

Serous Case Reviews: The evidence

One-to-one support project for Coventry

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1 Introduction

This the project is based on the existent---still limited---published (research) evidence of what works in serious case reviews (SCRs) in adult social care. Also, a number of local SCR guides are compared and certain similarities and differences are pointed out. The report

summarises also key messages from child protection SCR research: an area where much more substantial work has been done so far.

Further research is needed in establishing what works best in adult protection SCRs. Until such research is carried out, the best way to improve local practice on an evidence-informed way is through knowledge and 'good practice' sharing initiatives with other councils.

2 Published evidence on SCRs

The research or generally published evidence of what works in serious case review process in adult social care is still very limited¹. However, an extensive search of on-line databases, such as Social Care Online, CSA Illumina and Google Scholar revealed a few resources that are discussed here.

2.1 Serious Case Reviews in Adult Safeguarding Final Report (2009)

This report was written by Manthorpe and Martineau from the Social Care Workforce Research Unit, King's College of London and published in 2009 (Manthorpe & Martineau, 2009).

The researchers conducted a national survey, interviewed 14 people with experiences

¹For a general study of adult protection services, based on inspections in councils, fieldwork and councils' self-assessment reports, see CSCI's *Safeguarding adults: A study of the effectiveness of arrangements to safeguard adults from abuse* (CSCI, 2008). Also, see *Safety Matters: developing practice in safeguarding adults literature review* (Penhale, 2009), *Partnership and Regulation in Adult Protection* (Penhale, Perkins, Pinkney, Reid, Hussein & Manthorpe, 2007), *The Protection of Vulnerable Adults List: an investigation of referral patterns and approaches to decision-making* (Stevens, Hussein, Martineau, Harris, Rapaport & Manthorpe, 2008) and *UK Study of Abuse and Neglect of Older People* (O'Keeffe, Hills, Doyle, McCreadie, Constantine, Tinker, Manthorpe, Biggs & Erens, 2007).

of commissioning and conducting SCRs, analysed 15 serious case review reports and studied various examples of local policies in this area. Here is a summary of some of their findings:

- There is strong support for greater national guidance about SCRs. The authors 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 (a requirement for children's SCRs). However, the experts felt that SCRs are local reports and their commissioning and follow up should continue to be the responsibility of the local Safeguarding Adults Board (SAB).
- The interviewees supported the removal of the voluntary element in SCRs in adult protection, seeing in this that the government is taking seriously the protection of vulnerable adults.
- Learning lessons as the prime rationale of SCRs was supported but the authors suggest that **review periods** should be established by the Safeguarding Adults Boards (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, the authors recognise the cost implications and suggest that the statutory organisations in membership of the SAB share the costs of SCRs.
- As regards of the **observed common delay** in SCR reports, the authors suggest that if it is not possible to produce these within three months, the reasons for the delay are made explicit in the report and the SAB receives regular progress reports on a commissioned SCR, taking action if delay appears unreasonable.
- The authors found out that the **rationale and the methodology** for a report was not always clear, and suggest that the reasons for the SCR are contained in reports, and that the methods of the review are set out.

- An interesting points that the authors make is that the **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.
- The authors found out that the procedural guidance was constantly improving and expanding locally, in many areas to include media strategy, staff support and the involvement of family members (Mantorpe & Martineau, 2009)

Apart from the above messages from their study, the authors also draw an interesting comparison with the process of SCRs in children's services, based on a recently submitted report by Ofsted (the Office for Standards in Education, Children's Services and Skills), which looks at Part 8 Reviews of children's safeguarding (Ofsted, 2009)².

Here are some of the commonalities with children's services, according to the authors:

- There was failure on occasion to secure co-operation from all agencies, particularly, but not exclusively, from NHS Trusts in Part 8 reviews. Not all agencies in children's safeguarding systems were monitoring action plans. These conclusions seem to apply to some adult safeguarding systems and their efforts to review lessons learned.
- Independent Chairs were not the universal norm in either children's or adult SCRs.
- Some areas employ various forms of review, such as 'individual management reviews', 'case file audits' and 'lessons learned reviews' in children's and adult safeguarding. According to the authors, in adult safeguarding this is more understandable (if not forgivable) and has the potential to cause further confusion because there is little legal guidance or agreement about resources.
- There is a mismatch in children's services between the number of serious incidents and the number of reviews commissioned across different authorities, exposing local differences in practice and policy. The authors speculate that this seems to be the

²Ofsted's report is also discussed further in the current text.

