7.0 SERIOUS CASE REVIEW (SCR)

7.1 What is a SCR?

It is a method of carefully looking at what led up to an event that caused concern. Its purpose is to identify good practice and draw out lessons that agencies can learn for the future. It also aims to identify whether agencies worked together appropriately or whether this could have been more effective. It is not a disciplinary investigation – that is the task for each agency should disciplinary be required. It is also not an investigation into the cause of death or serious injury – that is the task of the Coroner's Office and other investigation agencies – the Police and Social Services.

7.2 What happens during a SCR?

There are numerous stages which make up the SCR process which, due to the nature of these stages can run into several weeks or months. A SCR concludes with a final overview report which brings together and analyses the findings of the various reports produced by the single agencies involved in order to make recommendations for future action. These recommendations which are then developed into action plans may not be implemented until a long period after the initial event which prompted a SCR due to the length of the process. As has been acknowledged by recent research there is a risk that SCRs can be time-consuming, resource intensive & conclude too late. It is for these reasons that the Safeguarding Adults Review Group should give very careful consideration to choosing this approach over any of the others identified within this toolkit.

The stages are as follows:

- Appointment of an Independent Author;
- Appointment of a Panel
- Informing the Care Quality Commission (CQC)
- Panel meetings – to agree Terms of Reference for the review, to consider the IMRs and the draft report
- Agency IMRs and chronologies
- Engagement with Coroner (if appropriate)
- Interviews with families (if appropriate)
- Production of an Overview report
- Publication of the report & possible media interest

7.3 Issues for the Safeguarding Adult Review Group to consider.

In making their decision about whether to conduct a SCR, the Safeguarding Adults Review group needs to consider what additional learning or outcomes there will be over and above that that would be achieved by undertaking another type of review. The costs and time resource will be far greater conducting a SCR.

Issues that the group should consider in making their decision are:

Was there clear evidence of a risk of significant harm?:

1. That was not recognised by agencies/professionals in contact with the adult/perpetrator?

2. That was not shared with other agencies?

3. That was not acted upon appropriately?

4. Was the adult in an institutional setting eg care home, day service, hospital?

5. Was the adult abused whilst being supported by the Local Authority?

6. Do one/more agencies consider that their views were not taken seriously or acted upon appropriately by another?

7. Does the abuse indicate that there may be failings in the local operation of the Safeguarding Adults Procedures that may go beyond the handling of this case?

8. Does the case have implications for a range of agencies/professionals?

9. Does the case suggest that the Safeguarding Adults Procedures or Protocols may need to change or that they are not widely acknowledged, understood or acted upon?

Once the group has considered all the issues they should decide either a) a Serious Case review is required or b) a different type of review is required.

The Chair should then complete **Template 2 – Decision record of the Safeguarding Adults Review Group.**

If the Chair has decided that a SCR should be commissioned, they should **immediately** inform the independent Chair of the Safeguarding Adults Board of this decision.

7.4 Commissioning a Serious Case Review

Where the decision has been made to commission a SCR the Safeguarding Adults review group will be responsible for:-

- Agreeing who should form the SCR panel, including who should chair it.

- Considering the initial scope of the review process.

- Establishing clear and individual terms of reference, including setting the timescales within which the review process should be completed.

- Consider who will write the Overview Report and whether an independent/suitably experienced external Author needs to be commissioned.

- Where an 'external' author is required, ensure that the commissioning process is started.

- Requesting each involved agency to complete an IMR & chronology in line with agreed Terms of Reference, using the standard templates provided **(attached as Appendix 8a & 8b).**

- The Safeguarding Adults review group reserves the right to give specific direction to any agency in relation to the collection of information required. For example, which agency takes the lead in contacting/interviewing family members.

- Ensuring administrative arrangements are in place to support the process, including setting up meetings, receiving reports, minuting meetings, collating the chronology from the individual IMR reports.

- Securing any legal advice required, in particular on Data Protection, Freedom of Information and Human Rights Act.

7.5 Appointment of an Independent Chair/Report author

When it has been decided that an Independent Panel Chair & report author is to be appointed, the Safeguarding Adults review group Chair will discuss this with the Chair of the Safeguarding Adults Board and they will decide who should be appointed, and ensure the appropriate arrangements are made.

7.6 Appointing members to the SCR panel

Membership of the Serious Case Review Panel will be comprised of appropriate representatives of the agencies. Where the Safeguarding Adults Review group members are eligible to form the panel their Chief Officers/Executive Directors with responsibility for safeguarding will be advised of this. Involved agencies will also be asked to identify as soon as possible the authors of their Internal Management Review (IMR) reports. Where Safeguarding Adults review group members are not the appropriate people to be IMR authors, the agency will have to nominate an IMR author for their agency.
All panel members and IMR authors must have the appropriate skills and experience.

7.7 Informing other agencies

The Chair of the Safeguarding Adults Review group must advise, as appropriate that a Serious Case Review is taking place:

- Care Quality Commission (QCQ)
- Coroners Office
- Police
- Chief Executives of the partner agencies involved

7.8 Media Handling

The Safeguarding Adults Review group in collaboration with the Local Authority Corporate Communications team will determine the media/communication strategy which will address e.g. if and how newspapers, TV, radio should be told about the SCR and when the final report is to be published; other Agency media advisors/Communications Teams must also be alerted & work in collaboration with the agreed way forward.

