

Haringey's Multi-Agency Safeguarding Adults Protocol for a Serious Case Review 2008



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1. What is a serious case review

Serious case reviews were established following the revised “Working Together” child protection guidance (Home Office et al 1991). A serious case review is a process of investigation, re-evaluation, analysing, scrutinising and making recommendations:

When a vulnerable adult who is receiving community care services dies

When a vulnerable adult is subject to a serious injury when there is suspected or actual abuse

When there is a safeguarding adults issue with major public concern.

Serious Case Review used to be known as Part 8 or Section 8 and the process is co-ordinated by the Chair of the Haringey’s Safeguarding Adults Board (HSAB) through the Case Review Sub Committee.

The guidance is issued under Section 7 of the Local Authority Social Services Act 1970. It does not have the full force of the law but, according to the DH, ‘should be complied with unless local circumstances indicate exceptional reasons which justify a variation’.

Relevant Standards: 1.22-9.10.15

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 review should be clear.

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

2. The purpose of a serious case review

The purpose of the serious case review is to:

- Identify involved professional(s)
- Establish the facts
- Establish whether there are lessons to be learnt from the case about the way in which local professionals and agencies worked together to safeguard adults
- Identify clearly what those lessons are, how they will be acted upon, and what is expected to change as a result; and as a consequence
- To improve inter agency working and better safeguarding of adults.

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 and a Domestic Violence Homicide Review then the two decision makers as to which process is to lead and who is to chair with a final joint report taken to both commissioning bodies. This process will be of specific benefit when the case involves a victim aged between 16-18.

3. Criteria for convening serious case reviews

A serious case review **must always** be held when an adult who is being provided with services by the local authority dies due to an actual, suspected or alleged abuse.

In cases where an adult has not died it is appropriate to hold a serious case review if **any** of the following criteria is met:

- There was a significant risk of harm to an adult which was unrecognised by agencies or professionals in contact with the adult or alleged perpetrator
- Risk(s) not shared with others or not acted upon properly
- The adult was abused in an institutional setting, for example, residential/nursing homes, day-centres
- Agencies or professionals consider that their concerns and suspicions were not taken sufficiently seriously or acted upon appropriately by another when the concern and suspicions were a determining factor.
- The case indicates that there may be failings in one or more aspect of the local operation of formal safeguarding adults procedures which extend beyond the handling of the case
- The adult had previously been subjected to a Protection Plan
- The case appears to have implications for a range of agencies or professionals
- The case suggests that there may be a need for the HSAB to change its protocols or procedures or that they need to be more effectively promoted, understood or acted upon.

4. Process for commissioning and carrying out of a serious case review

The HSAB 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.

There must also be mechanisms for the consideration of requests from the Coroner, MPs, Elected Members and other interested parties.

Applications must attract the support of the quorum of the Board be made in writing.

In the event of an application being turned down, the reasons need to be recorded in writing and shared with the applicant.

5. Initiating a serious case review

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

The HSAB will be responsible for the appointment of an Independent Panel Chair.

The HSAB will ensure the Serious Case review Panel Chair receives adequate support.

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 HSAB. They will also be responsible for ensuring administrative arrangements are completed and that the review process is conducted according to the terms of reference.

Any professional or agency working within the local safeguarding adults' network who concludes that a case review may be required must immediately notify the Chair of the HSAB.

Within a month of any such notification, the HSAB Chair should convene a Case Review Sub-Committee.

It is the duty and responsibility of the HSAB Chair to instruct the case Review Sub-Committee to undertake a Serious Case Review.

Members of this sub-committee may determine that a full case review is not justified and that internal management review/s might be more helpful. The results of any such internal enquiries within member agencies must be fed back to this sub-committee.

It is the responsibility of both the lead agency and the Case Review Sub-Committee to ensure feedback is undertaken.

If the Case Review Sub-Committee does not conclude that a serious case review is required, it should make this recommendation to the Chair of the HSAB who has the final responsibility for making the decision.

When the HSAB instigates a case review, they will be responsible for:

- Identifying the agencies/service providers whose part in the case is to be examined
- Make arrangements for each participating agencies Chief Officer to be written to informing them of the details of the process, and that they need to arrange an internal/management case chronology and review.

6. Immediate conduct

As soon as the HSAB Chair has decided that a Serious Case Review is required, s/he must immediately inform the relevant Service Manager or comparable officer who must then within 1 working day complete the following tasks:

- Convene an emergency Strategy Meeting to make arrangements for the safety of other vulnerable adults, for instance, in a care setting or in a domestic environment where there are other vulnerable adults.
- Check the electronic database to establish if service user is/was known and to identify involved professionals.
- Freeze and seal paper files: a senior manager in the agency must take possession of the file and ensures that a suitable member of staff numbers and initials both sides of each paper
- Limit access of all electronic database to approved person/s from the Case Review Sub Committee
- All agencies must make a photocopy of the file(s) so as to allow ongoing work and the original is held by a senior manager
- Files should not be entrusted to the postal service and must be delivered in person or by courier
- Inform The Director of Adult Services (in those case where s/he is not the Chair of the HSAB) or comparable equivalent and the Press Office
- Define those agencies which have been involved with the adult and alert them via a letter from the HSAB to Chief Executive/Officer, to their obligation to undertake an internal enquiry as a contribution to the overall case review
- Inform the Commission of Social care Inspection (CSCI)

Within 2 further working days, the manager who has taken possession of the active files must:

- Complete a briefing report for the Director of Adult Services, equivalent in Health, TPCT, HSAB and Serious Case Review Sub- Committee, the Social Services Cabinet/Committee Member and Press Office

7. Individual agency internal management reviews

The Main objectives of each agency review are to:

- Look openly and critically at organisational and individual practice
- Establish if the case indicates that changes could and should be made
- Identify how any such changes may be introduced
- Propose any other action required

To achieve these objectives, the following will need to be completed:

- Identification and reading of file material
- Interviews of relevant practitioners and managers
- Establishment of a chronology
- A determination of services provided as a result of the decisions made
- An analysis of involvement
- A summary of 'lessons learnt'
- Recommendations for practical action

8. Individual agency response to HSAB notification and internal management reviews

The HSAB case review notification will be received usually by the agency's Chief Executive. If it is received by someone else in the agency, the Chief Executive or equivalent should be informed as soon as possible. The Chief Executive will inform the agency lead for safeguarding adults.

The agency lead (or a member of staff appointed by them) will then:

- Ensure that the agency Serious Case Review policy has been instigated
- Read all the secured records and establish a chronology of the history of the agency's involvement
- Interview appropriate staff
- Complete an initial report which will include a chronology and an analysis of our services involvement
- Any initial recommendations made at this time will be in addition to recommendations and implementation/action plans made by the HSAB Serious Case Review Panel
- The completed report will be made available to the agency and senior management as outlined within the Serious Case Review Procedure
- The completed report will be sent to the case review panel

9. HSAB action on receiving reports

9.1. Ongoing conduct and timescales

The conduct of the review should be overseen by a Serious Case Review Sub Committee to be briefed at a session convened by the HSAB Chair. The overall time limit for submission of a Serious Case Review Report to the DoH is 4 months from the decision that such a review is required unless, as a result of complexity of a case or other circumstance, an alternative has been negotiated with the CSCI.

The HSAB Chair must also notify each member agency of the need to conduct and submit to the Chair of the Serious Case Review Sub Committee (within 3 months unless otherwise agreed), its individual agency review.

The HSAB is responsible for forming an Inter-Agency Case Review Panel with a clear term of reference

9.2. Responsibilities of serious case review panel

- The Inter-Agency Case Review Panel will usually draw its members from the HSAB Serious case Review Sub Committee, with other professionals co-opted for their specific skills/insight as required
- The Serious Case Review Panel is responsible for compiling an inter-agency chronology, carefully analysing all the information available and completing a final unnamed report.
- The Serious Case Review Panel may decide to re-examine case notes and agency based evidence, as well as interview staff to aid their analysis
- They will ensure that contributing agencies and individuals are satisfied that their information is fully and fairly represented in the overview report
- They 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 individual task, timescale with intended outcomes. It should set out also the means of improvements to be made in practice and systems for monitoring and reviewing
- Identify person(s) to whom the report or any part of it should be made available
- Disseminate report or key findings to interested parties as agreed

- Make arrangements to provide feedback and de-briefing to staff, family members of the vulnerable adult and the media as appropriate
- Provide a copy of the overview report, executive summary action plan and individual management report to the HSAB, CSCI and Health Care Commission

10. Overview report and follow up

The Serious Case Review Sub Committee is responsible for the production of a composite report (prepared by a nominated senior manager or an independent person) to the full HSAB which will:

- Provide an overview and include all relevant facts
- Offer an integrated chronology, using the template for internal agency chronologies
- Make recommendations for action by the HSAB and individual agencies

The format of the composite report should be as follows:

- **An introduction** summarising the circumstances which led to the review including its terms of reference and listing all contributions and contributors as well as clarifying the Serious Case Review Sub Committee members and author of the report
- **Facts** including an integrated chronology showing involvement of all agencies and an overview of what relevant information was known to each involved agency and professional, about the parent/carer/spouse, any perpetrator, and the home circumstances
- **An analysis** which considers how and why events occurred, decisions made and actions taken or not (this section can consider if outcomes might have differed if different decisions or action had been taken and can also usefully include examples of good practice).
- **Conclusion and recommendations** which the lessons to be drawn are outlined and proposals included as to their progression by relevant agencies (such conclusions and recommendations should be few in number, explicit, expressed simply and be realistic)

A process must be put in place in advance of formal submission of the overview report to the HSAB which enables feedback and de-briefing of staff involved.

The overview report should be submitted to the Chair of the HSAB within 1 month of the internal reviews being received.

11. The format of the composite report

11.1. The serious case review template

- Over the page (page 8)

11.2. The serious case review chronology format

- Page 9

Private and Confidential

1. Introduction

- 1.1 This management review has been completed by..... on behalf of the.....(organisational name) as part of the Serious Case Review following the
- 1.2 This review will be made available to the Serious Case Review sub-committee of the Haringey's Safeguarding Adults Board and copied to senior managers via the Serious Incident Group.
- 1.3 This review has been completed through examination of all located written evidence available to(organisational name), and through discussion with staff members.
- 1.4 Throughout this review initials for....., family and the professionals involved in his/her care have been used. A key will be made available to the review panel and on a "need to know basis" included in appendix 2.
- 1.5 The recommendations made in this review are aimed to improve practice at(organisational name). These will need to be seen in addition to the final conclusions and multi-agency recommendations made by the Haringey Safeguarding Adults Board case review sub-group

2. Overview

Name of client:

Service area(s) involved in the care of:.....

Dates covered by the review:.....

Events leading to the review:.....

3. History of service involvement and commentary

4. Key issue and analysis

5. Conclusions

6. Recommendations

Signed and dated by:

Copies to:

