

Good Practice Case Study

New model for Serious Case Reviews launched in Leicestershire ▼



An East Midlands safeguarding event

New process in place for Serious Case Reviews ▼

The East Midlands Joint Improvement Partnership (JIP) Safeguarding and Dignity Board was commissioned to undertake a review of Adult Protection Serious Case Reviews (SCRs) in the region. The project was hosted by Leicestershire County Council and funded by the East Midlands Improvement and Efficiency Partnership (EM IEP).

The project started in July 2010 and five current SCRs in the East Midlands were examined in order to develop the new process. The new four stage process will provide more options in safeguarding adults and should be more cost effective, less time consuming and ensure learning is disseminated, and acted upon more quickly.

“Adult Serious Case Reviews are something of a grey area. There has never been a thorough framework in place for adult Serious Case Reviews as is the case for children. This project has been a necessary and positive first step in developing a more robust process for adult Serious Case Reviews and hopefully reducing the number of SCRs in the future. The work done so far has focused on looking at the existing research around Serious Case Reviews and making recommendations for change, however, the next phase of the project will be implementation when we can truly test viability in the real world.”

Robert J. Nisbet
Programme Support to the East
Midlands Safeguarding and Dignity
Board
Regional Health & Criminal Justice
Lead
Department of Health, East Midlands

Understanding the legal landscape of Serious Case Reviews ▾

A SCR is usually conducted when an adult, who may meet the criteria for safeguarding, dies or sustains a serious injury or impairment of health as a result of abuse or neglect. There is no legal requirement to undertake a SCR in adult safeguarding.

The Department of Health first published 'No Secrets: guidance

on developing and implementing multi-agency policy and procedures to protect vulnerable adults from abuse' in March 2000, which gives guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. The project is timely because 'No Secrets' is currently under review.

A time for change ▾

At the start of the review, only three SCRs had been published in the East Midlands, a further two were due to be published in September and October 2010.

In order to move forward with the project, these earlier reviews were studied alongside previously published national research.

Example of SCR Reviewed

X was a man who had epilepsy and autism spectrum disorder. He lived in Area A and came from a specialist residential unit in Area B. He died after he missed four doses of a drug he took twice a day to control his seizures. Staff at the home had made a note in the handover book that the medication was running low but new supplies were not arranged. An inquest jury found that failure to provide the drug had materially contributed to his death, as well as systemic failures around stock keeping, record keeping and a lack of significant staff training.

Area B Safeguarding Adults Board commissioned a Serious Case Review, which made the following recommendations across several 'agencies':

- Care Home: Senior Management team were not to delegate down but take responsibility and ensure staff were performing their roles appropriately. Mentoring for managers was provided as

well as personal development plans for staff.

- Local Authorities: Terms of reference and staff were reviewed at Area B Quality Assurance; Placing Local Authorities needed to inform Hosting Local Authorities of placements that were being made, as well as sharing relevant information to inform the reviewing process.
- Care Quality Commission (CQC): To look at resolving the use of the terms "requirement" and "recommendation" in inspection reports.
- Area B Safeguarding Adults Board: Where a serious incident occurs in a care setting, the multi-agency procedures are promptly followed in order to safeguard the other residents. The family and carers of someone who has died or had a serious injury should be contacted at an early stage in the process and kept informed throughout.

Programme Objectives ▾

The key objectives of the programme were as follows:

- i. To undertake a review of all SCRs carried out in the region, focusing on lessons learnt and provide a report to share with local adult Safeguarding Boards.
- ii. For the host locality, with support from the consultant, to develop a scheme for best practice in undertaking multi-agency SCRs, rather than a single agency review, which was the current form in some areas.
- iii. To organise a regional conference to inform of lessons learnt from SCRs and how multi-agency reviews will make improvements to efficiency and for improved outcomes in adult safeguarding.

Limitations of the current SCR process

The review identified a number of limitations and issues with the current SCR process:

- Only one process existed for undertaking a SCR.
- The cost of SCRs vary depending on the use of external chairs and authors (no set fee structure or quality standards existed for this work).

- The process was not only time consuming but there was no consistency in the length of time a review took across the local authorities.
- Safeguarding Boards developed SCR Sub Groups who had varying levels of independence.
- It was taking too long for the learning to be disseminated.
- The quality of Individual Management Reports (IMR) was variable.
- Learning could easily get lost in the process, particularly disseminating to an operational level.

The programme reviewed the five published SCRs and a new model was proposed at the Safeguarding and Dignity Board on 1 November 2010. The new model received positive feedback and the board agreed to move forward with it.

The new model ▾

It is proposed that there will be four levels of review processes which represent different ways of reviewing cases according to the circumstances, requiring varying levels of independence.

