Sandwell Safeguarding Adults Board

Serious Case Review Process

Author: Protection Sub Group
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Amended 10th June 2011

Sandwell Safeguarding Adults Board

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INTRODUCTION

When a Vulnerable Adult either-

- dies
- suffers life threatening injuries
- or serious harm

and abuse or neglect are known or suspected to be a factor there is a requirement that a process should be followed in order that lessons can be learned by examining a case and the way it was handled by different professionals. This is the Serious Case Review (SCR) Policy.

Agencies should consider whether there are any lessons to be learned from the death/serious incident about the ways in which they work together to safeguard vulnerable adults. Consequently, when a vulnerable adult dies in such circumstances (which are detailed later in this Section), the Sandwell Safeguarding Adults Board (SSAB) should conduct a SCR into the involvement of each Agency with the adult and their family.

In order that there is a consistent approach a SCR Policy is required and this Chapter sets out how this process will operate in Sandwell. The basis of this policy is contained in the following documents-

- No Secrets (Department of Health 2000)
- The Association of Directors of Adult Services (ADSS) Protocol for Inter-Agency Investigations of Vulnerable Adult Abuse (Feb 2004)
- Safeguarding Adults Guidelines published by ADSS-National Framework of Standards (October 2005)
- ADASS advice in the preparation of Serious Case Review Policies and procedures (March 2007)

The purpose of a SCR is to-

- Establish whether there are lessons to be learned from the case in which local professionals and agencies work together to safeguard vulnerable adults.
- Identify what those lessons are, how they will be acted upon and what is expected to change as a result within a given timescale; and as a result to improve practice.
- Inform and improve local inter agency working
- Review the effectiveness of procedures (both multi agency and those of individual organisations) and make recommendations for improvement.

- To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to identify the learning points and make recommendations for future action.

SCRs are not enquiries into why an adult dies or who is culpable. These are matters for the Coroner's Court, Criminal Courts and employment procedures as appropriate.

SCRs are not disciplinary proceedings and should therefore be conducted in a manner which facilitates learning and appropriate arrangements must be made for support of those staff involved.

SCRs can uncover evidence that has not come to light during other investigations and the SCR Panel may need to decide how this new evidence will be addressed.

The SCR process has been divided into the following 4 stages -

STAGE 1 - Criteria for Serious Case Review

The SSAB has the lead responsibility for conducting a SCR. When more than one Safeguarding Adults Board has knowledge of a Vulnerable Adult, the Board for the area in which the adult is/was normally resident should take lead responsibility for conducting any Review. Any other Boards that have an interest or involvement in the case should be included as partners in jointly planning and undertaking the Review. A SCR should be considered if one of the following criteria are met-

- When a vulnerable adult experiencing abuse or neglect dies (including suicide), or it is suspected that abuse or neglect contributed to or was a factor in their death. In such circumstances the SSAB should always conduct a review into the involvement of agencies and professionals associated with the vulnerable adult.
- When a vulnerable adult has sustained a potentially **life threatening** injury through abuse, neglect, sexual abuse or sustained serious or 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.
- It is suspected that a lack of clear process and procedure (in any organisation) may have contributed directly or indirectly to the circumstances leading to the death or serious harm where a vulnerable adult was involved.
- The failure of staff to act may have contributed to the death of a vulnerable adult or to them sustaining a life threatening injury.
- Where serious abuse takes place in an institution or when multiple abusers are involved

- Any case(s) where the SSAB agree there is a specific need to carry out a review.

How to make a Referral

Any agency or professional can request a SCR by written representation to the Chair of the Protection sub-Group with a copy to the Chair of the SSAB and to the Sandwell Safeguarding Adults Manager. The referral must include all relevant details about the vulnerable adult(s) and the particular circumstances giving rise to the request. A SCR Referral form is available in the Appendices.

