

SUFFOLK ADULT SAFEGUARDING BOARD

JANUARY 2010

# Serious Case Review Protocol

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## Contents

Introduction .....	3
Relevant Standards .....	3
Procedure for the Review of Serious Adult Protection Cases .....	4
Purpose of a Serious Case Review .....	4
Criteria for conducting a Serious Case Review .....	4
Initiating a Serious Case Review .....	5
Conducting a Serious Case Review .....	7
Conduct of Serious Case Review: .....	8
Serious Case Review – Receipt of evidence .....	8
Serious Case Review – Discussion of evidence/“adjudication” .....	9
Implementing the review recommendations .....	9
Annual Report .....	10
Role of Adult Safeguarding Manager .....	10
APPENDIX “A” .....	12
APPENDIX “B” .....	15
APPENDIX “C” .....	16
APPENDIX “D” .....	17
Executive Summary of Serious Case Review in relation to xxx .....	23

# Suffolk Adult Safeguarding Board

January 2010

## Serious Case Review Protocol

### **1. Introduction**

1.1 The purpose of this document is:

- To ensure that local practice is in line with Association of Directors for Social Services (ADASS) guidance on Vulnerable Adult Serious Case Reviews.
- To support the view that the public interest is best served by the presence of an effective serious case review process
- 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' (March 2000) issued by The Department of Health 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.

1.3 The document Safeguarding Adults published by the ADASS (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 Safeguarding Adults Boards should have in place a serious case review protocol.

### **2. Relevant Standards**

It is recommended in "Safeguarding Adults" ADASS 2005 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.

## ***Procedure for the Review of Serious Adult Protection Cases***

### ***1. Purpose of a Serious Case Review***

The purpose of having a case review is not to reinvestigate or to apportion blame, or to establish how someone died? Its purpose is:

- 1.1 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
- 1.2 To review the effectiveness of procedures (both multi-agency and those of individual organisations)
- 1.3 To inform and improve local inter-agency practice
- 1.4 To improve practice by acting on learning (developing best practice)
- 1.5 To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action

It is acknowledged that all agencies will have their own internal/statutory review procedures to investigate serious incidents; e.g. an Untoward Incident. 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 a Serious Case Review, a Domestic Violence Homicide Review, Safeguarding Children Serious Case Review, Multi Agency Public Protection Review, Mental Health Service Review or other such formal review process then a decision should be made at the outset by the decision-makers involved as to which process is to lead and who is to chair with a final joint report being taken to the necessary commissioning bodies.

### ***2. Criteria for conducting a Serious Case Review***

- 2.1 The Suffolk Adult Safeguarding Board should take the lead responsibility for conducting a serious case review
- 2.2 The Board should always consider conducting a serious case review when a vulnerable adult dies (including death by suicide), and when abuse, or neglect, is known, or suspected, to be a factor in their death

2.3 In addition, the Board should consider whether to conduct a serious case review where a vulnerable adult has sustained

A life threatening injury through abuse or neglect

Serious sexual abuse

Serious or permanent impairment of development through abuse or neglect

Or where the operational case details give reason for concern about the way in which professionals and services worked together to safeguard vulnerable adults

2.4 In deciding whether a serious case review should be conducted in cases other than those involving a death (see criteria in [paragraph 2.3](#) above), the following questions should be considered.

- Was there clear evidence of a risk of significant harm to a vulnerable adult that was: not recognised, or shared, by professionals or agencies?
- Was the adult abused in an institutional setting?
- Does one, or more, professional, or agency consider that their concerns were not taken seriously, or acted upon appropriately?
- Does the case indicate that there may be operational failings in one, or more aspects of the use of the Adult Safeguarding Board (ASB) adult safeguarding procedures?
- Does the current adult safeguarding policy need to be amended or revised as a result of inadequacies or omissions?
- Does the case appear to have implications for a range of professionals or agencies?

