

**GUIDANCE FOR
CONDUCTING INTER-AGENCY
SERIOUS CASE REVIEWS
PAN DORSET AGREEMENT**

May 2008

INDEX

- 1. Introduction**
- 2. The purpose of Serious Case Reviews**
- 3. The Interface between Serious Case Reviews and other processes**
- 4. Establishing which Adult Protection Committee has lead responsibility**
- 5. Referrals to Adult Protection Committees for Serious Case Reviews**
- 6. Preliminary Case Audits**
- 7. Consultation and consent**
- 8. Serious Case Review Panels**
- 9. Determining the Scope of the Serious Case Review**
- 10. Timing of the Serious Case Reviews**
- 11. Abuse in Institutional settings**
- 12. Management Reviews**
- 13. Investigations and the Overview Report**
- 14. Implementation of Recommendations**
- 15. Accountability and Disclosure**
- 16. Learning lessons from the SCR**

Appendices:

- A: Flow Chart**
- B: Initial Referral**

**GUIDANCE FOR CONDUCTING INTER-AGENCY
SERIOUS CASE REVIEWS**

1. Introduction:

- 1.1 There is a fundamental duty for all agencies involved in the care, support and protection of vulnerable adults to ensure that the highest possible standards of care, support and protection are provided and maintained at all times. Part of this duty is a requirement to learn from mistakes. This is particularly important where serious shortfalls or breaches of practice occur, resulting in the death or serious injury of a vulnerable adult. There may have been a failure to invoke Adult Protection procedures, to implement them fully or a flaw in the procedures themselves.
- 1.2 To ensure that lessons are learned from such cases, it is essential that all agencies concerned with adult protection work agree to participate in Serious Case Reviews (SCR). In implementing this guidance the Dorset Adult Protection Committee seeks the full support and co-operation of all its partner agencies.
- 1.3 The document *No Secrets* (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 vulnerable adults from abuse.
- 1.4 The guidance suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees known as Safeguarding Adults Boards (known in Dorset as Adult Protection Committee).
- 1.5 When a vulnerable adult dies and abuse or neglect are known or suspected to be a factor in their death, local agencies should consider immediately whether there are other vulnerable adults at risk of harm who need safeguarding. Thereafter, agencies and the Adult Protection Committee (APC) should consider whether there are any lessons to be learned about the ways in which they work together to safeguard vulnerable adults. Similarly, the APC should consider whether there are lessons to be learned where a vulnerable adult sustains a potentially life-threatening injury or serious and permanent impairment of health and development or has been subjected to particularly serious sexual abuse; and the case gives rise to concerns about inter-agency working to protect vulnerable adults.

2. The Purpose of Serious Case Reviews:

- 2.1 The primary purpose of any SCR carried out under this guidance is to:
 - Establish whether there are lessons to be learned from the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
 - Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result;

- Improve inter-agency working, and better protection and support of vulnerable adults.
- 2.2 It should always be remembered that SCR are not enquiries into how a vulnerable adult died or who may be culpable - that is a matter for Coroners and Criminal Courts to determine respectively. Additionally, whilst a Serious Case Review is not primarily intended to be an exercise in determining negligence or blame by any agency or individual involved in the case, it has to be recognised that if serious issues are identified, management action may be considered by relevant agencies.

3. The interface between SCRs and other processes

3.1 There needs to be clarity over the interface that is likely to exist between the SCR processes and other processes such as:

- The work of the Coroner, which normally should be concluded prior to the SCR.
- Investigations, including criminal investigations. These should normally have been concluded prior to the SCR. If not, any proposals for SCR should be agreed with those leading the criminal investigations to make sure that they may not prejudice any subsequent criminal proceedings
- Disciplinary proceedings
- Care management - including ongoing help for vulnerable adults who have been allegedly abused

3.2 Liaison with H.M. Coroner

When a death of a vulnerable adult occurs, where either abuse or wilful neglect are known or suspected to be a contributory factor in the death, before the APC commissions a SCR, the following action must be taken in respect of the Coroner:

- The Police representative on the APC Sub-committee will cause enquiries to be made with the Coroner to identify whether an inquest will be or has been held.
- If an Inquest is to be held, the Chair of the APC will notify (in writing) the Coroner in whose area the death occurs that a review under these guidelines is being undertaken.
- When the terms of reference of the case review have been agreed by the APC, the Chair of the APC will forward them to the Coroner in whose area the death occurred and invite comments from the Coroner to avoid any conflicts between the two separate processes.
- Should a conflict be identified, then a meeting may be held between the Chair of the APC and the Coroner in an attempt to resolve the issues.
- The Police representative on the CRP will liaise between the Coroner and the APC with a view to identifying the time-scales for the Inquest.

- Should the SCR be completed prior to the Inquest being held, the Chair of the APC will forward an Executive Summary of the completed report to the Coroner prior to it being published and invite comments in relation to any conflicts between the two processes.

3.3 Liaison with the Criminal Justice Agencies

In some cases, criminal proceedings may well follow the death or criminal abuse of a vulnerable adult. Those co-ordinating the SCR should discuss with the relevant criminal justice agencies (Police and Crown Prosecution Service) how the review process should take account of such proceedings, and issues such as the timing of the review, the way in which the review is conducted (including interviews of relevant personnel), and who should contribute at what stage.

SCRs should not be delayed as a matter of course because of an on-going/outstanding criminal proceedings or an outstanding decision on whether or not to prosecute. Much useful work to understand and learn from the features of the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases, it may not be possible to complete or to publish a review until after Coroners or criminal proceedings have been concluded but this should not prevent early lessons learned from being acted upon.

3.4 Other Review Processes

Before commissioning a SCR, the Chair of the APC must establish whether a case review has been or is likely to be commissioned under the other review criteria such as a Domestic Abuse Homicide Case Review

4. Establishing which APC has lead responsibility

Where more than one APC has knowledge of a vulnerable adult, it is important that lead responsibility is recognised from the outset. It is expected that the APC of the local authority where an investigation has been or would have undertaken will have responsibility for considering whether or not to establish a SCR

5. Requests to APCs for SCRs

- 5.1 Any agency or professional may refer a case to the APC Chair if it is believed that there are important lessons for inter-agency working to be learned from the case.
- 5.2 If a vulnerable adult dies or is seriously abused in any of the circumstances below, the APC in the area where the death/serious abuse has occurred must be informed so that they may consider whether to conduct a SCR into the involvement of those agencies and professionals that were responsible for the safeguard and welfare of the vulnerable adult.
- 5.3 The following questions may assist the APC Chair in deciding whether or not a case should be the subject of a SCR in circumstances other than when a vulnerable adult dies. A 'yes' answer to one or more of these questions is likely to indicate that a review will yield useful lessons:

- Was there clear evidence of a risk of significant harm to a vulnerable adult, which was:
 - not recognised by agencies or any professional who was in contact with either the vulnerable adult or alleged perpetrator or
 - not shared with others or
 - not acted upon appropriately?
- Was the vulnerable adult abused in an institutional setting (e.g. such as a hospital or home)?
- Was the vulnerable adult abused whilst being looked after by the local authority?
- Does one or more agency or professional consider that its concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal Adult Protection 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 APC may need to change its local protocols or procedures, or that protocols and procedures are not adequately being promulgated, understood or acted upon?

6. Preliminary Case Audits

The APC Chair may decide that they have not received sufficient information to determine whether or not a SCR is appropriate. In such circumstances they may request that a Preliminary Case Audit is undertaken e.g. by the Local Authority Adult Protection lead manager. The purpose of the case audit is specifically to enable to Chair to be able to determine the future actions which are warranted.

7. Consultation and Consent Issues

Best practice dictates that before the commencement of any formal case review, it is suggested that the vulnerable adult's next of kin, family and/or representative (in cases where either the vulnerable adult has died or does not have capacity) are consulted so that they are aware of the process and purpose for holding the SCR. Similarly, in those cases where the vulnerable adult is alive and has the capacity to understand the reasons for holding this case review, consultation should also take place. Whilst the consent of the vulnerable adult's family/representative is not essential, the case review may be difficult to achieve unless their support and co-operation is provided. That said, the case review may still proceed irrespective of whether the vulnerable adult's family/representative provides their support to the process. It is also recommended that the vulnerable adult (where appropriate) and/or relatives/representatives be kept informed of the inquiry as this will also assist in building up rapport which may be crucial if certain pieces of information are missing.

8. Serious Case Review Panels

8.1 The core membership of the SCRP should be constituted as a minimum from:

- Social Services
- Health sector (Trust and/or Local Health Board as appropriate)
- Legal representative (local authority)
- Dorset Police
- CSCI (for regulated settings)

8.2 In addition to the core group of SCRP members, consideration should also be given on a case by case basis to co-opting other individuals onto the Panel where there are issues that require specific knowledge and expertise. This may include consideration of the inclusion of a suitably experienced lay person

8.3 All members of the SCRPs will be expected to possess appropriate levels of experience in investigating serious matters and inter-agency work and will have/had suitable qualifications and seniority within their agencies when for the task. Furthermore, in order that the SCRP's independence and objectivity is ensured, members must not have had any direct involvement in the case that is under consideration for review. It will be incumbent upon each member to declare such interest. The responsibility for ensuring this will rest with the Chair of the Adult Protection Committee.

