

1 Introduction

1.1 The purpose of this document is:

- To support the view that the public interest is best served by the presence of an effective serious case review process
- To provide guidance to Safeguarding Adults Boards (SGABs)¹
- To facilitate a consistent approach to the process and practice in undertaking a serious case review
- To acknowledge that there is no statutory requirement for agencies to cooperate with such reviews, however, voluntary involvement does lead to good practice development

1.2 The document 'No Secrets'² (March 2000) issued by DoH and Home Office under section 7 of the Local Authority Social Services Act 1970, issued guidance on developing and implementing multi-agency policies and procedures to protect vulnerable³ adults from abuse.

1.3 The guidance suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees known as SGAB.

1.4 The document Safeguarding Adults published by the Association of Directors for Social Services (ADSS) October 2005 provides a National Framework of Standards for good practice and outcomes in adult protection work. One of the standards in this document states that, as good practice SGABs should have in place a serious case review protocol.

2 Relevant Standards: 1.22 - 9.10.15⁴

It is recommended that:

¹ For the purpose of clarity throughout this document we will refer to 'Adult Protection Committee's' as Safeguarding Adults Board

² No Secrets – Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse DH 2000

³ As defined within 'No Secrets'

⁴ Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work ADSS October 2005

There is a 'Safeguarding Adults' serious case review protocol. This is agreed, on a multi-agency basis and endorsed by the Coroner's Office, and details the circumstances in which a serious case review will be undertaken. For example: when an adult experiencing abuse or neglect dies, or when there has been a serious incident, or in circumstances involving the abuse or neglect of one or more adults. The links between this protocol and a domestic violence homicide review should be clear.

There is a clear process for commissioning and carrying out of a serious case review by the partnership

3 Purpose

The purpose of having a case review is not to reinvestigate nor to apportion blame,

It is:

- 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
- To review the effectiveness of procedures (Both multi-agency and those of individual organisations)
- To inform and improve local inter-agency practice
- To identify clearly what the lessons are, how they will be acted upon, and what is expected to change as a result
- 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 ⁵ ; and
- As a consequence, improve inter-agency working and better safeguard and promote the welfare of vulnerable adults

It is acknowledged that all agencies will have their own internal /statutory review procedures to investigate serious incidents; e.g. an Untoward Incident⁶. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

Parallel processes in individuals agencies may impact on the timing of the serious case review i.e. if a root cause analysis is taking place the outcome of this in relation to system failure is relevant for the development of a Serious Case Review chronology.

⁵ The Secretary of State also has authority under the Local Authority Social Services Act 1970 to cause an inquiry to be held where he considers it advisable

⁶ An investigation within a healthcare setting

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.

4 Criteria for Serious Case Review

The SGAB has the lead responsibility for conducting a serious case review.

A serious case review should be considered when:

- 4.1 A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death. In such circumstances the SGAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
- 4.2 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, and the case gives rise to concerns about the way in which local professionals and services work together to safeguard vulnerable adults (See section 5 for commissioning guidance).
- 4.3 Serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to each specific case.

5 Process for commissioning and carrying out of a serious case review

- 5.1 The SGAB will be the only body which commissions any serious case reviews. The Board will publicise both the process under which applications for reviews may be made and the terms of reference for each serious case review.
- 5.2 Applications must attract the support of the quorum (Minimum of four members in an actual meeting or 'virtual meeting') of the Quality Sub Committee after being made in writing to the Adult Protection Manager. The applicant and representatives will be asked for information/preliminary reports to enable a recommendation to the Chair of the SAB (or if not available the Vice Chair) to be made either supporting or rejecting the application for a SCR to be undertaken. It is

the decision of the Chair/Vice Chair whether or not a SCR is undertaken. This decision must be made within 10 working days of the application being received. Once the decision is made the APM will inform the applicant of the decision with supporting reasons. If a SCR is to go ahead CSCI will also be informed. From the decision to proceed being made to the submission of the overview report to the SAB no longer than three months should elapse.

6 Alternatives to a serious case review –

6.1 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.

The aim of the Management Review is to look openly and critically at individual and organisational practice and in so doing to consider if changes in practice need to be made and how this can be done.

6.2 As part of Management Reviews, each agency will:

- a) Determine who will undertake the Management Review. The person must not have been directly concerned with the person and must be independent of the line management for the case and must be given sufficient time and resources to undertake the task. Have a named person to advise on how to conduct/complete such a Review.
- b) Ensure all the relevant information is obtained to complete the Management Review, inform key staff that a Management Review is to be undertaken and the process for feedback, support and debriefing, in advance of the completion of the Overview Report. Staff should also be instructed not to disclose any information verbally or in writing to anyone outside the agency with prior agreement of the agencies senior management
- c) Compile a Chronology of all records of involvement including correspondence and telephone calls. Conduct interviews of individual staff where required for the purpose of clarifying information obtained from the written records. The conduct of these interviews needs to be sensitively handled and be mindful of any agency disciplinary procedures. A written record of each interview should be made and shared with the interviewee.
- d) Where, during the collation of information the author of the Management Review comes across information that they believe is relevant and informative but outside the dates of the commissioned Report, include such information as background information.
- e) Compile the report . Staff and family members should be suitably anonymised in the Report and Chronology. The Report should include information on what files were read, who was interviewed and what procedures were referred to.