### **3. *Initiating a Serious Case Review***

3.1 Any agency, or professional may refer a case believed to conform to the criteria and guidance (as outlined in paragraphs [2.2](#), [2.3](#) and [2.4](#) above) using the format set out in [Appendix C](#). Referral should be made to the Chairperson of the Suffolk ASB, or to the Head of Adult Safeguarding Services, together with a brief outline of the case and the factors that suggest that it is appropriate for serious case review. Team managers, or others chairing adult safeguarding case conferences will be particularly well placed to identify those cases that warrant review

- 3.2 A summary of all cases that potentially meet the criteria will be submitted to ASB members for consideration
- 3.3 Any case that is considered appropriate for a serious case review will be delegated by the Chair of the ASB to a Serious Case Review Panel. This will comprise of at least one, or more, delegate from the following areas:
- Suffolk Adult Community Services
  - Suffolk Police
  - Care Quality Commission
  - Legal Representative
  - Voluntary/Customer Organisation
  - Health Representative

This will form the core membership of the sub-group.

- 3.4 In addition to this core group additional members may be co-opted to address particular case issues
- 3.5 Nominees will have appropriate levels of experience of adult safeguarding. In order to enhance the independence and objectivity of the sub-group, nominees selected to contribute to specific reviews will normally be chosen from an operational area that has no direct involvement with the case in question. The selection of contributors will be the responsibility of the Serious Case Review Sub-Group Chair.
- 3.6 The Serious Case Review Sub-group will be chaired by an independent person who, in turn, will be supported by the Head of Adult Safeguarding Services.
- 3.7 Before undertaking a serious case review the sub-group will draw up clear terms of reference for the conduct of the review and identify individuals/agencies to contribute. The terms of reference will address the following elements:
- What appear to be the most important issues to consider in order to enhance points of learning from the specific case?
  - How can the relevant information best be obtained and analysed, including any necessity to request relevant individuals to give a direct account?

- Over what time span should case details and chronology of intervention be reviewed?
  - What information from family, or service, history will assist the sub-group?
  - Which agencies or individuals should contribute to the review, and is there a need for other written information to be obtained from other sources?
  - Should the vulnerable adult, their family, or informal carers be invited to contribute to the review? If so, which is the most appropriate method to enable their participation?
  - How should the review process take account of a Coroner's inquiry, or any criminal investigation?
  - When should the review start and by what date should it be completed?
  - How will confidential information be recorded, stored, and distributed?
- 3.8 The Serious Case Review Sub-group will complete its deliberations, and make recommendations to the Chair of the ASB about what action should now be taken, within 3 months of the case being referred for review. A report outlining any recommendations will be presented to the ASB at the earliest opportunity.

#### **4. *Conducting a Serious Case Review***

- 4.1 Upon confirmation from the ASB that a case is to be reviewed a representative, independent core group, and Chairperson will be identified to conduct the review. The Serious Case Review Sub-group will identify relevant contributory individuals and agencies.
- 4.2 The Chair of the Serious Case Review Sub-group will formally request that relevant individuals and agencies prepare and submit a management report outlining their involvement with the vulnerable adult/family. (See [Appendix A](#) for details of the content of management reports for submission to the Serious Case Review sub-group)
- 4.3 The Chairperson for the SCR sub-group will, in conjunction with the Head of Adult Safeguarding Services (or delegated to the Adult Safeguarding Manager), be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to these procedures.

- 4.4 The sub-group will complete a review of the information commissioned, and a nominated member will produce a short overview report of its findings, conclusions, and recommendations for the ASB. (See [Appendix B](#) for detail of contents of sub-group reports for presentation to the ASB)

## **5. Conduct of Serious Case Review:**

### 5.1 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 Safeguarding Adults Board)
- 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
- Whether there is the need for the completion and implementation of media and communication strategies.

## **6. Serious Case Review – Receipt of evidence**

- 6.1 This stage of the process 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. *Serious Case Review – Discussion of evidence/“adjudication”***

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

The sub-group 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

### **7.2 Issues Arising**

If at any stage whilst undertaking the procedure contained in 7.1, information is received which requires notification to a statutory body, e.g. General Social Care Council (GSCC), DfeS, regarding significant omission by individual/s or organisations this should be undertaken by the Chair without delay.