The SCR Protection sub-Group will consider the case to see if it meets the criteria for a SCR. This will allow for a multi agency discussion of the case, to examine whether there are lessons to be learned by conducting a full SCR, or whether some form of review is required but in the form of, for example, a Single Agency Independent Management Review. Following a consideration of the circumstances of the case the Chair, who will be independent of all Statutory Agencies in Sandwell, will make a decision-

1. The criteria has not been met and the request denied.

2. The SCR criteria has been met and should proceed.

Referral Denied

In the event of a request being declined, the reasons need to be recorded in writing and shared with the referrer and the SSAB. In such circumstances, the Chair of the Protection sub-Group could request a service to conduct a Management Review relating to this case/situation.

Management reviews are reviews undertaken by a single agency/organisation and are a critical analysis of that organisation's management of the case. Management reviews must also always identify lessons the organisation has learnt from the review and the actions they intend to take to address them. Management reviews will be reported through the Protection sub-Group

Referral Accepted

In the event of a request being accepted, the Chair of the Protection sub-Group will:-

1. Notify the referring agency and all constituent agencies.
2. Notify all Board members that a SCR has been accepted.
3. Set up a SCR Panel, with appropriate membership dependent on type of case referred, and appoint an Independent Chair/Author.
4. Organise for all records, from all agencies involved, to be secured.

5. Where applicable notify the victim and/or their family as appropriate.
6. Inform the Care Quality Commission.
7. Notify other Safeguarding Adults Boards who have an interest in the case that Sandwell is conducting a SCR.

Once a SCR has been accepted, no member agency should comment publicly upon the case without the express agreement of both their senior management and the Chair of the SSAB.

Serious Case Review Panel

The Panel should be selected on the basis of independence of the immediate management of the case under review. The Panel should be made up of a minimum of four senior officers from statutory agencies, e.g.

- Black Country Partnership NHS Foundation Trust
- Sandwell and West Birmingham Hospitals NHS Trust
- Sandwell MBC (Adult Services)
- Sandwell Primary Care Trust
- Staffordshire and West Midlands Probation Trust
- West Midlands Police

A Chair/Author will be commissioned to lead the SCR. This person will be independent of all Agencies in Sandwell. This person will require administrative support which will be the responsibility of the Main Safeguarding Board

The Serious Case Review Panel (SCRP) will have the following responsibilities from the outset:-

- Establishing individual terms of reference
- Setting timescales in line with these procedures. Dates and times of the meetings will need to be fixed at the outset of the process
- Identify the agency reports required and notify the Chief Officers of those organisations.
- Identify the "evidence" required from each organisation/agency
- Identifying whether there are any other processes ongoing or plan and notify the relevant individuals/bodies or the plan to initiate a serious case review.
- Establish links with Police, CPS and/or Coroners where parallel investigations are taking place/will need to take place.
- Agree the nature and extent of legal advice required, in particular; Data Protection, Freedom of Information and Human Rights Act.
- Develop and co-ordinate a Communications Strategy to ensure that the lessons learned can be shared and made public-responsibility of SSAB
- Ensure an overview report is completed within agreed timescales which will require presentation at a SSAB meeting.

- Consider how families can be involved in the case review. Each case is unique and it is therefore is important that careful consideration is given to the best means of achieving this.

Terms of Reference

Better outcomes can be achieved if all the individual management reviews address the same questions and issues relevant to the case review being undertaken.

Time spent on this part of the process is crucial and will affect the quality of the individual management reviews and ultimately the overview report.

The terms of reference must be robust and **SMART** -

SPECIFIC-Set out exactly what should be done. This is usually one action
MEASURABLE-will describe the result which is to be achieved, answering questions such as how much, how many or how well.
REALISTIC-Take into account what is possible in the real world
ACHIEVABLE-Can this be done and can the Adult to whom the recommendation is addressed achieve the required outcome
TIMELY-Setting timescales that are achievable and realistic(Specific, Measurable, Realistic, Achievable, Timely). It is important that all agencies are very clear about the scope of the review and key issues to be investigated with specific timescales.

