WIRRAL
SAFEGUARDING ADULTS
PARTNERSHIP BOARD

Safeguarding Adults Inter-Agency Serious Case Review Procedure

Version	**1.0**
Approved by	Wirral Safeguarding Adults Partnership Board
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Part 1

Safeguarding Adults Inter-Agency Serious Case Review Procedure

Part 2

Appendices

Safeguarding Adults Inter-Agency Serious Case Review Procedure

1. Introduction

1.1 The protection of Adults at Risk is a complex process which can involve a wide range of statutory, voluntary and private sector organisations. In common with all other areas in the country, Wirral has developed robust systems which are intended to ensure that protective measures for Adults at Risk are timely, effective and proportionate. The document Safeguarding Adults, published by the Association of Directors of 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 Partnership Board's should have in place a serious case review protocol.

1.2 The National Guidance suggests that local agencies should collaborate to achieve effective inter-agency working, through the formation of multi-agency management committees, known as Adult Protection Committees. One of the standards in the ADSS document is, 'There is a clear process for commissioning and carrying out of a serious case review by the partnership'. (Paragraph 9.10.15, Safeguarding Adults). It 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 homicide review should be clear. (paragraph 1.22).

1.3 This Serious Case Review (SCR) procedure and guidance, is a key part of this process of learning and development. It has been developed to:

a) 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 Adults at Risk
b) to review the effectiveness of procedures (Both multi-agency and those of individual organisations)
c) to improve practice by acting on learning (developing best practice)
d) to prepare or commission an overview report which brings together and analyses the findings in order to make recommendations for future action for an agency or and the Safeguarding Adults Partnership Board.

2. Purpose of Serious Case Reviews

2.1 The purpose of having a Serious Case Review is not to reinvestigate, nor to apportion blame, it is 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 Adults at Risk.

2.2 A Serious Case Review is not an inquiry into how an adult died or was abused. Neither is it a means of deciding who is culpable. These issues are a matter for other processes. A Serious Case Review is instead a process of critical and reflective learning designed to lead to improved outcomes for people who use services.

2.3 It is acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents e.g. a significant event review or root cause analysis. This protocol is not intended to duplicate or replace these. However, careful consideration will need to be given by the Safeguarding Adults Partnership Board, on how these different processes compliment the Serious Case Review procedure. The Board will need to agree on whether any of the separate agency reviews should temporarily cease or continue when there has been a decision to conduct a Serious Case Review.

3. Principles underlying Serious case Reviews

3.1 Unlike Serious Case Reviews established under Safeguarding Children regulations, a Serious Case Review which relates to an Adult at Risk, is not underpinned by statute or regulation. To that extent, it is a voluntary process.

3.2 However, all partners in the Wirral Safeguarding Adults Board, have agreed that they will fully co-operate with any Serious Case Review which is undertaken using these procedures.

3.3 On that basis, the following principles have been agreed in conducting Adult Serious Case Reviews:

- The process of Serious Case Reviews in Wirral. is fully endorsed by all members of the Wirral Safeguarding Adults Partnership Board
- Serious Case Reviews are conducted in a spirit of openness and honesty, to ensure that they are critical and reflective, and lead to improved outcomes for people who use services
- Serious Case Reviews should lead to improved outcomes for people who use services, and must therefore be underpinned by clear recommendations for action, which are monitored and fully implemented by the Safeguarding Adults Partnership Board

- Serious Case Reviews are one part of a wider system of scrutiny, which includes case audit, external evaluations and research, inspections, complaints and compliments.

4. Criteria for conducting a serious case review

4.1 A Serious Case Review should be considered when all of the following conditions are satisfied:

- An Adult at Risk has died, including death by suicide, or sustained a life threatening or life limiting injury; and
- Abuse or neglect is suspected or known to be factor; and
- There is a 'demonstrable concern' about multi-agency working.

4.2 Checklist for considering whether the criteria are met for referral

In those situations where there has not been a death of an Adult at Risk, the following checklist is a guide which can help determine whether a Serious Case Review should be conducted:

Was there clear evidence of a risk of significant harm to an Adult at Risk which:

- was not recognised by agencies / professionals in contact with the adult or perpetrator and / or
- was not shared with others and / or
- was not acted upon appropriately
- was related to adult abused in an institutional setting?
- Identified failings in the application of the Mental Capacity Act of either the adult or the perpetrator?
- was related to adult abused whilst being supported by the Local Authority or the NHS Trust?
- more agencies or professionals feel that their concerns were not taken sufficiently seriously, or acted upon appropriately, by another?
- indicated that there may be failings in one or more aspects of the operation of local Adult Safeguarding procedures, which go beyond the handling of this case?
- appeared to have implications for a range of agencies or professionals?
- suggest that the Safeguarding Adults Partnership Board need to change its protocols and procedures, or that these protocols or procedures are not being effectively used or acted upon?
- demonstrates that there are clear current organisational learning's identified.