2.3 The process and function of SCRs in Kent and Medway

case in adult safeguarding (Manthorpe & Martineau, 2009).

These are only some summary findings from the report. It is worth reading through the whole text³ because of the plenty of local examples provided by the authors. Some of these examples are referred to in further sections of the current text.

2.2 Thresholds in adult protection

In February 2010 Collins published a study on the thresholds in adult protection, when a decision needs to be taken if a SCR needs to be instigated. He looks at the 'grey areas' in adult protection where many of the concerns of possible abuse relate to non-criminal situations in which neglect might have occurred. The author discusses a tool developed in Wales designed to provide guidance in decision making in these 'grey areas' (Collins, 2010).

The author draws on some differences between child and adult protection:

Within child protection, the vulnerability of the child, their capacity to consent and the duty of care owed to them are all, more or less, given. The question of significant harm may also be more easily determined. While in both child and adult protection physical and sexual abuse are matters of criminal law, psychological abuse is criminal only in child protection (Collins, 2010).

Collins quotes evidence from research suggesting that smaller concerns are not reported or shared, whereas they should be recorded. He refers to Cooper and others, who suggest that "... considering abusive behaviour a continuous spectrum rather than dichotomising it would be more helpful in clinical practice" (Cooper, Selwood, Blanchard, Walker, Blizard & Livingston, 2009).

The author examines a range of SCR reports and highlights a common theme of "the lack of thresholds and the failure to refer" thus justifying the put forward threshold tool, which is based on a range of practice examples.

In Powys, the adult protection co-ordinator agreed to produce guidance

and 'thresholds examples' to encourage consistent referral into adult protection of cases, whether or not the alleged abuse occurred in hospital, care home or domestic setting. The thresholds examples were welcomed and refined for use in Dyfed-Powys for all settings. In 2008, they were adopted and adapted by the South Wales Adult Protection Forum. They continue to be refined and further examples added, and they are soon likely to be used for the whole of Wales, where one adult protection policy and procedures document is being developed (Collins, 2010).

The full threshold framework is attached as an appendix to the article.

2.3 The process and function of SCRs in Kent and Medway

Brown published an article on the process and function of SCRs in The Journal of Adult Protection⁴ (Brown, 2009). She shares her experience as an independent chair of the SCR Panel in Kent, giving an account of the journey by which the SCR process have emerged and developed in Kent.

Kent and Medway established a multi-agency adult protection steering group in 1998 and embryonic adult protection policies and protocols in 1993, with Kent's first elder abuse guidance developed as early as 1987. Kent and Medway have also been collating adult protection monitoring data in a form that enabled basic comparisons as early as 1998 (Cambridge, 2009).

Based on Kent and Medway's experience, Brown provides a range of useful advice for developing the process of SCRs. Here is a summary of some of the main points she makes.

2.3.1 Criteria for SCRs

- **The severity of the abuse** and its impact on the victim is a first stage in a screening process for SCR: "... a review should take place for those cases where there has been a death or life threatening injury or a serious sexual assault or an assault of

³It is available on-line; please, see the reference list for further details.

⁴A key journal to monitor about research on SCRs in adult social care.

such severity that it has left a permanent impairment”.

- **Concerns about the perpetrator** is the second criteria: “. . .for example, where the abuse has taken place in an institutional setting, is seen as part of an abusive culture, and/or has been perpetrated by multiple abusers”.
- The third criteria is that SCR is needed when the case has **proven too much to handle by the agency**: “A complex case that has been handled well could also prompt learning for local services but may not need to be the subject of an SCR” (Brown, 2009).

