confirm and accept the terms of reference; identify the 'evidence' required from each participating agency; set the time scales within which the review process should be completed; agree the dates, times and venues of meetings; and establish the nature and extent of legal advice required.

Independent Chair sought access to appropriate and identified files and records which were either, in the case of the majority of the documents, copied in advance of SCRG meetings to the members or, with regard to a small number or follow up documents, circulated for inspection, interrogation, cross-referencing and discussion at the SCRG meetings themselves.

The Independent Chair has carried out interviews with: Mr. & Mrs. E, who supplied a number of background documents in support of their concerns; and staff in the various agencies still in employment of that agency who were involved in the case in 1997, other than those who declined to be involved. All interviews with such staff were written down and ratified by them and are included in the background documents used by the SCR Group. Given that this was to be a review of joint working and the procedures and systems used in 1997, not an investigation or inquiry, it was not considered necessary to trace and seek interviews with all former employees of the relevant agencies, as there is sufficient available written evidence. All former employees were treated equally in this regard. This latter point applied to Drs. M, D, G, and the Approved Social Worker.

Using the correspondence provided to the Review, a chronology was then compiled outlining the key events from all the participants and agencies' perspectives.

Using this chronology to consider and deliberate on all of the documentation available to them, the Group then agreed the key points to be included in the report and the recommendations for further action'.

Recommendations and action plans

The process of learning lessons elicits a set of recommendations. In the reports we analysed there was sometimes a conclusion that the problem lay in the lack of a lead agency, in the fact that the case was characterised by an accrual of incidents that were not identified, or that there were general dilemmas of self-determination of the service user versus the duty of care of the professionals involved. The majority of the reports focus on questions of inter-agency communication depending, of course, on the particular circumstances. These reports isolate the poor relationship between care staff or police or general practitioners or the hospital concerned and the apparatus of adult safeguarding. In three instances it was noted that the uncertainty surrounding the precise roles of the inspectorate of social care services in England, the Commission for Social Care Inspection (CSCI), together with the lack of a protocol explaining when it should be informed, were elements in the failings:

‘Whilst there is no statutory requirement for CSCI to be notified of serious case reviews (unlike for children’s serious case reviews) it is accepted as part of this agreed protocol that CSCI be formally made aware of both the instigation of any adults serious case review and its outcome’. (CSCI 2007, p.17)

However, as noted above, one local authority was concerned that its efforts to produce a thorough SCR had left itself open to criticism from CSCI and considered that CSCI had awarded it ‘poor’ grading, in light of the SCR when it read the CSCI report:

‘The Serious Case Review gave cause for a high level of concern especially about safeguarding within the service. Action planning following the Serious Case Review identified ‘systemic failings across most of the agencies’ (Extract from CSCI report to local authority 2007).

The recommendations of the SCR reports considered for this study varied in their degree of sophistication or reach. The subheads of two in particular warrant reproduction here, since they may be useful cases of illustrative practice. Both involved care homes, the first where there had been alleged sexual, physical and financial abuse. Here recommendations were broken down according to level:

- *National*: guidance was required in relation to inter-agency co-operation, information sharing and data protection. Also, in relation to SCR role and function.
- *Strategic*: this referred to systems of inter-agency communication, information sharing and data protection.
- *Human resources*: relating to the decision whether to undertake Criminal Records Bureau checks of volunteers.

- *Operational*: possible abuse should be communicated proactively and recorded. Training was required in relation to information sharing and adult protection procedures.

The other report reviewed what had happened in the run up to the closure of a care home; its recommendations were broken down as follows:

- *Communication*: e.g. between CSCI and other agencies defining a failing service.
- *Resources*: e.g. there should be named senior officers to lead on adult protection.
- *Guidance*: e.g. when a service is failing guidance should be issued by each statutory agency.
- *Promoting awareness*: district nurses and general practitioners should be made aware of their responsibilities with regard to adult protection.
- *Clarification of procedures and protocols*: e.g. with regard to all agencies' methods of monitoring services.
- *Training and development*: clarity as to who is responsible to ensure care workers have appropriate skills to work with vulnerable adults.
- *National issues*: informing the Secretary of State of the failure of the Protection of Vulnerable Adults (POVA) listing in this case (two nurses should have been referred, but because of the home closure this did not occur).