5. Referring a case for consideration for a Serious Case Review

5.1 Any agency of the Local Safeguarding Partnership Board (LSPB), can request that a serious case review be initiated, having satisfied themselves that the criteria above has been met. An initial discussion with the referrer and the Head of Safeguarding Adults and Children, will assist in establishing if the case meets the criteria outlined in 4.1 and 4.2, and the case would have to demonstrate that there are clear current organisational learnings identified.

5.2 Once it has been established that a referral meets the criteria a formal request to the Chair of the Serious Case Review sub-committee must be completed using the referring letter (Appendix 1). The referrer must complete standard letter A and send it to the Chair of the Serious Case Review sub-committee for consideration within seven working days of the concerns being identified by the referring agency.

5.3 The chair of the Serious Case Review sub-committee will discuss each referral with the Independent Chair of the Safeguarding Adults Partnership Board to consider whether the Serious Case Review sub-committee needs to meet to establish whether to initiate the Serious Case Review process. The Serious Case Review sub-committee is established to assist in making a recommendation on each case it has referred, as often it is not definitely clear at the onset, whether a case meets the criteria and more information gathering can help establish this. The core Serious Case Review sub committee group will agree any additional members for the panel deemed relevant to the case.

5.4 The Serious Case Review sub-committee

5.4.1 The Serious Case Review sub-committee is a standing sub-committee, and reports directly to the Safeguarding Adults Partnership Board. It has a standing membership made up of key agencies within the Safeguarding Adults Partnership Board, with the authority to speak and make decisions on behalf of the agency / organisation they represent. The Serious Case Review sub-committee is made up of senior officer from each of the following agencies:

- Wirral Borough Council Adults Services
- Merseyside Police
- NHS Wirral
- Wirral University Teaching Hospital NHS Trust
- Cheshire and Wirral Partnership Trust
- Wirral Community NHS Trust

5.4.2 The purpose of the sub-committee, is to receive requests for consideration of Serious Case Reviews and to support the Safeguarding Adults Partnership Board and chair to make decisions, through a

recommendation, on whether the criteria has been met or not for Serious Case Review. Members of the Serious Case Review sub-committee may also be also be members of the Serious Case Review panel, as they may represent their agency / organisation for Serious Case Review's.

5.4.3 The Serious Case Review sub-committee will meet within 14 working days of initial consideration by the chair of the sub-committee to gather information on any case it has referred from agencies / organisations and support decision making against the criteria laid out by these procedures. Within four weeks from the first sub-committee formally meeting a recommendation should be made to the Safeguarding Adults Partnership Board chair whether the criteria are met, or if not, whether another type of review under Safeguarding Adults Partnership Board process may be more appropriate.

5.4.4 Members of the Serious Case Review sub-committee should be able to provide a brief summary report to this meeting re:

- Their agency's involvement with the adult and his or her family
- Their agency's knowledge of the details of the family composition
- Any relevant background information and the sources of that information
- Information about any other services known to have been involved with the adult and family
- Recommend membership of the Serious Case Review Panel if required
- Determine what arrangements are to be made to involve the family in the Serious Case Review
- Consider what should be the arrangements between the Serious Case Review and other statutory, criminal or internal investigations or enquiries
- Identify agencies and organisations which will be required to undertake Individual Management Reviews
- Make recommendations to the Independent Chair of the Safeguarding Adults Partnership Board.

6. Decision making

6.1 The chair of the Safeguarding Adults Partnership Board ultimately has the final decision whether a Serious Case Review is undertaken. This decision will be supported by the discussion with the Safeguarding Adults Partnership Board legal advisor and the chair of the Serious Case Review sub-committee, following a recommendation being received. This final decision should be made within two weeks of receiving the recommendation in writing with relevant minutes from the sub-committee to support information gathering.

6.2 In the event that the Serious Case Review Sub-committee concludes that a case does not meet the criteria for a Serious Case Review, the recommendations to the Chair of the Safeguarding Adults Partnership Board can be:

a) no review to be undertaken
b) a single agency review is undertaken
c) multi-agency case audit overseen by the Serious Case Review Sub-committee. Any outcome from this should be reported back to the Safeguarding Adults Partnership Board as part of learning lessons from cases to improve practice.

6.3 The Independent Chair of the Safeguarding Adults Partnership Board might conclude that the criteria for a Serious Case Review are not met, but might still determine that it would be valuable to undertake the aforementioned actions (a-c).

6.4 The Chair of the Safeguarding Adults Partnership Board will write to agencies involved with the case, including the referring agency, and inform them of whether a Serious Case Review is to be undertaken. Equally, if a decision is taken not to undertake a Serious Case Review and another form of review has been decided upon, this will need to be formally communicated to agencies / organisations identifying the reasons for this decision with two weeks of the final decision being made.