2.3.2 The function of the SCR

According to Brown, SCRs specifically focus on the systemic issues and the service development agenda rather than on the unique circumstances particular to the individuals concerned. According to her, the review in Kent might be set up to cover any or all of the following functions:

- debriefing
- clarifying what has happened and disseminating lessons to staff
- revisiting the needs of vulnerable adults who may not have been helped to recover or seek redress
- re-investigating if management have not been held to account, or if individual wrong-doers have been allowed to evade responsibility
- conducting a further root cause analysis of what went wrong and who was responsible
- diagnosing the potential for strengthened safeguards
- auditing implementation of new safeguards or improved practice informing appropriate authorities of policy implications locally and nationally, including the need for legislative change or new guidance.

2.3.3 Method of the SCR

Brown provides a detail account of the process:

After an initial scoping discussion with panel members, I (in my capacity as chair) draw up a short narrative setting out the concerns that have led to the referral and the areas that have given rise to them. At this stage I formulate questions and indicate which agencies should address these in their reports to the panel. These reports may require a full chronology as well as an account of the agency's work with the client, service or with partner agencies and this initial brief directs their attention to the areas that they should spend time commenting on. It may be that this work has already been undertaken in a different format or is available in other records in which case we do not require the work to be duplicated. Court transcripts or coroner's reasoning will already have collated relevant accounts. The SCR is there to provide added value, not to revisit these adjudications, and usually its particular focus is the way agencies had worked together, rather than the discovery of further information about the case (Brown, 2009).

2.3.4 Comment

In her article, Brown provides a very elaborate account of the learning from SCRs in Kent and Medway; reading of the full text of the article is highly recommended. She also outlines a list of common themes of ‘what went wrong’, based on the adult social care SCRs that she has chaired; this list is beyond the scope of the current report and includes: significant undiagnosed mental health problems, dangerous assumptions that the person had capacity to make decisions, poor support, management and training for staff, etc.

2.4 Embedding the SCRs in the organisational learning

Continuing on the learning from Kent and Medway, Aylett provides an account of how SCRs messages have been embedded in training and other forms of organisational learning⁵

⁵For a more detailed account on Kent and Medway's strategy for multi-agency adult protection training, see Aylett (2009).

(Aylett, 2008).

- Kent and Medway multi-agency adult protection policy, protocols and guidance set out a **template for reflective review of cases** that have caused serious concern, and additional procedures are available on the website providing further guidance on making a referral for such a case to be reviewed by the serious case review panel.
- Lessons learned from these reviews are disseminated to practitioners through their use within the **training materials** for Level 4 'Joint working on criminal investigations' course and consideration is currently being given to external website publication of the fictionalised version.
- **Practice exchange meetings** are held between key practitioners, such as adult protection co-ordinators/agency leads and the multi-agency safeguarding vulnerable adults training consultant. The purpose of these meetings is to review complex adult protection work that is unlikely to be referred to the serious case review panel, but from which there are still significant lessons to be learned. These meetings provide a structured link between training and practice, providing practitioners with a framework within which to conduct reflective practice, outside managerial supervision, and the trainer with current/relevant casework analysis for use in training others.
- **Reflective practice and casework analysis** is also an integral part of the Level 3 training course 'The investigators guide' where delegates are encouraged to use one another as consultants in reviewing a recent or current challenging piece of adult protection work. This is then written up and the lessons learned are shared with the group for wider learning. Consequently, it has been possible to collate a considerable compendium of cases and to promote learning not only from the challenges but also from the successes of this work (Aylett, 2008).

2.5 Summary on the published evidence

The published (research) evidence in the area of adult social care SCRs is still scarce; apart

from the King's College of London study discussed above there is hardly any research available⁶. However, the lessons learnt from Kent and Medway highlight the value of looking at the particular local solutions that different local authorities have found in implementing the national policy in SCRs.

3 SCR Protocols from other councils

3.1 Wakefield & District

Wakefield & District's Serious Case Review Guidance follows very closely ADSS's *Vulnerable Adult Serious Case Review Guidance---Developing a local protocol* (ADSS, 2006) and is a revised version of the latter of the autumn of 2008 (Wakefield District Safeguarding Board, 2008). There is a range of similarities and differences with the already discussed Kent and Medway protocol.