8.4 The Chair of the SCRP will either be the APC Chair or will be appointed by them. The person appointed must possess a high level of experience in investigating serious matters and inter-agency working and hold/have held a management position within an agency/organisation. The appointee may be selected from any of the core partner agencies and in addition, consideration may be given to the appointment of a Chairperson who is independent of the core partner agencies involved in the review.

9. Determining the scope of the Serious Case Review

The SCRP should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference. Relevant issues include:

- What appear to be the most important issues to address in trying to learn from this specific case? How can the relevant information best be obtained and analysed?
- What actions will Panel members need to take to enable the Investigator(s) to conduct the Review?
- Who should be appointed by the Panel to undertake the Review and report back to them? An independent reviewer with appropriate experience and seniority will typically be required.
- Over what time period should events be reviewed, i.e. how far back should enquiries cover, and what is the cut-off point? What family history/background information will help better to understand the recent past and present which the review should try and capture?

- Which agencies and professionals should contribute to the review, and who else (e.g. proprietor of Care Home, Private Hospital) should be asked to submit reports or otherwise contribute?
- Should family members/carers be invited to contribute to the review?
- Will the case give rise to other parallel investigations of practice (e.g. a criminal investigation, a mental health related homicide/suicide investigation or disciplinary inquiry/proceedings), and if so, how can a co-ordinated review process best address all the relevant questions which need to be asked, in the most economical way?
- How should the review process take account of a Coroner's enquiry, and (if relevant) any criminal investigations or proceedings related to the case? Is there a need to liaise with the Coroner and/or the Crown Prosecution Service?
- Is there a need to involve agencies/professionals in other APC areas and what should be the respective roles and responsibilities of the different APCs with an interest?
- Who will make the link with relevant interests outside the main statutory agencies, e.g. independent professionals, voluntary organisations?
- When should the review process start and by what date should it be completed?
- How should any public, family and media interest be handled, before, during, and after the review?
- Does the SCRP need to obtain independent legal advice about any aspect of the proposed review?

Some of these issues may need to be re-visited as the review progresses and new information emerges.

10. Timing of Serious Case Reviews

SCRs should be completed within a time-scale identified by the Adult Protection Committee. In some cases, however, the complexity of a case will not become apparent until the actual review has been commenced. SCRs will vary widely in their breadth and complexity, but in all cases lessons learned should be acted upon as quickly as possible.

11. Abuse in Institutional Settings

When serious abuse takes place in an institutional setting, or multiple victims and/or abusers are involved, the same principles of review apply. However, these SCRs are likely to be more complex and on a larger scale, (for example considering systematic regime level abuse over long time periods) and may require more time. Terms of reference need to be carefully constructed to explore the issues relevant to the specific case. For example, if a number of vulnerable adults have been abused in an institutional setting, it will be important to explore whether and how management staff had taken steps to create a safe environment for vulnerable adults, and to respond to specific concerns raised

12. Management Reviews

- 12.1 The initial scope and terms of reference of the SCR should identify those who should contribute, although it may emerge, as information becomes available, that the involvement of others would be useful. In particular, information may become available through criminal proceedings, which may be of relevance to the review.
- 12.2 Each agency which has had involvement should be asked by the SCRP to undertake a separate **Management Review** of its involvement with the vulnerable adult and family. This should begin as soon as a decision is taken to proceed with a SCR if it has not already commenced. Relevant independent professionals (including GPs) should be asked to contribute reports of their involvement.
- 12.3 The request for a Management Review and report will be addressed to the chief officer or chief executive of the agency concerned. Although the task of completing the review and report may be delegated to a suitably qualified and experienced senior manager within the agency, it is important that the review and final report and recommendations are fully endorsed by the chief officer before submission to the Chair of the Review Panel.
- 12.4 The aim of the Management Review should be to look openly and critically at individual or organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about.
- 12.5 On receipt of the request, it is recommended that agencies should take action to secure all relevant records relating to the case to guard against loss or interference.
- 12.6 Where staff or other individuals are interviewed by those persons preparing the Management Review, a written record of such interviews should be made and this should be shared with the relevant interviewee. If any individual is also interviewed directly by the SCRP Investigator a formal note should be put on record.
- 12.7 Upon completion of the Management Review report by an individual agency, there should be an opportunity to facilitate feedback and de-briefing of staff involved within that agency. This should be in advance of the submission of the Management Review report to the SCRP and prior to the completion of the overview report. There may also be a need for a follow-up feedback session if the overview report raises new issues for the agency and staff members.
- 12.8 Once completed, the Management Review should be endorsed by the agency's chief officer and sent to the Chairperson of the Panel within the time stipulated in the original request. Any foreseeable delays should be communicated to the Chair as a matter of urgency.
- 12.9 The SCR to which the Management Reviews contribute are not a part of any disciplinary inquiry or process. However, information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with

disciplinary action. In some cases disciplinary action may be needed urgently to safeguard and protect other vulnerable adults.