In terms of follow-up, the reports generally revealed little evidence of action plans but, as one independent Chair pointed out, these were mostly the responsibility of the agencies involved or, according to the *ADASS Guidance*, they are the responsibility of the Safeguarding Adults Board to draw up on the basis of the recommendations in the report, presented to the Board as the commissioning body. According to one experienced SCR Chair, the typical practice was to conduct a follow-up six months following the production of the report in order to monitor progress of the action plan. A recent report from the Commission for Social Care Inspection (2008, p. 65) reported Councils' views that they were learning from SCRs but little substance was provided to support or disprove these opinions.

Example of commitment to follow up

'The SCR report contains the detailed action plans of all agencies involved. At each meeting of the APC in 2008, all of these agencies will submit a detailed progress report about the progress they have made. The APC will ensure that every agency fully implements the actions they said they would, in the timeframe they themselves have agreed'. (County APC, 2007)

Comments on Serious Case Reviews and Protocols

In the course of interviews with Chairs of SCRs and members of SABs, respondents made a range of suggestions as to how current practice might be improved. These centred on questions of **central prescription, national collation, and classification of the various forms of review** available. We also asked subjects for their advice to a prospective new SCR Chair. In the interim, before the new guidance emerges from ADASS and before decisions are made from the *No secrets* review, agencies that wish to consult detailed SCR protocols may find that of London Borough of Southwark is particularly informative.

Central prescription

By making SCRs in adult protection statutory and thereby compulsory, the government would be bringing this sector into line with children's services. 'Onerous and difficult and time-consuming though that would be' (§10), it would confirm that the government (and thus society) was taking safeguarding adults seriously. The same respondent suggested the reports should also be subject to the same kind of oversight that the children's reports receive (from Ofsted). Further advantages of this shift would be the ironing out of inconsistent approaches (exemplified in the section on guidance above), and the raising of the profile of such Reviews—SCRs are not about disciplining staff, but the nature of the relationship between SCRs, criminal investigations, inquests and disciplinary matters is not widely understood. The potential for conflict of interest would have to be addressed in respect of SCRs as some SCRs have pointed to difficulties or issues with regard to the role of regulation and inspection bodies. To provide regulators with a responsibility for oversight of SCRs might not be seen as independent or effective when SCRs have made comments on the performance of inspection and regulation at local levels.

As one SCR Chair remarked, she/he had not come across an occasion in the six Reviews she/he had conducted when an agency had refused to take part—it would show that agency in a poor light. However, others gave accounts of receiving from agencies the wrong kind of reports (for example, documents that were effectively internal reviews), or having difficulty in obtaining such reports in timely fashion:

‘The big stumbling block with SCRs is getting the reports, especially from hospitals. I had to go to the Strategic Health Authority [SHA] before the hospital would reply. The SHA were good and effective—I got the report.’ (§4)

Another respondent also reported that certain of their health partners (Primary Care Trust, Mental Health Trust or Acute Trust) did not take sufficient interest and ‘trailed in their responsibilities’ (§6) in this regard. The degree of participation by agencies is likely to vary due to the lack of a statutory requirement in relation to SCRs and also some lack of clarity about the SCR remit and process, and existing variations in practice relating to this across the country.

There was an expectation that the review of *No secrets* may recommend SCRs be made statutory, indeed that if such a proposal were not in the re-draft there would be adverse comment. In this way, the ADASS guidance may come in time to be the genesis of a national SCR policy. ‘A national policy will need to be agreed with the NHS and the police. It could be evolutionary.’ (§3). This would require agreements over: data sharing, the interface with legal and disciplinary processes and whether witnesses would be compelled to participate as well as reporting requirements and submission to the Department of Health for collation purposes.