The Chair of the Serious Case Review Sub-group should report back to the Safeguarding Adults Board and a decision made as to whether the serious case review process should be suspended pending the outcome of such notification.

### **7.3 Report Stage**

The Serious Case Review Sub-group will complete the review of agency IMR and those commissioned from any other source and advise the Sub-group Chair on the production of the Summary Report which brings together information, analyses it and makes recommendations. The Sub-group Chair will ensure that the Report is written and delivered within agreed timescales.

## **8. *Implementing the review recommendations***

8.1 On completion, the overview report will:

- Ensure that contributing agencies are satisfied that their information is fully, and fairly represented in the summary report.
- Translate recommendations from the summary report into an action plan, which will be endorsed by each agency.

The action plan will outline:

- Who will be responsible for various actions.
- The time-scales and targets for the completion of agreed actions.
- The intended outcome and purpose of recommended actions.
- The model used for evaluating, monitoring, and reviewing the necessary improvements in practice, policy, and/or systems.
- Clarify to whom the report, or sections of the report, should be made available.
- Disseminate the report, or key findings to interested parties and provide feedback and debriefing to staff, vulnerable adult, family, informal carers and media.

## **8.2 Action Plan**

The Safeguarding Adults Board will ensure that all planned action are put into effect and will request updates from agencies

The action plan will remain on the Safeguarding Adults Board Agenda until such time that all recommendations have been implemented.

## **9 Annual Report**

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

## **10. Role of Adult Safeguarding Manager**

The Adult Safeguarding Manager will:

- Be a point of contact for individuals / agencies requesting a serious case review
- Be a point of contact for individuals / agencies involved in other types of reviews who need to link to the Safeguarding Adult Board
- Be part of the SCR Sub-group in an advisory capacity

- Support the SCR Sub-group chair and play a major role in the SCR as directed by the chair
- Ensure that lessons learnt are disseminated through the Safeguarding Adults partnership to practitioners / managers / staff as appropriate
- Ensure reference is made in the Annual Report to any Serious Case Reviews undertaken

## **APPENDIX “A”**

### **INDIVIDUAL MANAGEMENT REVIEWS AND REPORTS BY PARTNER AGENCIES FOR CONSIDERATION BY THE SERIOUS CASE REVIEW SUB\_GROUP.**

1. When a case conforms to the criteria for conducting a serious case review, the chairperson of the Serious Case Review Sub-group will formally request that agencies conduct an individual management review (IMR) of their involvement with the vulnerable adult, the service, and/or their family/carers. Upon conclusion of this IMR the agency should submit a report detailing their findings.
2. The request for the IMR and report will be addressed to the chief officer or chief executive of the agency concerned. Although the task of completing the management review and report may be delegated to a suitably qualified senior manager within the agency, it is crucial that the final report and recommendations within are fully endorsed by the chief officer before submission.
3. On receipt of the request from the Serious Case Review Sub-Group, it is recommended that agencies should take action to secure all relevant records relating to the case, thus guarding against loss or interference.
4. The aim of the IMR is to look openly and critically at individual and organisational practice to identify whether the case indicates that changes could, and should, be made and, if so, how these changes will be achieved.
5. The serious case review is not part of any disciplinary inquiry. However, information that emerges in the course of the review may indicate that disciplinary action should be taken under established agency procedures.
6. Where staff or others are interviewed by those preparing management reviews then a written record of such should be made and this should be shared with the interviewee. If any individual is interviewed by the Serious Case Review Sub-group then a formal record will also be made.

## CONTENT OF MANAGEMENT REVIEW

### ***What was the agency's involvement with the adult and family?***

A comprehensive chronology should be compiled of involvement by the agency and its employees over the period of time specified by the Serious Case Review Sub-group.