6.5 As soon as the chair of the Safeguarding Adults Partnership Board has made a decision to proceed with a Serious Case Review they will commission the creation of a Serious Case Review Panel whose role is to review the case. The Serious Case Review Panel is made up of agencies / organisations that have had involvement with the case and other Serious Case Review sub-committee agencies / members. (See below).

6.6 The Chair of the Serious Case Review Panel will arrange for the appointment of an Independent Author.

6.7 The Serious Case Review Panel

6.7.1. When a decision has been taken by the Independent Chair of the Safeguarding Adults Partnership Board that a Serious Case Review should be initiated, a Serious Case Review Panel should be set up. The Serious Case Review Panel's role is to undertake the review of the case in question. A Chair should be identified for the Panel, by identifying an agency that has not had direct involvement with the case, and is also a member of the Safeguarding Adults Partnership Board. The appointment of a Chair for the Panel should be endorsed by the Independent Chair of the Safeguarding Adults Partnership Board. The Panel representatives will be nominated by their agency through identifying:

a) they have sufficient experience in conducting Serious Case Review's or similar reviews within their own agency
b) they have not directly line managed any of the staff involved in the case, and
c) they are sufficiently senior within their organisations, to undertake the tasks required for any agency/organisation involved in a Serious Case Review.

6.7.2. The Panel will be supported by the Safeguarding Adults Partnership Board Manager. Secretarial support will be provided to this group, and other officers will be drawn in to support the Group as required.

The Serious Case Review Panel is responsible for:

- drawing up terms of reference for the case
- support the independent author in providing information and reports for the Overview Report for the Safeguarding Adults Partnership Board
- ensuring that timescales are agreed and that work is done in a timely way as agreed by the Safeguarding Adults Partnership Board
- identifying the individuals or organisations which will need to make submissions
- considering the time span to be covered by the Review, and the key issues to be considered
- ensuring effective liaison and information-sharing with any other reviews or legal processes on the same case
- obtaining legal advice as required
- problem solving as required in order to allow the Serious Case Review process to be completed within required timescales
- providing members who can actively obtain additional information that may be required to provide a full picture of the situation.

When a decision has been made to proceed with a Serious Case Review, the relevant regulatory bodies for each respective agency / organisation will be notified by the nominated lead. This will include the Care Quality Commission who will be notified by the Safeguarding Adults Partnership Board Manager.

Determining the scope and terms of reference for the review

Recent regional developments in Adult Serious Case Reviews have highlighted the need to be more flexible in the approach to completing Adult Serious Case Reviews. Developments are being made in the use of the SCIE model for Child Serious Case Reviews being utilised in Adult Safeguarding. At this stage in the development, it is recommended that Serious Case Review Panels consider which methodology will best suit the learning needs for the Safeguarding Adult Partnership Board. It was agreed that consideration will be given to the most relevant approach for each case and this section will be further developed to incorporate both the SCIE and Current Children's Serious Case Review.

7. Individual Management Reviews (IMR)

7.1 Once it is known that a case is being considered for review, each organisation should secure its records relating to the case, to guard against loss or interference. Once it is decided that a Serious Case Review will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a chronology of their involvement with the adult and family.

7.2 The aim of Individual Management Reviews should be to look openly and critically at individual and organisational practice, and at the context within which people were working, to see whether the case indicates that improvements could and should be made and, if so, how those changes can be brought about. The Individual Management Review reports should be quality assured by the senior officer in the organisation, who has commissioned the report and when they are satisfied that the findings are accepted. This senior officer will also be responsible for ensuring that the recommendations of the Individual Management Review and, where appropriate the overview report, are acted on.

7.3 Each agency will be asked to:

- prepare a chronology of events
- produce a report by the time agreed, sent from the agency's chief officer to the chair of the Serious Case Review Panel
- act on any recommendations from the Serious Case Review Panel
- ensure the management report, plus any other information identified as necessary, will be passed to the chair of the Serious Case Review Panel, who will convene a meeting of the panel including any co-opted members for this specific review
- The Serious Case Review panel will complete the review of agency management reports and reports commissioned from any other source, producing a short overview report, which brings together information from the reports, analyses findings and recommendations for future action.

7.4 The Chair of the Serious Case Review Panel

The Chair will be responsible for:

- identifying, with the Safeguarding Adults Partnership Board Manager, an independent author to complete the Overview Report-see below
- ensuring that the Serious Case Review is delivered within agreed timescales
- ensuring appropriate challenge to each of the bodies responsible for submitting any required reports to the Review

- reporting on progress on a regular basis to the Chair of the Safeguarding Adults Partnership Board
- ensuring that the recommendations for the Safeguarding Adults Partnership Board are produced into an action plan.