12.10 Ideally those conducting Management Reviews of individual services, or producing the overview report, should not have given professional advice on the case and should not have been directly concerned with the vulnerable adult or family, or the immediate line manager of the practitioner(s) involved. If this is not practical their role should be clearly stated.

12.11 Data protection issues are likely to arise during the course of a SCR, as it will be necessary for those agencies participating in the review to process and share 'sensitive personal data' relating to the case under review. In such circumstances, the key principles for managing such data must be adhered to at all times and local guidance on inter-agency sharing of information must be followed

13. Investigations and the Overview Report

The Investigator(s) appointed by the Panel will consider the Management Review reports submitted to them and any other written submissions received. Such follow up investigations and interviews should be conducted as necessary, following which all of the evidence gathered should be analysed and then condensed into an Overview Report to the Panel.

The report will bring together the information and analysis contained in the individual Management Reviews, together with investigations and reports commissioned from any other relevant interested parties. Overview reports will be produced, as with Management Reviews, the precise format will depend upon the features of the case. This outline will be most relevant to abuse or neglect which has taken place in a family setting.

14. Implementation of Recommendations

On receiving the Overview Report the Panel must: ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the Report; Once the Panel is satisfied with the Report and its recommendations a Final Report should be submitted to the APC.

To implement the Review recommendations, the APC will:

- Translate recommendations into an action plan which should be endorsed and adopted at a senior level by each of the agencies involved. The plan should set out:
 - Who will be responsible for various actions;
 - Time-scales for the completion of actions;
 - The intended outcome of the various actions and recommendations made;
 - The means of monitoring and reviewing intended improvements in practice and/or systems

- Clarify to whom the report, or any part of it, should be made available;
- Disseminate the report or key findings to interested parties as agreed. Make arrangements to provide feedback and de-briefing to staff, the vulnerable adult and if appropriate family of the vulnerable adult, and the media, as appropriate.

A flow chart of the SCR process setting out the stages of the processes is provided in appendix A.

15. Accountability and Disclosure

15.1 APCs should consider carefully who might have an interest in the outcomes of the SCR both in terms of process and the final overview report, for example - elected and appointed members of authorities, staff, members of the vulnerable adult's family, the public and media. In this regard, APC will need to consider what information should be made available to each of these interests. There are a number of difficult interests to balance, amongst which are:

- The need to maintain confidentiality in respect of personal information contained within reports on the vulnerable adult, family members and others;
- The accountability of public services and the importance of maintaining public confidence in the process of internal review;
- The need to secure full and open participation from the different agencies and professionals involved;
- The responsibility to provide relevant information to those with a legitimate interest; and
- Constraints on sharing information when criminal proceedings are outstanding, in that access to the contents of information may not be within the control of the APC.

15.2 It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for de-briefing the vulnerable adult and/or family members/carers or for responding to media interest about a case, in liaison with contributing agencies and professionals. In all cases, the APC overview report should contain an executive summary that will be made public, which includes as a minimum, information about the review process, key issues arising from the case and the recommendations that have been made. Such publication will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of the vulnerable adult, relevant family members and others.

16. Learning Lessons from the Serious Case Review

16.1 SCRs are of little value unless lessons are learned from them. At least as much effort should be spent on acting upon recommendations as on conducting the review itself. The following may help in getting maximum benefit from the review process:

- As far as possible, conduct the review in such a way that the process is a learning exercise in itself, rather than a trial or ordeal;
- Consider what information needs to be disseminated, how and to whom, in the light of a review. Be prepared to communicate examples of both good practice and areas where change is required;
- Focus recommendations on a small number of key areas, with specific and achievable proposals for change and intended outcomes;
- The APC should put in place a means of auditing action against recommendations and intended outcomes.

16.2 Day to day good practice can help ensure that SCRs are conducted successfully and in a way most likely to maximise learning. This can be achieved by:

- Establishing a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed;
- Having in place clear, systematic case recording and record keeping systems;
- Developing good communication and mutual understanding between disciplines and APC members;
- Communicating with the local community and media to raise awareness of the positive and 'helping' work of statutory services with vulnerable adults, so that attention is not focused disproportionately on tragic events involving vulnerable adults;
- Making sure staff and their representatives understand what can be expected in the event of a vulnerable adult death/case review.

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ss/reports/Serious Case Review

SERIOUS CASE REVIEW FLOW CHART