We found strong support for national guidance on SCRs.

National collation

In line with a call for national policy or guidance were calls for a national collation of SCRs: all should be pulled together regularly and systematically analysed and the results and recommendations should be shared, given that similar scenarios are probably unfolding across authorities. The MS Society has commented:

‘We believe that follow-up reviews should be undertaken in order to inform and improve practice. The dissemination of examples of good practice should be coordinated at a national level if possible. The idea of a national database of recommendations from serious case reviews could play a part in this. The database would have to be fully confidential in order to protect the identity of those involved in each

case but this could certainly aid with the learning process and could be rolled out nationally in training programmes'. (MS Society 2009)

A prototype of this proposal has been undertaken in one English county comprising several local authorities where a learning day was recently held involving. By looking in-depth at two SCRs, lessons were shared. Another such day is planned and this stands in addition to the regular contact service managers sustain across the county. Information sharing, so often a concern within the Reviews themselves, should become a priority in relation to the analyses and recommendations that flow from them:

'If SCRs from other places were available [anonymously] that would be good as I am sure we can learn from other areas. You only know your local area.' (§8)

The question of whether there should be a database of recommendations at national level is one included in the Department of Health's consultation on the review of *No secrets* (Department of Health 2008; See Appendix II). Such a database may reduce the danger of lessons that have been gleaned from one segment of the care and support sector not being communicated to others. As an example of this, Benbow (2008) considers the high profile Rowan Ward report, published in 2003 following an investigation into allegations of abuse on a hospital ward in Manchester providing long-term care for older people with mental health problems. She highlights the similarities between the failings uncovered in this report and that of others before and since its publication, for example, the Avonside Review (Independent Inquiry Team 2004), commenting:

'A striking conclusion from studying the Rowan report and similar inquiries is that as we have defiantly failed to learn lessons, problems are likely to continue.' (Benbow 2008: 9-10)

In particular, while the Rowan report led to an audit of inpatient care for older people with mental health problems (Butler 2004 gives a description of an instance of this process), Benbow suggests that the care home sector often faces comparable problems. Such problems include poor and institutionalised environments, low staffing levels, high use of temporary (bank and agency) staff, limited staff development or training and poor staff supervision—and yet the local care home sector had not been involved in the subsequent attempts to share the lessons. The importance of the SAB taking a system wide approach is evident here and there may be points to learn about whether NHS reviews fully engage with adult safeguarding processes and how this may be facilitated.

We found strong support for national collation of SCRs.

Classification

Both central prescription and national collation would go toward bringing greater definition to the practice of SCRs. According to one experienced SCR Chair, this would assist in differentiating between the various kinds of review available when things go wrong. These would include *Public Inquiries*, *Internal Enquiries* (which can call witnesses), *Serious Case Reviews* (which do not always call witnesses or interview staff, but which seek retrospective analysis from the agencies in the form of reports), and then the more minor procedures of *Case Audit* and *Debrief*. Our survey undertaken in 2007 supports this proposal in that it uncovered a variety of names for procedures ranging from *Case Reviews* to *Investigations* to *Critical Incident Reviews* and uncertainty in a number of responses as to the defining characteristics of a SCR.

Clearer definition would also enable effective co-operation with National Health Service procedures. Two interviewees called for the Department of Health to consider, in particular, the interface between SCRs and Serious Untoward Incidents reports or similar, proposing that a joint protocol would, for example, facilitate the co-ordination of timescales. One SAB member commented:

‘We get really good co-operation locally around safeguarding policies but with regard to roll out into the NHS they do have different systems and I am not sure how untoward incidents and so on fit with a SCR or NHS Complaints and so on. We need to make the links.’ (§8)

We found strong support for guidance on the relationships of SCRs to other forms of enquiry, with similar duties to co-operate.