7.5 The role of the independent author for the Serious Case Review

7.5.1 The independent author appointed for the case will be accountable to the Serious Case Review Panel for the quality of their work and timescales. Timescales will be agreed between the Panel and the independent author in the first instance, taking into account individual agency progress and any other parallel processes. Delays will need to be agreed with the Safeguarding Adults Partnership Board and reasons for delays outlined to Board through the Safeguarding Adult Partnership Board Manager and the agency representative.

7.6 Involvement of family members and other interested parties

7.6.1 All agencies involved in a Serious Case Review will be expected to complete a detailed management report about their involvement. There are, however, few opportunities to gather the views and opinions of wider groups of people involved in the process. Family members may have a valuable perspective which can add to the learning, arising from a Serious Case Review.

7.6.2 As a general principle, the Independent Author for the Serious Case Review should make direct contact with any family members or other significant figures of the person concerned, to establish whether they wish to contribute to the Serious Case Review process, and to support that contribution where appropriate. Where appropriate, the support of an advocacy service should be considered for the family.

7.6.3 The exceptions to family involvement will be determined on a case by case basis.

7.6.4 If criminal investigations or proceedings are pending, or are being taken on the key family member involved in the review, then the principle of family involvement should still apply. However, the Serious Case Review Panel Chair will need to determine an interim solution for gaining family / interested party information which should be agreed by the Safeguarding Adults Partnership Board Chair.

7.6.5 If a decision is being considered to exclude a family member or significant other person from the process, legal advice should always be sought. The final report by the Independent author should include reference to whether or not the family have been involved, and how the decision was reached. The Serious Case Review Panel Chair will also undertake to feed back to family members / interested parties the lessons that have been learned and how they are being taken forward.

7.7 Costs of Serious Case Reviews

7.7.1 It is expected that no single agency will fully bear the costs of conducting a Serious Case Review, particularly when an Independent Author is commissioned, and that the responsibility for this will be shared with the other statutory organisations who are members of the Safeguarding Adults Partnership Board. The Safeguarding Adults Partnership Board will consider regularly how costs are apportioned and negotiate this with the partner organisations as the need arises.

8. Liaison with HM Coroners

8.1 Where a death of an Adult at Risk occurs, where either abuse or neglect are known or suspected to be a contributory factor in the death, the following action must be taken by the Safeguarding Adults Partnership Board before a Serious Case Review is commissioned:

- The police representative on the Serious Case Review sub-committee will contact the Coroner to identify whether an inquest will be or has been held; if one is to be held, the timescales for this will be established, and this will be reported to the Chair of the Safeguarding Adults Partnership Board
- If an inquest is to be held, the Chair of the Safeguarding Adults Partnership Board will notify the Coroner in whose area the death occurred, that a Review under the Safeguarding Adults Procedure Board procedures is being undertaken
- The Chair of the Serious Case Review Panel will forward to the Coroner, any terms of reference for the Serious Case Review that have been developed, and invite any comments from the Coroner, to avoid any conflicts between the two separate processes
- Should such a conflict be identified, a meeting may be held between the Coroner and the Chair of the Serious Case Review Panel to resolve any issues.

9. Communication with the Media

9.1 An event that is so significant as to result in a Serious Case Review may attract media attention. In the event of a Serious Case Review being commissioned by the Safeguarding Adults Partnership Board, a statement will be prepared by Press and Public Relations for the Independent Chair of the Safeguarding Adults Partnership Board.

10. Accountability and Reporting

10.1 There is no national standard reporting framework for Serious Case Review's on completion.

10.2 Each of the agencies involved will report directly to their own governing bodies on the findings of the Serious Case Review.

Template for Drawing up Terms of Reference

The panel should consider, in the light of each case, the scope of the review process, and draw up clear terms of reference). It may be useful for the panel to consider each of the following, indicating where an issue is not applicable and adding additional considerations where appropriate.

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?
Which of the criteria for a Serious Case Review appear to be met?
Who should be appointed as the Chair of the Serious Case Review Panel? Why?
Are there features of the case, that indicate that any part of the review process should involve, or be conducted by, a party independent of the professionals / organisations who will be required to participate in the review?
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 organisations and professionals should contribute to the review?
How should family members and significant others contribute to the review, and who should be responsible for facilitating their involvement?
Will the case give rise to ▪ criminal investigations undertaken by the police ▪ inquests conducted by a Coroner ▪ internal Serious Case Reviews completed by individual agencies ▪ Domestic Homicide Reviews How should the review process take account of a Coroner's inquiry, and (if relevant) any criminal investigations or proceedings related to the case? How best to liaise with the Coroner and / or the Crown Prosecution Service?

Who will make the link with relevant interests outside the main statutory Organisations, who are members of the Safeguarding Adults Partnership Board?
When should the review process start, and by what date should it be completed?
How should any public, family and media interest be managed before, during and after the review?
Does the Safeguarding Adults Partnership Board need to obtain independent legal advice about any aspect of the proposed review?
Other Considerations

Appendix 2

Wirral Safeguarding Adults Partnership Board

Serious Case Reviews

Practice Guidance and Template for Authors of Individual Management Review reports

1. INTRODUCTION

1.1 This Individual Management Review (IMR) is to be used whenever a Serious Case Review (SCR) has been commissioned by the Wirral Safeguarding Adults Partnership Board. The Individual Management Review process has been agreed by all agencies who are members of the Safeguarding Adults Partnership Board.

