

Manchester Safeguarding Adults Board

Vulnerable Adult Serious Case Review Protocol

Revised July 2010

1. Purpose

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 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.

2. Policy Context

2.1 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.

2.2 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 Board.

2.3 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 Safeguarding Adults Boards should have in place a serious case review protocol.

2.4 Manchester's Multi Agency Safeguarding Adults Policy defines a vulnerable adult as those

` who are, or may be ,in need of community care services because of learning or physical disability, older age or physical or mental illness. Who are or may be unable to take care of themselves, or unable to protect themselves from harm or exploitation by others`.

3. Functions of a Serious Case Review

The purpose of having a case review 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

It is acknowledged that all agencies will have their own internal /statutory review procedures to investigate serious incidents e.g. an Untoward Incident and any disciplinary matters that may arise. 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.

4. Criteria for Serious Case Review

The Manchester Safeguarding Adults Board (MSAB) 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 MSAB 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 When serious abuse or neglect 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.
- 4.4 Where more than one agency has been involved in the care and support of the service user and there has been serious abuse or neglect and the case suggests that the MSAB may need to change its protocols or procedures, or that protocols are not being understood or acted upon.

5. Commissioning and carrying out of a serious case review

- 5.1 The MSAB 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 The decision to commission a SCR must be made in writing by the MSAB chair to the applicant and need majority support of the SCR sub group.
- 5.4 The outcome of considerations by the SCR sub group must be recorded in writing with reasons clearly evidenced, and shared with the applicant.

6. Initiating a serious case review –

- 6.1 The case for review will be referred to the SCR sub group for consideration. The SCR sub group will consider referrals against the criteria for holding a serious case review and will make recommendations to the Chair of the MSAB.
- 6.2 The SCR sub group will convene within 14 days to consider the request. For a meeting to be quorate, either the sub group Chair or Vice Chair must be in attendance, plus three other members.
- 6.3 The Chair of the MSAB will decide whether or not to commission a serious case review based on the recommendation of the SCR sub group.
- 6.4 If it is agreed to hold a SCR, a multi agency Serious Case Review Panel will be set up. The SCR sub group will advise on the constitution of the SCR panel.
- 6.5 Proper consideration should be given to ensuring the Chair of the SCR and the report author are both sufficiently independent and appropriately experienced and skilled to ensure they provide a high quality, objective and thorough report.
- 6.6 The MSAB will ensure the Serious Case Review Panel Chair receives adequate support.
- 6.7 The SCR sub group will be responsible for the appointment of an independent Panel Chair and an independent author for the report, where appropriate. The costs of engaging an independent chair and/or independent author for the SCR will be met via the MSAB budget or by contributions from partner agencies agreed by the MSAB.
- 6.8 The SCR sub group will be responsible for establishing individual terms of reference and setting time scales for the review on behalf of the MSAB. The sub group will also be responsible for ensuring that the review process is conducted

according to the terms of reference and establish agreed target date for completion, which should be within a maximum 6 month period.

- 6.9 The Chair of the MSAB will write to the Chief Officers of all the agencies involved for nominations to the Serious Case Review Panel.
- 6.10 Membership of the Serious Case Review Panel will be comprised of appropriate representatives of the agencies with relevant involvement in the case. Each agency will nominate a representative who has appropriate experience. Members of the Panel should not be authors of IMR's except in exceptional circumstances.
- 6.11 CQC should be informed of any Serious Case Review taking place.
- 6.12 The chair of the MSAB will liaise with Coroner when appropriate

7. Conduct of Serious Case Review:

7.1 Initial Meeting

This will consider and agree;

- the terms of reference drafted by the SCR sub group
 - 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
- the chair of the SCR panel will arrange for letters to be sent to identified relevant organisations requesting they complete an IMR. The request will include details of the terms of reference and the timescale for completing the IMR including a chronology of the agencies involvement in the case.

7.2 Serious Care Review-receipt of evidence

IMR reports will be returned to the chair of the SCR panel who will arrange for copies to be forwarded to each member of the panel.

The first meeting of the SCR panel 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 what might have been done differently takes place.

The review panel will:

- review and 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, ISA Barred Lists , regarding significant omission by individual/s or organisations this should be referred by the Chair of the SCR panel to the MSAB Chair for action, without delay.