3.1.1 Criteria for instigating an SCR

A serious case review is considered when

- **A vulnerable adult dies** (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death...
- **A vulnerable adult has sustained a potentially life-threatening injury** through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect...
- Serious abuse takes place in an institution or when **multiple abusers** are involved (including in residential setting) (Wakefield District Safeguarding Board, 2008)

The guidance does not include an explicit criterion present in Kent's policy⁷, namely that "SCR is needed when the case has proven too much to handle by the agency... and ... a complex case that has been handled well could also prompt learning for local services but may

⁶Some messages from child protection SCRs are transferable; these will be discussed in a further section of the current report.

⁷See page 4.

not need to be the subject of an SCR" (Brown, 2009).

However, Wakefield's guidance states that SCR takes place when "...the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults". In any case, this is not as elaborate as in Kent's policy.

3.1.2 Function of the SCR

The way SCR functions are defined by Kent and Wakefield are almost identical with the only difference that Kent specifies a 'debriefing' function and Wakefield specifies the review of effectiveness of procedures (including multi-agency).

3.1.3 Alternatives to SCR

Wakefield & District's policy specifies an alternative to SCR process, when SCR is not appropriate.

Where a there is decision made that a Serious Case Review is not the appropriate response it is important to find other ways to ensure that potential learning is not lost. For example a Single Agency Management Review following a similar format to the Serious Case Review may be a helpful and appropriate method to ensure that lessons continue to be learned (Wakefield District Safeguarding Board, 2008)

Please read the source document for further details on the process, initiating, commissioning and conducting SCRs in Wakefield & District and also note that it follows almost exactly the original 2006 ADSS guidance (ADSS, 2006).

3.2 Camden

Camden's SCR protocol has been effective since July 2008 (Camden Safeguarding Adults Partnership Board, 2008).

3.2.1 Function of the SCR

Camden make very explicitly that SCR is not an investigation.

A Serious Case Review is not an inquiry into how an adult died or suffered injury or who is culpable. The case under review will be used only to **trigger positive recommendations for improvements** to Safeguarding Adults work. Any reports leading to, or setting out, these recommendations and which is available beyond members of a Review "panel" will contain no personally identifiable information or details of the case (Camden Safeguarding Adults Partnership Board, 2008).

Otherwise the SCR functions are very similar to the other local policies discussed above.

3.2.2 Criteria

The criteria for instigating an SCR specified by Camden are somewhat streamlined compared to the other local authorities.

- The death of a vulnerable adult
- A life threatening injury sustained by a vulnerable adult through abuse or neglect
- Sexual abuse of a serious nature of a vulnerable adult
- Significant or permanent harm to a vulnerable adult through abuse or neglect.
- Significant abuse has taken place in an institution or where multiple abusers are involved.

There are no major differences in the process running and reporting on a SCRs in Wakefield and Camden, according to their respective protocols.

3.3 Somerset

Somerset's SCR Toolkit (Neil & Wilmot, 2008) breaks the common pattern and is laid out in a user-friendly format, starting with an Introduction, which defines 'a vulnerable adult', and in general is much more specific about the steps that need to be taken. It features a range of appendices of exemplary letters, request forms, agency report templates, action plan, etc.

3.5 Learning from the Cornwall experience

3.3.1 Somerset's criteria for instigating an SCR

- A vulnerable adult dies (including death by suicide) **and** abuse or neglect is known or suspected to have contributed to their death. In these circumstances the Safeguarding Adults Board should **always** carry out a review. . .
- A vulnerable adult has suffered:
 - A possible life-threatening injury through abuse or neglect
 - Serious sexual abuse
 - Persistent, serious and permanent damage to health or development through abuse or neglect,
 - **and** the case gives rise to concerns about the way in which local professionals and services worked together to safeguard vulnerable adults
- Serious abuse takes place in an institution or when a number of abusers are involved. In these cases, however, Reviews may be more complicated, involving more people and needing more time. Terms of References need to be carefully written to identify the issues in each case

These are quite similar to the criteria from the other local authorities discussed above, with *SCRs in all cases of death contributed by suspected abuse and in non-lethal cases when the safeguarding 'working together' of the services is under question.*

It is recommended to look at the Somerset Toolkit in terms of accessible language it is written in and the range of appendices attached. Content-wise, no significant differences from the rest.