1.2 Although the Individual Management Review is lengthy and detailed, it is intended to provide a consistent approach to the gathering of information from all organisations involved in the care and support of the person, who is the subject of the Serious Case Review. To be effective, it should be used fully, but it also has substantial and helpful notes of explanation throughout.

1.3 If in any doubt about aspects of the Individual Management Review, organisations will have been told the name and contact details of the Serious Case Review Panel Chair, and are invited to contact this person for clarification. Reference should also be made to the Serious Case Review Policy and Procedure.

1.4 An Individual Management Review has three parts, each requiring a template to be completed:

- A comprehensive single agency chronology
- The main Individual Management Review
- Recommendations and Action Plans

2. The Individual Management Review (IMR) process

2.1 When a Serious Case Review is taking place, and an agency or organisation has been asked to submit an Individual Management Review report, these will only be accepted using the pro-forma Serious Case Review Template for authors of Individual Management Review reports. Please ensure that your Individual Management Review is compliant with the following:
All type must be Arial 12 apart from chronology and action plan, where font 10 is sufficient

- Address issues of diversity
- Include and consider the view and perspective of the person concerned if possible, and of any significant other person
- Ensure that the information provided is appropriately evidenced in the report.

2.2 When completing an Individual Management Review, the notes in the Template in blue and italics are there as support and guidance to authors.

They MUST be deleted before the report is submitted to the Serious Case Review Panel.

2.3 Please anonymise the Individual Management Review from the outset.

2.4 Organisations will receive letters from the Safeguarding Adults Partnership Board / Serious Case Review Panel which will detail three dates for submission:

- date for confirming the agency's involvement with the case and advising on who will be authoring the report;
- date for submission of a completed comprehensive chronology;
- subsequent date for submission of the remainder of the Individual Management Review report, including analysis, recommendations for action and a completed comprehensive Single-Agency Action Plan.

2.5 It is important that Individual Management Review authors do not assume that people who read their reports have any knowledge of the issues under examination. Consequently, it is important to ensure that the evidence, upon which conclusions and recommendations are drawn, is clearly stated. Do not use abbreviations, jargon or initials.

2.6 Those people who are completing Individual Management Reviews should not have been directly concerned with the person who is the subject of the Serious Case Reviews, or the immediate line manager of the practitioners concerned. If this is unavoidable, this should be made clear when the Individual Management Review is submitted.

3. Individual Management Review Template

3.1 The Template for the Individual Management Review appears below, and should be used fully. The document can be typed straight into and the guidance notes shown in italics should be deleted once each section is complete

Individual Management Review Report

This is the front sheet for the Individual Management Review report, and needs to be signed and submitted each time the Individual Management Review is amended

Serious Case Review in respect of	***Initials of person to whom Serious Case Review relates***
Date of Birth	
Date of Death or serious incident **Delete as appropriate**	
Author of IMR	***Please insert Name and Designation of report Author here*** Signature Date
Agency	**Name of agency Brief agency profile - what your agency does**
Quality Assured and Approved by	***Name and Designation of person quality assuring and signing off the report on behalf of the agency*** Signature Date
Date of Submission	***Date the report was submitted to Serious Case Review Group***
Date of revision	***Date revised version submitted if applicable***
Date of final Submission	***Date the final report was submitted, if applicable***

***GUIDANCE*: Please note that a final front sheet which is signed by the author and countersigning person will be required for the final Individual Management Review. Please ensure that the countersigning person has seen the Individual Management Review at each submission stage.**

TABLE OF CONTENTS

Section 1

Introduction *(why is this been done)*

GUIDANCE This is an example Introduction to the report. You do not have to use these phrases exactly, this example introduction sets out the rationale for an Individual Management Review. Continue to type in the box as you wish.

All Text Boxes expand to fit typed text

This Individual Management Review (IMR) report of (insert Name of the Organisation here), is produced in accordance with the Wirral Safeguarding Adults Partnership Board, (SAPB) procedure for conducting a Serious Case Review (SCR). It will form part of a multi-agency Serious Case Review Overview Report. This report has been prepared following a review of the (Insert specific agency and the service provided), to (insert name of subject of Serious Case Review). Its purpose is to look openly and critically at individual and organisational practice, to see whether the case indicates changes could and should be made, and if so, to identify how those changes will be brought about.

Section 2

Terms of Reference (what is the scope and remit of your report)

GUIDANCE

Cut and paste these in from the letter you received which requests an Individual Management Review. These have been approved by the Safeguarding Adults Partnership Board Chair, but it is possible that these will be amended by the Serious Case Review Panel in the course of the review.