Level 1 – Serious Case Review

The triggers for a SCR were outlined as follows:

- i. A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death.
- ii. A vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, or sustained serious and permanent impairment to their health or development. The case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults.
- iii. Serious abuse takes place in an institution or when multiple abusers are involved.
- iv. Death or serious harm results from alleged harassment, bullying, anti-social behaviour or hate crime.

The SCR Sub Group will decide which agencies it is appropriate to involve in the Serious Case Review, appoint a chair and appoint an independent report writer with expertise in this area.

When the SCR process criteria are not reached but there are serious safeguarding implications and lessons which could be learnt, one of the three new levels proposed would take place:

- i. Significant Incident Learning Process (SILP)
- ii. Peer Reviews
- iii. Individual Agency Reviews

The triggers for the new levels were defined as follows:

- i. Where an adult who may have been in need of safeguarding dies or experiences serious harm which is not due to direct abuse but there is evidence of self-neglect and/or refusal of service, and there may be concerns about their capacity to self-care and understand the consequences of not doing so.
- ii. Multiple incidents or concerns which are repeatedly happening, with increasing severity and the same provider agency is consistently involved.
- iii. Where serious harm and/or abuse was likely to occur but has been prevented by good practice.

The process for the three new levels is as follows:

Level 2 – Significant Incident Learning Process (SILP)

The key agencies and professionals involved in an identified case will be invited to a half or full day event to examine the case together. Rather than an IMR, agencies will provide chronologies of events, one facilitator will chair the event and another will write up the learning. An external facilitator may be used if the complexity of the case meant it was necessary to do so.

This process will involve operational staff and their managers who would own the summary of learning at the end of the process, leading to these being disseminated more quickly at an operational level.

A second event would take place to review how the agreed actions had been met and how the learning was disseminated within agencies.

Level 3 – Peer Review

For this process, the SCR Sub Group would identify an individual from within the Safeguarding Adults Board to review the multi-agency working in an identified case as part of a reciprocal arrangement.

Level 4 – Individual Agency Review

The project identified that there are a number of reviewing processes undertaken around safeguarding cases within individual agencies represented within the Safeguarding Adults Board arrangements. There are valuable lessons which could be shared from other agencies, for example, the Serious Untoward Incident process undertaken by Health Boards, and it may be appropriate for the Safeguarding Adults Board to have an overview of these.

It was therefore proposed that when an individual agency is conducting an investigation of this kind involving a safeguarding issue, the SCR Sub Group is advised of this to enable them to assess whether there may be transferable learning within multi-agency arrangements.

Consultation Event

The new model was presented to the regional safeguarding leads at an event in November 2010 to get feedback and understand if this is a workable approach. The event was an opportunity to learn from other models and share best practice.

Eight out of nine upper tier authorities were represented at the event.

There was support for the four levels proposed in the new model, as well as valuable input into helping ensure the model is flexible enough to be potentially adopted across the region by different Safeguarding Board structures.

The proposed new process includes a suggestion that the SCR Sub Group for each Safeguarding Board will receive referrals for cases which may meet the SCR criteria, and will decide whether the criteria are reached, and which process will be the most appropriate under which to review the case. If it is agreed that the case reaches the formal SCR criteria, those agencies will then be asked to nominate a panel member. The SCR Sub Group will then agree who should chair the panel and also agree on an independent report writer. This proposed process was also well received at the event.



An East Midlands Safeguarding Adults Development Day Event

Next Steps ▾

A multi-agency conference was held on 14 February 2011 to share the learning and present the model. Regional training events were held around facilitation of the SILP and in completing IMRs to support the conference. A number of keynote speakers, with national profiles around this subject area, attended the conference. A series of workshops took place to utilise the experiences of individuals and organisations within the East Midlands region.

In this way it is hoped to gain feedback on the model from those who will use it in their day-to-day working lives. This feedback will influence the final report, which will be presented to the Safeguarding and Dignity Board at the end of February and include full operational process of the SCR model for use across the region.

“We look forward to sharing the learning from this project and the new model at the conference in February. Leicestershire County Council approached the JIP Board to express interest in this project and we are delighted to have hosted this work on behalf of the East Midlands Improvement and Efficiency Partnership (EM IEP) with the Department of Health in the East Midlands.

The work done so far is just the beginning and we hope that the long-term outcome of this project will be a safer future for adults.”

Laura Sanderson
Safeguarding Adults Manager
Leicestershire County Council

East Midlands Improvement and Efficiency Partnership Case Studies

The East Midlands Improvement & Efficiency Partnership (EM IEP) is funding the Serious Case Reviews in Adult Safeguarding project to the value of £70,000.

The East Midlands Improvement & Efficiency Partnership (EM IEP) is committed to celebrating the successful, innovative and imaginative project work that exists in the East Midlands region.

The EM IEP Support Team publish case studies showing how East Midlands councils are improving services and delivering significant improvements and efficiencies.

The case studies are intended to inspire councils in the region, and indeed nationally, to transform services and benefit from the processes developed by those councils that have pioneered the way forward.

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