Advice to Chairs of Serious Case Reviews

Advice to those undertaking the conduct of a Serious Case Review for the first time focused on matters of clarity and support. It was critically important to establish clear terms of reference at the start, and the Chair’s own involvement in this process was integral to the independent component of their role. One Chair respondent who saw his/her report being re-written by the SAB regretted that this had not been ruled out by the terms of reference. Another Chair commented on the use also that the contract with an independent Chair could be put to in achieving clarity with regard to expectations and the role and responsibilities of those involved in the Review. Being seen to be independent—‘outside of the structure’ (§14)—was also described as very important.

Administrative support was viewed as essential. For example, the handling of chronologies from multiple sources, a routine element in SCRs, required care. Time was also an important consideration: ‘My advice to others would be that it takes more time than you think.’ (§9). The Chair needed sufficient time to

interrogate reports, interview managers and frontline staff and to read and track down internal investigations. Reviews should be done 'carefully rather than urgently' (§14).

Finally, psychological support was important. In light of the often disturbing material and the difficulties in tracing accountability, it was important to have a sounding board or supervisor—by analogy with the supervisor role in psychotherapy—or mentor, as is commonly the case now in the mental health services. Having just one person conducting the Review allowed for a light touch, but, on the other hand, difficult subject matter meant that it was important that a Chair should have access to support or coaching.

We found support for independent chairs, but not as a matter of course.

Wider perspectives

As this report was being compiled, a number of responses were being received following the consultation on the Review of *No secrets*. While these do not represent the full comments, the following observations were being received:

'Serious case reviews must also be placed on a statutory footing, including a duty for agencies to cooperate with investigations. There is a lack of clarity on this issue which means that there is uncertainty over when a serious case review should be carried out and by whom. As a result, a number of high profile cases have not been investigated to the extent which Mencap thinks appropriate and vital lessons have not been learned. This must be addressed urgently as part of this review'. (Mencap 2009, p.2).

'Sense supports Mencap's call for serious case reviews to be placed on a statutory footing, including a duty for agencies to cooperate with investigations. There is a clear need to end the current uncertainty around how, when and by whom a serious case review should be carried out. In some cases this uncertainty has resulted in serious cases not being dealt with as quickly and thoroughly as would be appropriate'. (Sense 2009).

Further elements that were not considered in this overview are the possible interactions with the newly established Independent Mental Capacity Advocate services, which may lead to greater or earlier identification of concerns. One SCR published in 2003 noted:

'It is expected that the implementation of the Mental Capacity Act 2005 and the role of an independent mental capacity advocate will assist in

addressing such serious adult protection concerns in future'. (County Council local authority)

Suggested improvements and Conclusions

In the period 2000-2006 at least 94 SCRs were conducted, were in progress or were in prospect in England (across 62 authorities), and at least seven Reviews were conducted in Wales (across five authorities). There is an uneven distribution of such Reviews and we found **strong support for greater guidance** about SCRs, particularly reiterating their potential as learning vehicles among local agencies in social and health care sectors.

We suggest a **national reporting system** be devised by the Department of Health for SCRs. There is strong support for **national collation** of SCRs in order to disseminate lessons learned or points of difficulty. This is a requirement for children's SCRs, but, as one of the interviewees in the present study remarked, although they had wanted to send their Report to the Department of Health, they did not know exactly where to send it. The Department of Health would have strong support for the development of such a role. However, SCRs are local reports and it is strongly felt their commissioning and follow up should continue to be the responsibility of the SAB at local level. We did not find support for the regulatory or inspection system to be the body to receive and scrutinise SCRs.

There may be good cause to **formalise the classifications** of the various reviews at the local authority's and other agencies' disposal and their relationship to each other when more than one needs to be undertaken. Greater integration of health and social care services may compel such developments but we suggest that that the Department of Health refers this matter to the new, integrated Care Quality Commission in 2009 to minimise the gaps and duplications that were hinted at in this study. The potential of scrutinising 'near misses' might usefully be considered in adult services in the context of safeguarding as well as by clinical and care providers.