The 'Terms of Reference' for the Serious Case Review are as follows: *Type your text in this box*

Section 3

Author's Details *(your details)*

GUIDANCE You should use this section to state what your role is, how this equips you to undertake this review, and clarify that you do not have any operational involvement in the case.

Type your text in this box

Section 4

Methodology *(how you did your review)*

GUIDANCE Please explain how you did your report here. List the sources of information that your agency has used to compile your report. This might include paper records, IT systems searched, computer records, supervision notes etc. It should also include some details about staff that have been interviewed as part of this review, or if not why not. Please say if files could not be found and why. Also use this section to include list of abbreviations / codes used (for names etc)

The following sources of information regarding (insert Name of Subject(s) here) have been used to inform the report:

Type your text in this box

Section 5

Household Composition as known to the agency *(who lived at the address)*

GUIDANCE Please use this section for the household details as known to your agency. If your agency is not aware of any of the information below please specify as 'not known'. Please add additional people to list below as needed.

Anonymised Name	Relationship to subject (if applicable	Date of Birth	Address	Ethnicity or diversity needs

Section 6

Comprehensive Chronology *(what was your agencies involvement with this Adult and their family)*

GUIDANCE Construct a comprehensive chronology of involvement by the agency and / or professional(s) in contact with the person who is the subject of the Serious Case Review over the time period set, and in light of the 'Terms of Reference' for this Serious Case Review.

Agencies are expected to provide a detailed chronology of their involvement including information about when the person was seen, details of that contact and relevance to the Terms of Reference. Also, please briefly summarise decisions reached, the services offered and / or provided to the person and other action taken.

Please note, the chronology should be created separately from your Individual Management Review and should be the first thing you do. You are asked to submit it separately from the report as it needs to be collated with other chronologies for the combined chronology. However, it should also be inserted in to the report at the relevant point.

You will be required to submit a completed chronology BEFORE the other sections of the Individual Management Review report.

Date	Time	Source of info	Subject of reporting	Event/ descriptions/actions outcomes	Expected standard/Practice	Person seen Yes/No

Section 7

Narrative (tell the story)

GUIDANCE This section should bring the chronology to life and tell the story of the person's involvement with your agency. This section will also include a description of the key events, highlighting concerns, omissions and good practice.

Type your text in this box

Section 8

Critical Analysis *(did your agency do the right thing?)*

Guidance

In this section, the author must review the information in the comprehensive chronology and produce a critical analysis. The information provided and the analysis should be appropriately evidenced and explicitly linked to each Terms of Reference.
Please ensure to clearly specify if any of the Terms of Reference are not relevant to your agency and / or service and the reasons why. Using the Terms of References as headings, may be a good way to construct your critical analysis, learning and recommendations. The report should focus on the person subject to the Serious Case Review, and explicitly address issues of diversity. The author must consider how the services offered, took account of the person's individual needs, and were sensitive to their Race and culture, Age, Disability, Faith, Gender, Sexuality and Economic Deprivation.

- Please make sure to answer to the following questions:
- Does your agency routinely collect this information?
- Does your agency use this information in assessments?
- Have you any evidence that these have been taken account of in the delivery of a service to the person concerned?

Practice at individual and organisational levels must be openly and critically analysed against national and local statutory requirements, professional standards and current procedural guidance.

- Were existing internal policies and procedures adhered to?
- Were Safeguarding Adults Procedure Board or multi -agency policies and protocols adhered to?
- Consider the actions take (or not taken) against the person's needs and the agency's safeguarding duties?
- How did the person feel about the service being offered?
- Do their decisions and actions adhere to current best practice, national guidance and your agencies professional standards?
- Where research is available on the issues being addressed, how the actions in this case compare to research findings?
- Where decisions and actions did not adhere to duties, policies and procedures guidance and professionals standards, analyse what staff practise and organisational factors contributed?

Your analysis should reflect willingness by your agency to challenge practice and address wider agency responsibility. Please focus attention on why procedures were not followed, as well as identify what procedures had been followed or were lacking. Good practice should be highlighted and areas for change in practice must be clearly identified. Where practice has changed

from that detailed in the chronology, i.e. new service or revised procedures, this should be explained in the report.

Additional considerations to support analysis: Consider the events that occurred, the decisions made, actions taken and actions not taken. Where judgments were made or actions taken that indicate that practice or management could be improved, try to get an understanding not only of what happened, but 'why'. Consider the context in which decisions were made and what was going on in your agency at the time which may have influenced decision making.

