# Vulnerable Adult Serious Case Review Guidance-Developing a local protocol

- 1 Introduction
- The purpose of this document is: 1.1
  - 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)<sup>1</sup>
  - 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
- The document 'No Secrets'<sup>2</sup> (March 2000) issued by DoH and Home 1.2 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 vulnerable<sup>3</sup> adults from abuse.
- 1.3 The guidance suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multiagency 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 - 9.10.15<sup>4</sup>

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

<sup>&</sup>lt;sup>1</sup> For the purpose of clarity throughout this document we will refer to 'Adult Protection Committee's' as Safeguarding Adults Board

<sup>&</sup>lt;sup>2</sup> No Secrets – Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse DH 2000

As defined within 'No Secrets'

<sup>&</sup>lt;sup>4</sup> Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work ADSS October 2005

# 3 Purpose

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

It is:

- 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 <sup>5</sup>

It is acknowledged that all agencies will have their own internal /statutory review procedures to investigate serious incidents; e.g. an Untoward Incident<sup>6</sup>. This protocol is not intended to duplicate or replace these. Agencies may also have their own mechanisms for reflective practice.

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 two 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. This process will be of specific benefit when the case involves a victim aged between 16 and 18.<sup>7</sup>

# 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.

<sup>&</sup>lt;sup>5</sup> 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

<sup>&</sup>lt;sup>6</sup> An investigation within a healthcare setting

<sup>&</sup>lt;sup>7</sup> Note – consultation Document Guidance for Domestic Homicide Reviews under Domestic Violence, Crime and Victims Act 2004

- 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 There must also be mechanisms for the consideration of requests from the Coroner, MPs, Elected Members and other interested parties.
- 5.3 Applications must attract the support of the quorum of the Board be made in writing.
- 5.4 In the event of an application being turned down, the reasons need to be recorded in writing and shared with the applicant.

# 6 Initiating a serious case review -

The case for review will be passed to the Chair of the SGAB to initiate a discussion / decision by the quorate Board. If it is agreed, a multi agency Serious Case Review Panel will be set up:

- 6.1 The SGAB will be responsible for the appointment of an Independent Panel Chair.
- 6.2 The SGAB will ensure the Serious Case Review Panel Chair receives adequate support.
- 6.3 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.
- 6.4 The Chair of the SGAB will then write to the Chief Officers of all the agencies involved for nominations to the Serious Case Review Panel.

- 6.5 Membership of the Serious Case Review Panel will be comprised of appropriate representatives of the agencies.
- 6.6 Each agency will nominate a representative who has appropriate experience.
- 6.7 CSCI have asked that they be informed of any Serious Case Review taking place
- 7 Conduct of Serious Case Review:

#### 7.1 Initial Meeting

This will agree;

- the terms of reference
- the "evidence" required from each participant
- 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
- 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

#### 7.2 Serious Care Review-receipt of evidence

This stage of the meeting is a formal "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
- Ensure any other management reports and other relevant information are made available

#### 7.3 Serious Care Review-discussion of evidence/ "adjudication"

This stage is where the assessment of alternative courses of action takes place.

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

### 7.4 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, DfeS, 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.

### 7.5 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.

#### 7.6 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
- Ensure that the Overview Report contains an Executive Summary that can be made public
- Translate recommendations from the overview into an action plan, which should be endorsed at senior level by each agency

#### The action plan 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
- To whom the report or parts of the report should be made available, and indicate the means by which this will be carried out
- The processes for dissemination of the report and/or key findings to interested parties, for the receipt of feedback and for any debriefing to staff, family members and, where appropriate, the media

### 7.7 Recommendations

The SGAB will ensure that all recommendations are actioned and will request updates from agencies

The action plan will remain on the SGAB Agenda until such time that all recommendations have been implemented

# 8 Annual Report

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

#### APPENDIX Other Considerations for a Serious Case Review

- There will be a need to address the budgetary requirements for undertaking a Serious Case Review
- Time scales for the completion of a Serious Case Review will need to be put in place to ensure that the process takes place within a timely and specific framework. By comparison, a Domestic Violence Homicide Review aims to be completed within three months
- SGAB are advised to liaise with their local Coroners Office to ensure that the arrangements for undertaking a Serious Case Review are acceptable
- Due regard for criminal/civil process should be observed at all times
- Arrangements to obtain or secure records through statutory agencies should be utilised whenever appropriate, e.g. Police, CSCI
- Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered
- The right under the Freedom of Information Act and the Environmental Information Regulations to request information held by public authorities, known as the 'right to know', came into force in January 2005
- There are 'absolute' and 'qualified' exemptions under the Act. Where information falls under 'absolute exemption', the harm to the public interest that would result from its disclosure is already established
- If a public authority believes that the information is covered by a 'qualified exemption' or 'exception' it must apply the 'public interest test'

- The public interest test favours disclosure where a qualified exemption or an exception applies. In such cases, the information may be withheld only if the public authority considers that the public interest in withholding the information is greater than the public interest in disclosing it
- The Data Protection Act 1998
- Children Act 1989 updated 2004
- There may be need for the completion and implementation of media and communication strategies

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