Serious Case Review Procedure

A. Introduction

The purpose of this document is to ensure that there is a consistent approach to the process and practice in undertaking Serious Case Reviews (SCRs) where a vulnerable adult(s) is the victim(s) of abuse and concerns are expressed about factors in the case. For example. some safeguarding adults cases raise issues that are beyond the scope of the multi-agency enquiry, such as the potential for institutional abuse, risks to people not supported by Leeds Adult Social Care, concerns about multi-agency working and risk management, poor communication and practice. In such cases a serious case review will consider these issues and recommend actions to address them.

The overall purpose of a serious case review is to promote learning and improve practice.

There is no statutory requirement for agencies to cooperate with such reviews, but voluntary involvement will enable the partnership develop good practice.

The Association of Directors of Social Services (ADSS) published a National Framework of Standards for Good Practice and Outcomes in Adult Protection Work in 2005. Standard One states that:

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 an agreed multi-agency protocol for the commissioning and undertaking of 'Safeguarding Adults' serious case review.

B. Purpose

Serious Case reviews are not inquiries into how a person died or suffered injury, or to re-investigate or to apportion blame. The purpose of a Serious Case Review is to:

- Establish whether there are lessons to be learnt from the circumstances of the case and the way in which local professionals and agencies work together to safeguard vulnerable adults;
- Review the effectiveness of procedures;

- Inform and improve local inter-agency practice and working together to better safeguard adults;
- Improve practice by acting on learning and developing best practice;
- 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;
- Recommend further enquiries or investigations arising from the review, preparing Terms of Reference and recommending responsible agencies for such enquiries or investigations.

It is acknowledged that all agencies will have their own internal / statutory procedures to investigate serious incidents. This procedure is not intended to duplicate or replace these, but to focus consideration of how we continually improve our partnership working to safeguard adults.

C. Criteria for serious case review

The Leeds Safeguarding Adults Board will undertake the lead responsibility for conducting a serious case review.

A Serious Case Review should be considered when:

a) a vulnerable adult dies (including death by suicide) *and* where abuse or neglect is known or suspected to be a factor in their death;

or,

b.) a vulnerable adult has sustained any of the following:

- A life threatening injury through abuse or neglect;
- Serious sexual abuse;
- Serious or permanent impairment of development through abuse or neglect;
- Serious inhuman or degrading treatment;
- Abuse or neglect arising from institutional factors.

and,

where the case gives rise to concerns about the way in which local professionals and services worked together to safeguard vulnerable adults.

The Safeguarding Adults Board can also consider conducting a serious case review into any incident(s) or case(s) involving vulnerable adult(s) where it is clearly in the public interest to do so.

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

See Appendix 1 for a checklist to be used to help agencies consider whether a serious case review should be considered.

D. Referral of cases for a serious case review

Any agency representative or professional may refer a case believed to conform to the criteria and guidance contained in section C. Referral may be made directly to the Chair of the Safeguarding Adults Board or to the Safeguarding Coordinators. The referral should be made using the form set out in Appendix 2. Safeguarding Adults Enquiry Coordinators (SAECs) should be particularly well placed to identify cases that warrant review.

The Chair of the Safeguarding Adults Board will decide whether a case meets the criteria for a Serious Case Review. This decision will be made, where possible, in consultation with the Board. Where this is not possible, due to time constraints, the Chair will consult with appropriate Board members before deciding to commission an independent chair to lead a Serious Case Review.

E. Information sharing

The Serious Case Review Panel should bear in mind that the review is likely to handle highly sensitive information and will ensure that it is managed in accordance with the principles set out in the Data Protection Act (1998).

The Leeds Safeguarding Adults Team will provide secure and appropriate storage of all information provided to the Review Panel.

Information sharing by all agencies is covered by the Leeds Information Sharing Agreement. However, if any agency has concerns about sharing information with the Panel, or about this being recorded within the Panel's final report, its chief officer should discuss this with the Panel Chair. If the agency decides it cannot share information, this should be recorded.

F. Initiating a Serious Case Review

The Serious Case Review (SCR) Panel will be chaired by an Independent Chair who will be commissioned by the Chair of the Safeguarding Adults Board. The Independent Chair will be supported by the Leeds Safeguarding Coordinators.

The Independent Chair will lead a Panel that will comprise a representative from each of the following agencies:

Leeds City Council Adult Social Care
Leeds Partnership Foundation Trust
Leeds PCT
Leeds Teaching Hospitals Trust
West Yorkshire Police

These will form the core membership of the Panel.

In addition to this core group additional members may be co-opted to address particular cases or issues.

Those nominated to the Panel will have appropriate levels of experience of safeguarding adults and inter-agency work and will have suitable qualifications and seniority within their agencies when contributing to a SCR. In order to enhance the independence and objectivity of the Panel, nominees selected to contribute to specific reviews will normally be chosen from an operational area having no involvement with the case in question. The selection of contributors will be the responsibility of the Chair of the SCR Panel in discussion with Panel members.

The SCR Panel will meet to consider the SCR referral.

The Safeguarding Adults Coordinators will make relevant information available to the Independent Panel Chair and other members of the Panel either at this initial meeting or by prior correspondence.