Consider specifically:

- When and in what way were the person's wishes and feelings heard and addressed? Was this information recorded? How was this responded to by your agency? This is particularly important to include in your review report.
- Were practitioners sensitive to the needs of the person in their work?
- Knowledgeable about potential indicators of abuse or neglect and about
- What to do if they had concerns?
- Did the organisation have in place policies and procedures for
- safeguarding and promoting the welfare of Adults at Risk, and acting on concerns about their welfare? If not, this needs to be addressed in your report. Were these adhered to? If not, why not?
- What were the key relevant points / opportunities for assessment and decision making in this case in relation to the person? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? If not, why not?
- What are the management support systems like? Are training, supervision, administrative and recording systems satisfactory?
- Do previous serious case reviews undertaken by the agency have similar issues raised? What progress has been made with actions identified in past serious case reviews and consider if practice has changed
- Constructive use of hindsight will benefit the analysis.

Critical Analysis- Report

Section 9

What do we learn from this case? *(What could we do better?)*

Guidance

Following on from the critical analysis section previously, the author should identify specific lessons which his / her agency can learn from the case. These can include areas of good or poor practice identified, as well as ways in which practice can be improved. Relate the answers to the terms of reference.

Lessons can be learnt, from both good or poor practice.

Every area identified in section 5 where practice requires improvement should have a corresponding lesson learned in this section.

Every lesson learned and identified should have a corresponding recommendation in section 9.

- Have lessons from this case been identified for the way in which the organisation works to safeguard and promote the welfare of Adults at Risk?
- Is there good practice to highlight as well as ways in which practice can be improved?
- Are there implications for ways of working: training (single and multiagency), management and supervision, working in partnership with other organisations, resources, policies and procedures, resources (financial, human assets, or technological).

Please note that this section will inform the subsequent section on recommendations for action.

Lessons Learnt

Section 10

Recommendations for Action and Single Agency Action Plan

(how will we do it better and by when)

Guidance

Recommendations for action must flow from the previous 'What do we learn from this case?' section. Any recommendation about improving or developing new procedures should be specified in terms of the expected practice outcomes and followed through to ensure it happens. Individual agency recommendations for action contained in this Individual Management Review report will be considered by the Serious Case Review Panel for inclusion in the Overview Report. The Serious Case Review Panel may also recommend further actions for your agency to be included in the Overview Report. You should add as many actions for your agency as necessary.

Please note that any individual agency recommendations not included in the Overview Report are expected to be acted on within individual agency governance arrangements. Recommendations for action must be included in the Single-Agency Action.

Plan Template and the Template needs to be fully completed in order to be clear about:

- What action should be taken, by whom and by when?
- What outcomes should these actions bring about, and how will the organisation evaluate whether they have been achieved?

Action Plan Template

[PERSON'S INITIALS] – SERIOUS CASE REVIEW – [AGENCY NAME]
Lead Person: [NAME]

No	Recommendation	Key Actions	Evidence	Key Outcome	Lead officer	Date
1	*As they are written in section 9*	*Indicate the actions or series of actions to be taken to achieve the expected outcomes.*	*Describe the evidence you will provide to the Board to show the actions are being undertaken or achieved*	*What improvements in service and adult safeguarding should result from actions*	*Designation of lead officer charged with implementing the actions*	*Date by which actions will be completed*
2						
3						

Add additional rows as required. All Text Boxes expand to fit typed text

Appendix 3

Serious Case Reviews

A Guide for Professionals Involved in a Serious Case Review

1. What is a Serious Care Review?

The protection of Adults at Risk is a complex process which can involve a wide range of statutory, voluntary and private sector organisations. In common with all other areas in the country, Wirral has developed robust systems which are intended to ensure that protective measures for Adults at Risk are timely, effective and proportionate.

The document Safeguarding Adults published by the Association of Directors of Social Services (ADSS) October 2005, provides a National Framework of Standards for good practice and outcomes in Safeguarding Adults work. One of the standards in this document states that, as good practice, Safeguarding Adults Partnerships Board's should have in place a serious case review protocol.

1.1. Purpose Of Serious Case Reviews:

The purpose of having a serious case review, is not to reinvestigate or to apportion blame, it is 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 Adults at Risk. A Serious Case Review is not an inquiry into how an adult died or was abused. Neither is it a means of deciding who is culpable. These issues are a matter for other processes. A Serious Case Review is instead a process of critical and reflective learning designed to lead to improved outcomes for people who use services.

2. What is the Safeguarding Adults Partnership Board?

The Safeguarding Adults Partnership Board is a committee which is formed in each Local Authority and brings together senior representatives from each of the agencies involved in safeguarding Adults.

The responsibilities of the Safeguarding Adults Partnership Board include:

- To develop and agree local Safeguarding adults policies
- To Audit and evaluate how well services work together
- to protect Adults at Risk
- To agree objectives and performance indicators for
- Safeguarding adults
- To encourage and develop effective working
- Relationships.

3. When will I know the outcome of the Serious Case Review?

Once the Safeguarding Adults Partnership Board have considered and accepted the Overview Report, the Manager from your agency will contact you to give you feedback.