### ***Analysis of Involvement***

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

For example:

- Were practitioners sensitive to the needs of the vulnerable adult and their family?
- Were they knowledgeable about potential indicators of abuse or neglect?
- Were practitioners, or was the agency, clear about its' roles and responsibilities in protecting vulnerable adults from abuse?
- Did the agency have policies and procedures for safeguarding vulnerable adults?
- What were the key relevant points/opportunities for assessment and decision making in this case?
- Do these assessments, or decisions, appear to have been made in an informed and professional way?
- Did subsequent actions accord with any assessments or decisions made?
- Were appropriate services offered or provided in light of the assessment?
- Where care plans reviewed?
- Were the views and feelings of the vulnerable adult, family, or referring body ascertained? Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic, and religious identity of the adult, family, or family carer?

- Was information shared appropriately in order to alert other managers or agencies of concerns?
- Was the work in this case consistent with the agency's and ASBs adult safeguarding policy and wider professional standards?

***What has been learned from the case?***

Are there lessons from this case for the way in which this agency works to safeguard vulnerable adults and promote their welfare?

Are there examples of good practice, or ways in which practice could be improved?

Are there implications for ways of working; training (single and multi-agency); management and supervision; working in partnership with partner agencies; shortfalls in resources or service provision?

***Recommendations for action?***

What action should be taken, by whom, and by when?

What outcomes should these actions bring about?

How will the agency review whether they have been achieved?

A report of the management review should be completed, endorsed by the agency's chief officer and sent to the Chairperson of the Serious Case Review Sub-group, or the Head of Adult Safeguarding Services. Any foreseeable delays should be communicated as a matter of urgency.

## **APPENDIX “B”.**

### **SUMMARY REPORT BY SERIOUS CASE REVIEW SUB-GROUP CHAIR**

1. Upon receipt of management reports provided by partner agencies, The SCR Sub-group members will review the report’s content and any other information, with the aim of providing an overview report for the ASB.
2. The report will be set out in the following format:

#### *Introduction*

1. Summary of circumstances that led to the review being undertaken
2. Terms of reference of the Serious Case Review
3. List of contributors to the review and the nature of their contribution.

#### *The Report Detail*

4. Details of the family and care services provided
5. Summaries of information known to the agencies and professionals involved about the adult, family, family carer, or perpetrator.

#### *Analysis*

6. Examination of how, and why, events occurred, including decisions made, actions taken, or omitted. Reviewers can consider, with the benefit of hindsight, whether different decisions or actions may have resulted in an alternative course of events. This section should also highlight good practice.

#### *Conclusion*

7. A summary of the lessons that, in the opinion of the sub-group, are to be drawn from the case and how these lessons should be translated into recommendations for action. These recommendations should be focussed, specific and achievable. If there are lessons for national, as well as local, policy and practice, then these too should be highlighted.

## **APPENDIX “C”**

### **REFERRAL TO ASB REQUESTING A SERIOUS CASE REVIEW**

The format for requesting a serious case review must include the summary information listed below.

All requests will be assessed and submitted to the ASB. If the matter requires urgent attention then it will be sent directly to the Chair of the ASB. They will decide if the committee needs to be convened on special grounds.

#### Content of the report

1. Name of the person submitting the application for a serious case review
2. Position of applicant
3. Agency of the applicant
4. Contact details, to include address, telephone number, and E-mail
5. Brief details of the adult protection issue, to include:

The name and date of birth of the victim

Name of any service provider involved

Details of why, in your opinion, the case meets the serious case review criteria and guidelines.

**APPENDIX “D”**

**Letter requesting a Serious Case Review (to be attached to the request form)**

Date:

**F.A.O The Chair of the Safeguarding Adults Board**

C/O The Head of Adult Safeguarding Service  
Endeavour House  
Russell Road  
Ipswich  
Suffolk  
IP1 2BX

Dear

I am writing to request that you consider the need for a Serious Case Review under Suffolk County Council Adult Safeguarding Serious Case Review protocol.

I have given brief details of the case on the attached form.