3.4 Devon

Devon's Procedures and Guidance for SCRs were developed in June 2009 ([Devon Safeguarding Adults Board, 2009](#)). They comprise an elaborate 38-page document that includes 11 appendices. It follows closely the original 2006 ADSS brief. In terms of criteria, it stipulates a similar yet somewhat different from Somerset 'or' / 'and' logic flow.

Devon's guidance includes elaborate graphic flowcharts for carrying out and disseminating the learning from SCRs, various forms and what is more interesting, **lists of the defined**

roles and scopes of various participants in the process.

3.5 Learning from the Cornwall experience

One of the most notable SCRs extensively referred to recently in the literature is the one following the death of Steven Hoskin ([Flynn, 2007](#)). Backed up with extensive literature, it provides elaborate conclusions and recommendations, divided into **system-wide adult protection, agency and individual.**

To demonstrate the approach and style of the report, here are some selected quotes⁸

6.1 At every stage following Steven's departure from his family home, from the comparative safety of his rural community, to Newquay and then to St Austell, all Serious Case Review contributors could have been potential rescuers, but every part of the service system had significant failures in this role.

6.4 Serious Case Review colleagues have been willing to explain and amplify the weaknesses of their own agencies. This does not imply that these agencies are without merits or strengths or that they are wholly culpable, but is intended to convey their acknowledgement of their individual and collective under-performance, and what has to change in the light of the magnitude of cruelty experienced by Steven.

7.2.3 The Chair of the Cornwall Adult Protection Committee raises with the central government the need, where appropriate, for Serious Case Reviews to have access to court transcriptions without charge. It was only three-quarters of the way through the Review process, that the Chair learned certain facts which had been revealed during the trial which again illustrated his prolific and intensive use of emergency services.

7.2.7 The Chair of the Cornwall Adult Protection Committee raises with the Department of Health that the shift to self-directed care

⁸There are at least few more publicly available (online) SCRs with full web-links to the documents provided in the reference list ([Cornwall & of Scilly Safeguarding Adults Board, 2009](#); [Cumbria County Council, 2008](#); [Cumbria County Council, 2009](#)).

for vulnerable adults living alone (e.g. Direct Payments Recipients and those receiving Individual Budgets), should always be accompanied by the monitoring of their personal safety (Flynn, 2007).

Please note these are only selected examples and do not substitute reading the whole executive summary of the report, available on-line.

In 2009 Flynn wrote a further review *The successes achieved and barriers encountered in delivering the Steven Hoskin Serious Case Review action plans* (Flynn, 2009). The text is based on the outcomes of a discussion meeting held in December 2008 and Flynn identifies a range of successes and barriers:

- The progress in Cornwall is considerable and goes far beyond minimalist adjustment.
- ...the degree of connectedness across sectors is energising. It confirms the consensus within Cornwall that recovery from the events leading up to the Serious Case Review had to be action-oriented.
- Some of the barriers to change are the people ones as well as old fashioned practices.
- All services struggle with information sharing protocols. It does not help that it is unlawful to share information in MAPPA about un-convicted individuals.
- There have been four directors in the Department of Adult Social Care since March 2008 (Flynn, 2009).

3.6 Serious Cases and the media

Working with the mass-media is an important task of a local authority when a tragedy happens. This subject area is beyond the scope of the current report.

Prof Ray Jones from the Kingston University who is the head of the newly established Centre for Inquiries and Reviews⁹---set up with a grant of £10,000 from the Government's Higher Education Innovation Fund---is an expert in this area (<http://www.kingston.ac.uk/pressoffice/findanexpert/profile/42/Ray-Jones/>).

⁹The centre offers advice to local safeguarding children's boards, health trusts and councils on the way they carry out investigations.