The Chair should report back to the MSAB 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 SCR review panel will complete the review of agency management reports and those commissioned from any other source.
- The SCR Panel has responsibility for producing the final versions of the overview report, Exec Summary and action plan, as well as deciding who the Executive Summary and action plan should be disclosed to, and providing feedback to the family.
- The SCR sub group quality assures the process and ensures that the report is written and delivered within agreed timescales.

7.5 Acting on the recommendations of the Serious Case Review

On completion, the Overview Report will be presented by the author, to the MSAB which will:

- ensure contributing agencies are satisfied that their information is fully and fairly represented in the Overview Report ;
- ensure that an Executive Summary that can be made public is produced
- translate recommendations from the overview into an action plan, which should be endorsed at senior level by each agency.

The action plan will indicate:

- who will be responsible for various actions;
- the 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;
- clarify to whom the report or parts of the report should be made available, and indicate the means by which this will be carried out;
- disseminate the report and/or key findings to interested parties, as agreed and provide feedback and debriefing to staff, family members and, where appropriate, the media.

7.6 Recommendations

The MSAB SCR sub group will monitor compliance with recommendations of completed SCR's for a period of 12 months after completion of overview report (as agreed by MSAB) and will ensure that all recommendations are actioned and will request updates from agencies.

The action plan will remain on the MSAB 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.

9. Review of the SCR Protocol

The protocol should be reviewed in the light of experience on an annual basis

10 Other Considerations to Serious Case Review

- 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 will be a need to address the budgetary requirements for undertaking Serious Case Reviews.
- Time scales for the completion of Serious Case Reviews will need to be put in place to ensure that the process is driven within a timely and specific framework.
- There may be need for the completion and implementation of media and communication strategies.

Appendix 1

Manchester Safeguarding Adult Board

Request for A Serious Case Review

The request for Serious Case Review must include a summary of how it meets the criteria for SCR as set out in section 4 of this protocol.

The request must be sent in the first instance to the Chair of the Manchester Safeguarding Adults Board.

Content of the Report

- 1. Name of person submitting request for a series case review .**
- 2. Position/designation**
- 3. Name of Organisation making request**
- 4. Contact details to include address, telephone and email details**
- 5. Brief details of the adult protection issue to include;**
 - Name and Date of Birth of victim**
 - Name of service provider involved**
 - Local Authority involved in the adult protection case**
 - Details of why in the person's opinion, the case meets the criteria and guidelines contained within section 4.**

Please note that the report should not exceed two sides of A4 paper. If additional information is required you will be contacted.

Appendix 2 – Standard Letter

Strictly Confidential – requires urgent attention

Dear

Re: Serious Case Review (Name, DOB and Address)

A decision has been made that the above named vulnerable adult is to be made subject of a Serious Case Review.

As Chair of the Manchester Safeguarding Adults Board I am writing to formally request that you take action to ensure that your agency files in respect of the above named vulnerable adult are immediately secured to guard against potential loss or interference, and to enable the Serious Case Review process to commence.

It will be necessary for you to identify a manager of sufficient seniority and experience to undertake your Internal Management Review. The manager appointed should have had no line management relationship with practitioners working with the vulnerable adult or any direct contact themselves with the vulnerable adult. I would be obliged if you would forward me the name and contact details of this person as soon as possible.

The purpose of this Serious Case Review is to establish whether there are any issues in relation to interagency working under the local adult safeguarding procedures and any lessons to be learned, and to achieve this, each agency that has had involvement with the family is required to look openly and critically at their professional practice with the vulnerable adult.

I have attached information and a template relating to the individual agency management reports and in relation to the chronology which your agency is required to complete. I would be obliged if you would please ensure that this material is forwarded to your review manager.

The chronology will apply for the period to in relation to the following: *(Names and DOB)*.

The findings from the individual management review should be agreed and accepted by yourself as the senior officer in the organisation who has responsibility for ensuring that the recommendations are acted upon.

It is most important that the Serious Case Review Panel receive your Agency's report by I am sure you will appreciate that if there is a delay by any of the agencies within this process, this will seriously compromise the Panel's ability to provide a multi-disciplinary overview report, and will therefore

impact upon our ability to learn important professional practice issues locally. It is important that in undertaking this work, that the Safeguarding Adults Board can demonstrate a robust and timely process.