I look forward to hearing from you,

Yours sincerely

Job Role/position  
Organisation/department

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SERIOUS CASE REVIEW PROTOCOL

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**Request for a Vulnerable Adult Serious Case Review Suffolk County Council  
Adult Safeguarding Serious Case Review Protocol**

<b>Person requesting Serious Case Review:</b>
<b>Job Title:</b>
<b>Organisation:</b>
<b>Workplace:</b>
<b>Address:</b>
<b>Contact No:</b>
<b>E mail:</b>
<b>Other named contact:</b>
<b>Job Title:</b>
<b>Contact No:</b>

**Brief Details of incident. Please include how you feel the incident meets the criteria for a Serious Case Review (see over page)**

**Date: Details:**

**Brief Details of incident**



ADULT SAFEGUARDING BOARD – JANUARY 2010  
SERIOUS CASE REVIEW PROTOCOL

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**Any other information you feel is relevant:**

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**Signed:**  
**Print Name:**  
**Date:**

ADULT SAFEGUARDING BOARD – JANUARY 2010  
SERIOUS CASE REVIEW PROTOCOL

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Serious Case Review - Summary report

Subject name:

Date of birth:

Address at time of incident

Summary of circumstances that led to the review being undertaken

Terms of reference of the review

- To ensure that local practice is in line with ADASS guidance on Vulnerable Adult Serious Case Reviews.

ADULT SAFEGUARDING BOARD – JANUARY 2010  
SERIOUS CASE REVIEW PROTOCOL

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- To support the view that the public interest is best served by the presence of an effective serious case review process
- To facilitate a consistent approach to the process and practice in undertaking a serious case review
- The document 'No Secrets' (March 2000) issued by The Department of Health 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.
- The document Safeguarding Adults published by the Association of Directors for Social Services (ADASS) October 2005, provides a National Framework of Standards for good practice and outcomes in adult protection work.

**Contributors to the review and the nature of their contribution**



*Executive Summary of Serious Case Review in  
relation to xxx*

Suffolk Adult Safeguarding Board

Date

## 1) INTRODUCTION

1.1 Circumstances leading to the decision to hold a Serious Case Review

1.2 The need for a serious case review was confirmed on

1.3 The first meeting of the Serious Case Review Sub-group was held on

.....

### **Purpose of the Serious Case Review**

1.4 Serious case reviews are well established in Children's Services and required by statute. This is not the case in services for vulnerable adults; however, they are seen as good practice and a national review currently being carried out by the government may result in their also being put on a statutory basis.

Safeguarding vulnerable adults is still a relatively new process for agencies working together in the United Kingdom. The first government guidance in this area - *No Secrets* – was published in 2000. In 2001, the first policies and procedures were agreed in Leicester, Leicestershire and Rutland. These were revised in 2004. These were supplemented in November 2007 with the first agreed protocol for serious case reviews involving vulnerable adults. This serious case review has been the first undertaken locally under this protocol.

1.5 Under the agreed protocol, the purpose of having a case review is not to reinvestigate or to apportion blame. The emphasis is on learning from the review so that individual and partnership practice can improve. In this, the approach is consistent with serious case reviews in Children's Services, in which government guidance says that 'Serious case reviews are not inquiries into how a child died or who is culpable. That is a matter for Coroners and criminal courts, respectively, to determine as appropriate'.

1.6 **The Serious Case Review Sub-group agreed the following purposes for this case review:**

## **1.7 Contributors to the review**

## **1.8 Agency management reports were prepared by:**

### **Summary**

*This Summary provides a resume of the circumstances of this case, the main issues arising from it and recommendations which have been made to further improve safeguarding arrangements in Suffolk.*

(Headings for use)

### **INVOLVEMENT OF AGENCIES WITH THE FAMILY**

- Name
- Involvement date
- Chronology where relevant

### **ANALYSIS**

- Agencies provide a statement of purpose in context to their service provision and relevant policies where the customer accessed their service, including any legal context.

### **Approaches to the support of vulnerable people**

### **Partnership working**

### **RECOMMENDATIONS**

Serious Case Reviews have an important function in drawing out lessons to inform future policy and practice. These can concern individual agency issues or multi-agency working.

Where appropriate, individual agencies identified recommendations in their management reports. These are summarised below.

**Recommendations from individual agencies**

*Name(s) of agencies/recommendations*

**Serious Case review Recommendations**

*List recommendations taken from each agency and then overall recommendations by the independent chair.*