- f) Complete an analysis of involvement, lessons to be learnt and recommendations for action. Any immediate action required must be highlighted.
- g) Submit the completed Management Review Report for approval to the senior officer in the agency who has commissioned the report; the senior officer will be responsible for ensuring the quality and accuracy of the report and determining any immediate action to be undertaken arising from the recommendations of the Management Review, and ensuring that the recommendations are acted upon.
- h) Consider the need for a follow-up feedback session where issues for the agency and its staff are raised
- i) Consider the need for any disciplinary action

7 Initiating a serious case review -

The case for review will be passed to the Chair of the SGAB for agreement. Once agreed, a multi agency Serious Case Review Panel will be set up:

7.1 The Adult Protection manager will be responsible for arranging the selection of the Independent Serious Case Review Panel Chair. The four large statutory organisations represented on the Board (i.e. Family Services, the PCT, Mid-Yorkshire and South West Yorkshire Trusts) will each nominate a suitably qualified, trained and experienced person who is available to act as chair. Once the decision is made to call a Serious Case Review the organisation with least involvement in the case and where there is no potential conflict of interest will be asked to provide the chair to ensure transparency and independence.

7.2 The SGAB will ensure the Serious Case Review Panel Chair receives adequate support.

7.3 The Chair of the Panel will be responsible for establishing individual terms of reference and setting time scales for the review in agreement with the SGAB. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference and reported back to the Board.

CSCI have asked that they be informed of any Serious Case Review taking place

8 Conduct of Serious Case Review:

8.1 Initial Meeting

The duration of each review will vary depending on the nature of the case but unnecessary delay must be avoided. The chair of the Serious Case review and Adult Protection Manager will agree the process to be followed and terms of reference including the gathering of evidence and the need to seek attendance.

The initial meeting will agree;

- The terms of reference required the “evidence” required from each participant in the form of a chronology , or in person
- the support and other resources needed (any perceived deficits to be referred to Chair of SGAB)
- the time scales within which the review process should be completed –A maximum timescale of four months should be the target
- dates, times and venues of meetings
- the nature and extent of legal advice required, in particular: Data Protection, Freedom of Information and Human Rights Act
- the formal notification of staff involved that a serious case review is to be carried out

8.2 Serious Care Review-receipt of evidence

Meetings of the panel should begin with an “information sharing” session where agencies will be encouraged to query and comment on the reports presented.

Each agency involved will be asked to:

- Present and examine the chronology of events, highlighting any discrepancies
- Present a comprehensive report of the actions by their agencies using an agreed framework
- Ensure any other management reports and other relevant information are made available

It may be necessary to adjourn meetings awaiting essential relevant evidence
The Adult Protection Manager will secure the services of a minute taker

8.3 Serious Care Review-discussion of evidence/ “adjudication”

The review panel will:

- Cross-reference all agency management reports and reports commissioned from any other source
- Examine and identify relevant action points
- Form a view on practice and procedural issues
- Agree the key points to be included in the report and the proposals for action

8.4 Issues Arising

If at any stage whilst undertaking the procedure contained in 7.3, information is received which requires notification to a statutory body, e.g. GSCC, Ofsted, DCSF regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

The Chair of the review panel should report back to the SGAB and a decision made as to whether the serious case review process should be suspended pending the outcome of such notification.

8.5 Report Stage

The review panel will complete the review of agency management reports and those commissioned from any other source and advise the Chair on the production of an overview Report which brings together information, analyses it and makes recommendations. The Chair will ensure that the Report is written and delivered within agreed timescales.

Once signed by the chair of the Review the overview report will be submitted to the next meeting of the Board and anyone with an interest in the case review advised of this.

8.6 Acting on the recommendations of the Serious Case Review

On completion, the overview Report will be presented to the SGAB, which will:

- Ensure contributing agencies are satisfied that their information is fully and fairly represented in the overview Report
- Translate recommendations from the overview into an action plan, which should be endorsed at senior level by each agency
- The action plan which is part of the report to the Board will indicate:
 - Responsibilities for various actions
 - Time-scales for completion of actions

- The intended outcome of the various actions and recommendations
- Mechanisms for monitoring and reviewing intended improvements in practice and/or systems

8.7 Recommendations

The SGAB will ensure that all recommendations are actioned and will request updates from agencies. At the Board at which the Serious Case Review is considered review dates will also be set.

8.8 Annual Report

- All Serious Case Reviews conducted within the year should be referenced within the annual report along with relevant service improvements

Appendix WAKEFELD & DISTRICT SAFEGUARDING ADULTS BOARD

SERIOUS CASE REVIEW CHRONOLOGY:

Date and time	Doc Ref	Family Members (initials)	Information	Agency	Action	Other Info	Management Review Officer's Comments

Please expand as necessary.