Central prescription or a duty to co-operate—the removal of the voluntary element in SCRs in adult protection—was widely supported by interviewees. In addition, interviewees supported the need for SCRs in adult safeguarding to be put on a similar footing to Part 8 reviews in relation to children. They saw this as representing a sign of how important the government sees the practice of safeguarding adults. The current review of *No secrets* is seeking information of whether there is wider affirmation of this perspective.

Learning lessons as the prime rationale of SCRs is well understood and supported, as evidenced in interviewee responses and the generic terms of

reference used in reports. We suggest that this rationale continue. However, **agreed review periods** for action plans should be established by the SAB to monitor if lessons have been taken on board.

An independent Chair was agreed as important in order for there to be neutrality in relation to all the agencies involved. However, it is not universal practice and it is costly. We suggest that the **decision to have an independent Chair or otherwise is made explicit** in the report but is not centrally prescribed. Statutory organisations in membership of the SAB should **share the costs** of SCRs.

As with children's SCRs, there is a question mark over the length of time it is taking to produce some reports in adult safeguarding. Where it is not possible to produce these within three months, we suggest that the reasons for the delay are explicit in the report. The SAB should receive **regular progress reports on a commissioned SCR** and take action if delay appears unreasonable.

Reports are often characterised by a failure to consider expressly the issue of threshold (what makes this particular case or incident deserving of a review) and by the absence of a full record of the Review's methodology, so the rationale for the review/report is not always clear. We suggest that the **reasons for the SCR are contained in reports and that the methods of the Review** are set out, with observations on any lack of co-operation or approaches that seemed to have been particularly fruitful. Decisions about anonymity and confidentiality should be taken at local level by the SAB, informed by legal advice if necessary. A chronology of events and communications is helpful to readers, although these may suggest, with the benefit of hindsight that events were more predictable than they might have been

In relation to guidance, this is in the process of being expanded and improved by the ADASS (for example, in relation to media strategy, staff support and the involvement of family members). We note the effectiveness of the championing of these issues by the **ADASS network** and suggest that this network engages with other sectors in devising further guidance to cover all sectors, particularly the NHS, with encouragement from the Department of Health.

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Department of Health. We write this report in memory of the lives affected by the tragedies that led to Serious Care Reviews and in tribute to the many who have loved and cared for them.

Appendix I: Serious Case Reviews in Child Protection

- More than one interviewee in our study referred to SCRs in the children's sector as if they stood as a benchmark in comparison with which those in adult protection were seen to be wanting. In 1999, the government announced biennial overviews of reports of SCRs for children (Department of Health *et al* 1999) which has led to a sizeable body of research on this subject (see Rose and Barnes 2007; 2008) and policy review (Ofsted 2008a and b);
- Serious Case Reviews and public inquiries in the area of children safeguarding indicate the value of a systems approach to improving the quality of services and material related to this is usefully drawn together by SCIE (2009). The messages for adult safeguarding practice might be worth exploring jointly by children's and adult safeguarding stakeholders.

Appendix II: Department of Health Consultation on review of No secrets

The Consultation document's treatment of Serious Case Reviews and associated question read as follows:

'A number of serious case reviews, other investigations and reviews have been published in recent years, which have highlighted lessons for local safeguarding systems. Some of these have been concerned with the way health or social care services are delivered (e.g. Rowan Ward, North Lakeland Healthcare, Cornwall, Sutton and Merton), and others were concerned with older adults or adults with learning disabilities who have died or been harmed as a result of serious abuse or neglect. Some reviews have been carried out by national regulators, while others have been commissioned by local safeguarding adults boards. However, there appears to be no common understanding of when such reviews should be undertaken, the terms of reference they should be conducted under, or where findings should be reported to. There is, for instance, no national collation and distribution of findings. Nor is it clear whether organisations that are the subject of recommendations in reviews are required to respond formally. Does important learning result from these reviews? Do we need more consistency about how and when these reviews are carried out?

...

Q3e. Should we have a national **database of recommendations** from serious case reviews at a national level? Should we review the effectiveness of serious case reviews as learning tools? What should trigger a serious case review, and how should the conclusions be disseminated?