7.9 Consulting with victim(s) and family members

Circumstances may arise whereby it is appropriate to consult or involve a victim of abuse or a relative. This involvement should be carefully considered; including how a victim of abuse or a relative are to be contacted, to what extent and what about and what additional support may be needed for these individuals and families.
(**see section 4.0 on Engaging with Adults at Risk during reviews for guidance).**

7.10 Conduct of the SCR process

7.11 A **pre-meeting** of the SCR Panel Chair, SCR Panel, Safeguarding Adults Review group Chair the IMR authors and the independent Overview Author (if required) will be arranged to confirm the terms of reference and process of the review.

7.12 The Chair of the Safeguarding Adults Review group will contact all relevant agencies in writing giving guidance on the content of the review and requesting that they instigate their own internal management review to be returned within **six weeks** of the request. In most cases the IMR report should also contain a detailed chronology of events showing key points of contact with the vulnerable adult by their agency. It should also contain recommendations and an action plan so that the key learning points begin to materialise at the earliest opportunity. **See Appendix 8a & 8b for the template IMR report and chronology.**

7.13 It is important that the IMR, chronology, recommendations and agency action plan are fully endorsed by the Chief Officer of the agency before submission to the SCR Panel. This should be shown on the document by a clear signature and date.

7.14 At **panel meeting 1** the SCR panel along with the Overview Author will meet to consider receipt of the IMR reports and other evidence. The role of the SCR panel chair is to ensure that the review process is conducted according to the terms of reference.
This first meeting will consist of formal information sharing where each agency will be asked to present a comprehensive report of actions taken by their agency, their chronology of events, highlighting any discrepancies and where things have gone wrong and also highlighting good practice. Agencies should also state what action has been taken to reduce the likelihood of the same or similar incidents occurring again. All relevant information and reports must be available for this meeting.

7.15 The panel will commence a process of discussion of all the above evidence. This is where the assessment of alternative courses of action takes place and next steps are agreed. The panel and Overview author will:

- Cross-reference all agency management reports and reports from any other source.
- Examine and identify relevant action points.
- Form a view on practice and procedural issues.
- Agree the key themes to be included in the overview report and the proposals for recommendations
- Request further information from agencies as required.

7.16 The overview report author will commence completion of the **first draft of the Overview Report,** which brings together information, analyses it and makes recommendations. This will be circulated to all panel members for comments. As these reports are confidential they should be password protected and only forwarded onward with the permission of the author.

An overview report will usually as a minimum cover:

- Any matters of concern affecting the safety and wellbeing of adults at risk in the area of the authority;
- Any general public health, safety or well-being issue arising from the death of an adult at risk;
- Any need to review policy, practice or procedures;
- Possible dissemination to other local authorities;
- Identification and integration of learning points from serious case reviews from other areas or research and best practice guidance

7.17 On completion of the draft, the Overview report, recommendations and Executive summary will shared with the SCR Panel members to ensure contributing agencies are satisfied that their information is fully and fairly represented. There will be opportunity for discussion and changes at this stage.

7.18 The panel will meet again for **panel meeting 2** at which the panel will agree the content of the **final overview report.** The panel chair will ensure the report is written and delivered within agreed timescales. This meeting can also be used as an opportunity to share the report with other key people such as media leads and legal.

7.19 Sharing the Overview report with the Safeguarding Adults Review group

Upon completion of the SCR process, the final draft Overview report will be presented to the Safeguarding Adults Review group at the next scheduled meeting (or sooner by arrangement). The group will then:

- Ensure that the Overview Report contains an Executive Summary that can be made public including as a minimum, information about the review process, key issues and recommendations. The content should be anonymised to protect the confidentiality of the adult and relevant family members/others.
- Draft actions arising from the Overview Report which are SMART and have been endorsed at senior level by each participating agency.
- Ensure that CQC receive a copy of the final report and action plan.

7.20 Sharing the report with the East Riding Safeguarding Adults Board

Arrangements will then be agreed with the SCR panel chair, overview report author and the chair of the East Riding SAB for the presentation of the report to the Safeguarding Adults Board meeting for approval and sign off and action to take forward its learning points and recommendations. This will be at the next scheduled meeting if the timing is appropriate, or alternatively at a pre-arranged extra-ordinary meeting. The board will task the Case review sub-group with:

- ensuring that the executive summary, recommendations and action plans are sent to individual agencies and other Sub-groups of the SAB for dissemination and implementation;
- monitoring the progress against all actions by partner agencies within the agreed timescales via regular monitoring update reports. Exceptions will be reported to the SAB Chair and the SAB if appropriate.

7.21 Monitoring the action plan

The SCR and action plan will remain in the SAB agenda until such a time that all the recommendations have been implemented. The responsibility will be on each agency to provide updates on progress at each Board meeting until the recommendation(s) have been fully implemented.

The action plans must have clear timescales and a named identified lead responsible for implementing the actions.

Throughout the whole process of the SCR, all appropriate agencies and individuals with a direct interest should be kept informed about progress, including victims and their families as appropriate.

7.22 Publication of the SCR

Given the focus on learning, the normal expectation is that the executive summary of each SCR would be published and thus become public documents. They must be anonymised before publication. The normal method of publication will be on the SAB website.

All SCRs conducted within the year should also be referenced within the Boards Annual Report.

8.0 Embedding the Learning from reviews

The purpose of a Safeguarding Adults review (using any method) is to learn and improve practice and services. It is essential therefore that the learning from reviews is widely disseminated.
All Safeguarding Adults review action plans should have a specific action setting out how the learning will be disseminated and embedded. In addition to this, the Safeguarding Adults review group will disseminate the learning more widely via; training & workshops, inclusion in annual reports and other reports, publication on the website and by ensuring individual agencies take responsibility for specific actions.