4 Lessons to be learnt from child protection SCRs

Evaluation of the child protection cases SCRs has much longer tradition and since we believe some of the learning is transferable across to adult services, here is some key evidence.

4.1 Towards a new means of inquiry into child abuse cases

The above is a title of a key article written by Corby back in 2003, which provides a good historical overview of the serious case review process and puts forward new (then) ways of inquiring into child abuse deaths (Corby, 2003).

Corby criticises the system by which the reviews were held

- First, the extent to which these reviews of child abuse deaths and serious incidents have enabled social work and other professionals to eliminate mistakes from their practice is somewhat questionable. We simply do not know how effective the serious case review process has been in improving practice in individual areas, as there has been no evaluation of its impact.
- ...the reviews they studied were concerned mainly with procedural matters and provided little useful material for professionals wishing to improve their practice.
- ...these reviews are largely carried out away from the public gaze and for the most part, unless the cases have aroused public concern (a matter of judgement in itself), the findings have not been made public. There are reasons why publicity is a problematic issue for case reviews – for example, families might wish to ensure confidentiality and professionals and agencies might be concerned about the way in which public material might be used to support disciplinary procedures or negligence claims. Nevertheless, not publishing results gives the impression of having something to hide¹⁰ (Corby, 2003).

¹⁰Commenting on the latter criticism, some of the examples given in the current report show that the outcomes of the SCRs have become increasingly accessible to the public.

4.2 Learning lessons from SCRs: Year 2

Following his extensive criticism of the inquiry system---the above three are a selection only---Corby suggest a SCR system, which tries to achieve the following

1. that all child deaths from abuse and all instances of serious abuse of children in the community and institutional care are inquired into
2. that the findings of such inquiries are made available to the general public, with suitable arrangements to preserve confidentiality
3. that the findings of inquiries are used by the agencies concerned in particular cases to revisit procedures and practice, in conjunction with the Social Services Inspectorate or Welsh Office
4. that the findings of inquiries are made available to all child protection agencies, so that they can be used as source material for training and can also inform policy developments
5. that inquiries are carried out within time-limits aimed at ensuring that their findings are put to effective use
6. that inquiries are concerned with both the workings of systems and with the conduct of individual professionals (Corby, 2003)

The above criteria for a good SCR process do not say anything uniquely different from the 2006 ADSS guidance (ADSS, 2006) but rather validate and additionally stress the importance of having a system based on the evidence what works and what the public's and professional's expectations are.

4.2 Learning lessons from SCRs: Year 2

This is the title of a second substantial report published by Ofsted in 2009 (Ofsted, 2009). It covers the evaluations of 173 SCRs. Here is a selection of the key findings:

- There is evidence to suggest that Local Safeguarding Children Boards are taking a **more robust approach** in relation to serious case reviews and that some of the previous barriers to learning are being removed.

- However, **many of the weaknesses in practice identified in our previous report remain** and there is still much to do to ensure that lessons are truly learned and that all agencies who support our most vulnerable children and young people work together to safeguard them more effectively.
- **A greater number of Local Safeguarding Children Boards** are carrying out more serious case reviews, with a consequent increase in volume. This is despite the numbers of children killed or seriously injured where abuse or neglect is suspected remaining stable.
- The backlog of historic cases has largely been addressed. Local Safeguarding Children Boards are increasingly aware that lessons must be learned from these tragic incidents quickly and are more willing to explore the issues involved. However, Local Safeguarding Children Boards' **exploration of the social, cultural and ethnic issues** within serious case reviews remains a weakness.
- In instances where the history of a case spans more than one area, Local Safeguarding Children Boards are cooperating more readily across boundaries in undertaking a serious case review jointly to see if there are lessons to be learned.
- Fewer serious case reviews are being judged as inadequate, although the overall proportion remains too high.
- Local Safeguarding Children Boards have responded positively to the 2008 ministerial letter of 16 December 2008 clarifying the **independence requirements regarding chairs of panels** and overview writers. As a consequence there has been a steady improvement in levels of independence within the serious case review process.
- The pace of improvement in serious case reviews has accelerated in recent months. Several factors have been identified as supporting this improvement by interviewees from the 'good practice' survey conducted as part of this report. These include:

- **direct feedback to Local Safeguarding Children Boards by Her Majesty’s Inspectors** (HMI) as part of the evaluation process has improved the depth of their learning, as evidenced by improvements in subsequent reviews
 - **the increased requirements** on Local Safeguarding Children Boards announced by the Secretary of State in the wake of the Baby Peter tragedy have ensured that the serious case review process and the subsequent depth of learning are more effective
 - processes for conducting serious case reviews have been strengthened with more robust **quality assurance, recommendations and action plans** (Ofsted, 2009).
- The Department for Children, Schools and Families should revise Working Together to Safeguard Children to underline the importance of a **high quality, publicly available executive summary** which accurately represents the full report, contains the action plan in full, and includes the names of the Serious Case Review panel members.
 - Local Safeguarding Children Boards should ensure all Serious Case **Review panel chairs and Serious Case Review overview authors are independent** of the Local Safeguarding Children Board and all services involved in the case and that arrangements for the Serious Case Review offer sufficient scrutiny and challenge.
 - All Serious Case Review panel chairs and authors must complete a **training programme** provided by the Department for Children, Schools and Families that supports them in their role in undertaking Serious Case Reviews that have a real impact on learning and improvement.
 - Government Offices must ensure that there are enough trained Serious Case Review panel chairs and authors available within their region.
 - Ofsted should share full Serious Case Review reports with HMI Constabulary, the Care Quality Commission, and HMI Probation (as appropriate) to enable all four inspectorates to assess the **implementation of action plans** when conducting front-line inspections.
 - Ofsted should share Serious Case Review executive summaries with the Association of Chief Police Officers, Primary Care Trusts and Strategic Health Authorities to promote learning.
 - Ofsted should produce **more regular reports, at six-monthly intervals, which summarise the lessons from Serious Case Reviews** (The Lord Laming, 2009).

For earlier systematic research on child protection SCRs, please see *Learning from Past Experience---A Review of Serious Case Reviews* (Sinclair & Bullock, 2002).

4.3 The Lord Laming Report 2009

Here is a list of the directly linked to the SCR process recommendations from The Lord Laming Report on the death of Baby P (The Lord Laming, 2009):

- The Department for Children, Schools and Families should revise Working Together to Safeguard Children so that it is explicit that the formal purpose of Serious Case Reviews is **to learn lessons for improving individual agencies, as well as for improving multi-agency working**.
- The Department for Children, Schools and Families should revise the framework for Serious Case Reviews to ensure that the **Serious Case Review panel chair has access to all of the relevant documents** and staff they need to conduct a thorough and effective learning exercise.
- Ofsted should focus its evaluation of Serious Case Reviews on the **depth of the learning a review has provided** and the quality of recommendations it has made to protect children.

5 Conclusions

1. The research and published in general evidence in the area of adult social care SCRs is still scarce.
2. Professionals are in favour of the creation of a **national reporting system** and **national collation of SCRs** to foster the learning from SCRs.
3. Review periods should be established for each SCR and through inspection or peer-inspection the implementation of action plans should be monitored.
4. The inclusion of **chronology of events and communication** is useful but attention needs to be paid that this might suggest that events had been more predictable that they were.
5. The **rationale and methodology** of the SCRs studies was not always clear. The current report shows that there are some differences in the way local protocols define those.
6. A major difference between the child protection and adult protection domain is that in child protection the question of significant harm is more easily determined.
7. There is substantial published work on the experience of **Kent and Medway** in developing the SCR process.
8. SCRs tend to focus mainly on **procedural matters** and professionals felt they provided little useful material for those at the front line wishing to improve their practice.
9. The SCRs main purpose is to **learn lessons** for improving individual agencies, as well as for improving multi-agency working.
10. While the process of research and evaluation in adult protection SCRs is still in its embryonic stage, there is a lot to be learnt through **knowledge sharing and cross-facilitation experience** between different councils.

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