4. Can I see the Overview Report?

Once the Safeguarding Adults Partnership Board have approved the Overview Report, an Executive Summary will be prepared which includes an analysis, conclusions and recommendations. A copy of this will be given to you by the manager in your agency. The manager who completed the Management Review for your agency should be able to share with you directly and it should be possible for you to have sight of the overview report.

5. Will anyone else see the report?

The Executive Summary will be a public document. Publication will be timed in accordance with the conclusion of any related Court proceedings.

6. Will I be named in the report?

No, nobody will be identified. Staff involved will be given an identifying number, e.g. HV1 for Health Visitor 1.

7. Can I disagree with the Manager's findings?

Not usually. If you disagree with the notes of your interview you should send your comments to the Manager in writing.

8. Is this process part of the Disciplinary Procedure?

No.

9. Will disciplinary action be taken against me?

If the outcome of the Management Review finds that policies and procedures were not followed, or other shortcomings were identified, there may be the possibility that action will be taken. In these circumstances, you should refer to your agency's disciplinary procedure, and seek advice from your union or professional body representative.

10. What happens next?

A multi-agency chronology and Overview Report will be prepared. The chronology details contacts with the Adult/family by all agency staff. The overview report is commissioned by Safeguarding Adults Partnership Board. It brings together all the individual agency Management Reviews, analyses the findings of the Management Reviews and makes recommendations for future action. To undertake Serious Case Reviews and review Deaths of Adults at Risk where abuse is or suspected as being a factor in the death. To ensure that multi-agency Safeguarding Adults training is provided.

11. How long will a Serious Case Review take?

The guidance sets out a timescale of 4 months for the review to be completed. However, sometimes criminal proceedings can delay the process. The manager conducting the review will be able to give you some indication of the timescales involved.

12. Why were my records/files removed?

To prevent any loss or interference, and to inform a Management Review which will be undertaken. You will be given a copy of the records if you are still working with the Adult at Risk or for future reference.

13. What is Management Review?

A Senior Manager from your own agency will conduct a Management Review, using the guidance from Safeguarding Adults Partnership Board Serious Case Review Policy and procedure. The aim of the review, is to look openly and critically at individual and organisational practice to determine whether changes could or should be made. You will be interviewed as part of this process. Your Manager and colleagues may also be involved.

14. Who will interview me?

The Senior Manager conducting the Management Review for your agency.

15. What will the senior manager be looking for and what will I be asked?

As per the guidance in Safeguarding Adults Partnership Board Serious Case Review Policy and procedure, the Manager will have to construct a chronology of involvement by you and other staff within your agency, over the period of time under review.

The manager will also consider:

- The events that occurred
- The professionals involved
- The actions taken, or not
- The decisions taken
- Whether policies and procedures were followed
- Whether appropriate services were offered
- Whether the Adults wishes and feeling, racial, cultural, linguistic and religious circumstances were taken into consideration.

The manager may also ask about your qualifications and experience, the training you have received and your supervision arrangements.

Notes will be taken at the meeting and a copy of what you have said can be sent to you if you wish. This will give you an opportunity to request any amendments. These findings will be reported in a Management Review report.

16. Can I have somebody with me when I am interviewed?

Yes. A friend or colleague can be present. Their role is to support you, not represent you.

17. What other form of support will I be able to have?

This can be a stressful time, and you may like to talk to somebody about your feelings and about what has happened. The Manager undertaking the review should tell you about the support arrangements within your agency, if they don't tell you please ask.

18. Is everybody interviewed?

Usually everybody is interviewed, but it will depend on a number of factors, e.g. the length and nature of their involvement.

Standard Letter A

Request for Serious Case Review consideration

to Chair
Wirral Safeguarding Adults Partnership Board

date

your ref
my ref SCR/
service
tel
Please ask for
fax Your fax number
email

Dear

Re: Serious Case Review Request

In Line with the Wirral Safeguarding Adults Partnership Board Serious Case Review Policy and Procedure, I wish to request that the case of *Insert Adults Name* be considered for a serious case review.

Adults Name *(insert details)*
Adults DOB *(insert details)*
Adults Address *(insert details)*

It is felt that the case of *Insert Adults Name* meets the criteria for consideration for a serious case review due to the information presented below:-

Details of case that give course for concern:-
(insert details)

Yours sincerely
(insert your name)

Appendix 5

Standard Letter B

to Chair
Wirral Safeguarding Adults Partnership Board

date

your ref
my ref SCR/
service
tel
fax Your fax number
email

Please ask for

Dear

Re: Serious Case Review Group – name of Adult at Risk

The Serious Case Review group has considered this case, to see whether it meets the criteria to initiate a serious case review. The group feels that this case does / does not meet the criteria to commence a Serious Case Review.

We would be grateful for your decision.

Yours sincerely

Chair
Serious Case Review Group
Enc

Need password protect policy
Need guidance on font and size for Individual Management Reviews to fit with Overview report.