(Department of Health 2008: 23-24)

References

Association of Directors of Adult Social Services, 2006, *Vulnerable Adult Serious Case Review Guidance - Developing a local protocol*, London: Association of Directors of Adult Social Services, at <http://www.adss.org.uk/publications/guidance/vulnerableadult.pdf> (accessed 28 August 2008).

Association of Directors of Social Services, 2005, *Safeguarding Adults. A National Framework of Standards for good practice and outcomes in adult protection work*, London: Association of Directors of Social Services.

Benbow, S. M., 2008, 'Failures in the system: our inability to learn from inquiries' *Journal of Adult Protection*, 10(3): 5-13.

Bostock, L., S. Bairstow, S. Fish, & F. Macleod, 2005, *Managing risks and minimising mistakes in services to children and families*. London: Social Care Institute for Excellence.

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

Butler, T., 2004, 'Learning from Rowan ward - developing an audit tool to improve the systems and processes for quality of care and safety of service users' *Journal of Adult Protection*, 6(4): 22-26.

Commission for Social Care Inspection (2008), *Safeguarding adults: protocol and guidance*, London: Commission for Social Care Inspection.

Commission for Social Care Inspection 2008, *Safeguarding adults: a study of the effectiveness of arrangements to safeguard adults from abuse*, London: Commission for Social Care Inspection.

Cornwall Adult Protection Committee 2007, *Adult Protection Committee: The Murder of Steven Hoskin, Serious Case Review, Multi-agency and Single-agency Recommendations and Action Plans*, Cornwall.

Department of Health, 2008, *Safeguarding Adults. A Consultation on the Review of the 'No secrets' Guidance*, London: Department of Health.

Department of Health & Home Office, 2000, *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*, London: Department of Health.

Department of Health, Home Office and Department for Education and Employment, 1999, *Working Together to Safeguard Children*. London: The Stationery Office.

Hitchen, S., 2007, 'The use of collaboration to produce more effective serious incident inquiry reports' *Journal of Integrated Care* 15(6): 22-29.

HM Government, 2006, *Working Together to Safeguard Children. A guide to inter-agency working to safeguard and promote the welfare of children*, London: HM Government.

Independent Inquiry Team, 2004, *The Avonside Review. Report of the Independent Inquiry Team*.

Mencap, 2009, *Mencap response to Safeguarding Adults: A consultation on the Review of the 'No Secrets' guidance*, London: Mencap.

Metropolitan Police (2006) *Guidelines for Multi-agency Domestic Violence Murder Reviews*, London: Metropolitan Police.

MS Society, 2009, *Safeguarding adults: A consultation on the review of the 'No Secrets' guidance, Submission from the MS Society*, London: MS Society.

National Assembly for Wales & Home Office, 2000, *In Safe Hands. Implementing adult protection procedures in Wales*, Cardiff: National Assembly for Wales.

Ofsted, 2008a, *The Annual Report of Her Majesty's Chief Inspector of Education, Children's Services and Skills 2007/08*, London: The Stationery Office.

Ofsted, 2008b, *Safeguarding Children. The third joint chief inspectors' report on arrangements to safeguard children*, London: Ofsted.

Reith, M. 1998, *Community Care Tragedies: a practice guide to mental health inquiries*, Birmingham: BASW.

Rose, W and Barnes, J., 2007, *Improving Safeguarding Practice: Study of Serious Case Reviews 2001-2003*, Milton Keynes: The Open University.

Rose, W and Barnes, J., 2008, *Improving Safeguarding Practice: Study of Serious Case Reviews 2001-2003*, London: Department of Children, Schools and Families.

Sense, 2009, *Sense's response to: Safeguarding Adults – a consultation on the review of the 'No Secrets' guidance*, January 2009.

Social Care Institute for Excellence (SCIE) (2009) *Learning together to safeguard children: developing a multi-agency systems approach for case reviews*, London, SCIE, Guide 24.

Stanley, N. and Manthorpe, J. (eds), 2004, *The age of the inquiry: learning and blaming in health and social care*, London: Routledge.