Thank you for your assistance in this important matter. Please send your individual management review to the Head of Adult Safeguarding whose contact details are given below.

Yours sincerely

**Chair
Manchester Safeguarding Adults Board**

Appendix 3 – Template for IMRs

MANCHESTER SAFEGUARDING ADULTS BOARD

INDIVIDUAL MANAGEMENT REVIEW

Subject:

Date of Birth:

Author:

Countersigned:

Date of submission:

Format for Individual Management Reviews

1. Introduction

Include brief summary of the situation

2. Methodology

Record the methodology including details of documents used and interviews undertaken.

3. Terms of Reference

4. Agency Involvement

The review should detail the involvement of the agency with the subject over the period of time set in the terms of reference for the review. It should summarise the events that occurred, information known to the agency, decisions reached, services offered and provided, and any other action taken.

5. Comprehensive Chronology

6. Analysis of involvement

The review should consider events that occurred, the decisions made and actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why.

The following areas will need to be considered:

What was the agency's involvement with the vulnerable adult and/or their family?

Summarise decisions reached, the services offered and/or provided to the adult, family/carer, and other action taken.

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 safeguarding adult processes in place, and care plan reviews and/ or safeguarding reviewing processes complied with?

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

Were more senior managers or other agencies and professionals involved at points where they should have been?

Was the work in this case consistent with agency and Manchester Safeguarding Adults policy, protocols and guidance for safeguarding vulnerable adults and wider professional standards?

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

Is there good practice to highlight ways in which practice can be improved?

Are there implications for ways of working; training; management and supervision; working in partnership with other agencies; resources?

What has been learned from the case?

7. Action Plan

Each agency should produce and submit an action plan setting out any changes or improvements to their practice in light of this case. This should include possible disciplinary or regulatory action. The agency should set out how the plan will be reviewed to determine if the outcomes have been achieved.

Appendix 4 Chronology

MANCHESTER SAFEGUARDING ADULTS BOARD SERIOUS CASE REVIEW

Agency Chronology

Please complete the chronology below. The information required under each heading relates to each contact your agency had in relation to the person subject of the serious case review. The last column “Comment” should be used if the agency reviewer wishes to comment on the appropriateness/quality of the intervention, or whether it raises any other professional issue. It is important to insert the date as per the example to facilitate merging with chronologies from other agencies.

Please return to the Head of Safeguarding, Directorate for Adults, Manchester City Council by the date given in the accompanying letter.

Name of Agency:

Name(s) of Adult(s):

Ethnic Origin:

Dates covered by the chronology:

Date	Source of Evidence: Case Record, electronic record, minutes, interview etc	Name of professional in your agency who had the contact	Contact with (initials of person) and agency/role	Communication/reason /incident/contact location	Actions taken/decisions made	Comment including any gaps in service or missing records
dd/mm/yy						
dd/mm/yy						
dd/mm/yy						

Date	Source of Evidence: Case Record, electronic record, minutes, interview etc	Name of professional in your agency who had the contact	Contact with (initials of person) and agency/role	Communication/reason /incident/contact location	Actions taken/decisions made	Comment including any gaps in service or missing records
dd/mm/yy						

Chronology continued

List of Documents

Please list all source documents you have used in completing your individual management review.

Appendix 5 – Action Plan

Serious Case Review Action Plan Template

INSERT YOUR LOGO HERE

[Initials of subject] – SCR – [AGENCY NAME]

Lead Person: [NAME]

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead Officer	Date
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1.	As they are written in the report	Indicate the actions or series of actions to be taken to achieve the expected outcomes. These must be Specific Measurable Achievable Realistic Time scale Examples might be delivery training, develop new policy, Introduce new standard, Review working practices , etc	Describe the evidence you will provide to the Board to show the actions are being undertaken or achieved These might include correspondence, minutes of meetings, new policy, training material, etc	What improvements in service should result from actions e.g. increased awareness of multi-agency referrals, quicker access to services	Designation of lead officer charged with implementing the actions	Date by which actions will be completed
2.						
3.						
4.						
5.						