The Panel will draw up the Review's terms of reference. The terms of reference will address the following elements:

1. What are the most important issues to address in order to learn from this case?
2. Which agencies and professionals should contribute to the review and who from other sources (e.g. proprietor of a care home) should be asked to submit management reports?
3. Which issues should each agency address?
4. Would it assist the SCR Panel to bring in an outside expert at any stage of the review process?
5. Over what time period should events be reviewed?
6. What family service history and background information will help to better understand the case?
7. Should the victim(s) or family members be asked to contribute to the review?
8. Will the case be likely to give rise to any parallel investigations? (e.g. a Serious Untoward Incident, a domestic homicide review).
9. Is there a need to involve professionals from other authorities?
10. How should the review process take account of any Coroner's enquiry and any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and / Crown Prosecution Service?
11. When should the review start and by what date should it be completed?
12. How should the public, family and media interest be handled, before, during and after the review?
13. Does the Safeguarding Adults Board need to gain legal advice prior to the start of the Review process?

G. Conducting a Serious Case Review

On receipt of the SCR Panel's terms of reference, the Chair of the Leeds Safeguarding Adults Board will formally request relevant agencies to prepare and submit a management report and where appropriate, a management action plan.

Guidance will be provided to agencies to enable them to focus their report on the issues requiring a response. This guidance is set out in Appendix C.

The management reports, chronology, plus any other information identified as necessary, must be sent by e-mail (marked confidential) to the Safeguarding Adults Team Administrator within 6 weeks of the report being requested.

The management reports and chronologies will be amalgamated and all the documentation will be forwarded to the Independent Chair of the SCR Panel for a draft report to be prepared. The Chair of the Panel will ask the Administrator to convene a meeting of the Panel including any co-opted members to consider the issues in the case.

The Panel will consider the draft report and review the management reports and information provided by any other source, and agree the content of the overview report. This should bring together information from the reports, analyse findings and make recommendations for future action plans.

The review process should be completed within three months of the Leeds Safeguarding Adults Board Chair recommendation to conduct the review, unless an alternative time-scale has been agreed.

H. IMPLEMENTING THE REVIEW RECOMMENDATIONS

On completion, the overview report together with an executive summary, recommendations and actions plans will be presented to the Chair of Leeds Safeguarding Adults Board who will:

a.) Ensure contributing agencies are satisfied that their information is fully and fairly represented in the overview report.
b.) Ensure that the recommendations and actions plans from the overview report are endorsed at senior level by each agency. The action plan will indicate:

- Who will be responsible for various actions.
- Time-scales for completion of actions.
- The intended outcome of the various actions and recommendations.
- The means of monitoring and reviewing intended improvements in practice and/or systems.
- It must be made explicit in each case to whom the report or parts of the report should be made available and agree the means by which this will be carried out.

c.) Disseminate the report, executive summary, recommendations and action plans to interested parties as agreed and provide appropriate feedback and debriefing to staff, family members and media.

I. Annual report

All Serious Case Reviews will be included in the Leeds Safeguarding Adults Board's Annual Report along with relevant service improvements.

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Appendix 1

Checklist for the assessment of the suitability of a Serious Case Review

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?

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Appendix 2

Referral for a Serious Case Review

The format for requesting a SCR must include the summary information listed below. This should be sent to: Emma.R.Mortimer@leeds.gov.uk

All requests will be submitted to the Chair of the Leeds Safeguarding Adults Board for consideration.

Content of the referral:

1. Name of the person submitting the application for a SCR.

2. Position of applicant.

3. Agency of the applicant (if applicable).

4. Contact details, to include Address, Telephone Number, Fax and E-mail.

5. Brief details of the safeguarding adults concern, including:

    a. the name(s) and date of birth of the victim(s).

    b. the name of any service provider involved.

    c. the name of the Safeguarding Adults Enquiry Coordinator (SAEC)

    d. details of why the case meets the SCR criteria (see procedure, section C)

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Appendix 3

Management Case Review Guidance

The purpose of a serious case review management review is for each agency with involvement with the case(s) in question to detail the scope of their involvement and to provide an analysis of their actions. Each agency should remember that the purpose of a serious case review is to provide the partnership with learning.

The management review should include:

a.) A comprehensive chronology. This should be compiled to detail involvement by the agency and/or professional(s) in contact with the adult and family over a period of time set out in the review's terms of reference.

b.) A brief summary of the decisions reached, the services offered and/or provided to the adult, family/carer, and other action taken.

c.) An analysis of involvement.
Consider the events that occurred, the decisions made, and the actions taken (or not taken). Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. Consider specifically:

- Were practitioners sensitive to the needs of the adult in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a vulnerable adult?

- Did the agency have in place policies and procedures for safeguarding vulnerable adults and for acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult, family/carer? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did action accord with assessments and decisions made? Were appropriate services offered/provided, or relevant enquiries made in the light of the assessments?

- When, and in what way, were the adult's wishes and feelings ascertained and considered? Was this information recorded?

• Was the person's mental capacity appropriately assessed and taken into account throughout the agency's involvement with the client?

• Where relevant, were appropriate care plans or adult protection processes in place, and care plan reviews and/ or adult protection reviewing processes complied with?

• Was practice sensitive to the racial, cultural, linguistic, age, disability and religious identity of the adult, and family/carer?