The terms of reference should identify:-

- What appear to be the most important issues to address in trying to learn from this specific case.
- Which agencies and organisations are needed to contribute and who else should be asked to submit reports or contribute to the process.
- The means by which non-professionals should contribute to the reviews.
- The time period - i.e. how far back should enquiries cover and what the cut-off point is.
- What family history/background will help better to understand the recent past and present.
- The evidence required to support the report.
- How decisions were made when, by whom and reasons for these actions.
- Policies and procedures required, does the agency have them and if they were followed.
- Training required, was it provided, when and by whom.
- What risk assessments were conducted, when and by whom.
- What assessments were carried out, how were assessed needs met
- Resource issues, the context and how resource issues were addressed.

- Any racial, cultural, linguistic or religious identity and how these were met.
- Senior management knowledge and decisions surrounding this case.
- Inter agency working.
- The need for a coordinated approach if other parallel enquiries, such as Coroner's Court, Crown Prosecution etc, are being conducted or if other Safeguarding Adults Boards have an interest.

Individual Management Reviews will be requested using a standard letter from all the organisations involved. The Individual Management Reports will be required to address all the issues within the terms of reference, including the timescales. The terms of reference will inform organisations of the information required.

STAGE 1 MUST BE COMPLETED WITHIN FOUR WEEKS

STAGE 2 - Individual Management Reviews

The aim of Individual Management Reviews is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be brought about. They must include a conclusion with identified lessons the organisation has learnt from the review and the actions they have taken or intend to take to address them.

Reports should be prepared by a senior officer and should provide a critical analysis of the organisation's management of the case. Where this creates difficulties, particularly for smaller organisations, the senior officer should be independent of the case and the Practitioner. The authors should make this clear in their IMR and document their efforts to provide some independence into the process.

The reports must be written using the template provided. Using the template will make it easier for the Panel to compare information under the headings provided.

The report must include:-

- Background to the referral
- Individuals the organisation/agency liaised with during the period of the work
- A chronology (template in the appendices) of significant events highlighting any discrepancies.
- An analysis of the organisation's practices
- An assessment of whether procedures were followed

- The organisation's/agency's summary of findings
- Any initial and ongoing risk analysis of the case
- Any identified lessons the organisation has learnt from their review and the actions they have taken/ intend to take to address them.
- Recommendations.

Reports such as Health Trust 'Serious Incident Reports', complaint reports etc may be combined with the Individual Management Reviews so long as they are relevant to the Terms of Reference.

Individual Management Reviews must be signed off by the appropriate Senior Officer of each organisation.

(Detailed guidance re IMRs are included in the appropriate Appendix)

Involving Victims/Families/Significant Others

The SCR Panel must have considered the degree to which victims/families will be involved in the review and how families will be informed of this review.

Normally victims/families (family members who have played a significant role in the life of the service user) should be notified that the case review is taking place. Involvement can be:-

- Formal notification only
- Inviting them to share their views in writing or through a meeting.

The timing of such notifications is crucial particularly where there are Police Investigations. Under these circumstances, the decision about when to notify needs to be taken in consultation with the police.

STAGE 2 MUST BE COMPLETED WITHIN EIGHT WEEKS AFTER STAGE 1

STAGE 3 - Panel Meetings

The purpose of the Panel and its meetings is to:-

- receive individual management reports
- cross reference information within the reports
- identify any omissions or discrepancies between reports
- collate a comprehensive chronology
- examine and identify relevant action points
- form a view on practice and procedural issues

- agree the key points to be included in the overview report and the proposed actions.

The process will normally take four separate steps.

1. Receiving reports and reading
2. Report presentations
3. Debating the findings and agreeing the issues
4. Agree the overview report.

Step 1 – Receiving Reports and Reading

All Panel members will have two weeks to read all the individual management reports before the presentation meeting.

Step 2 – Presentation meetings

- Individual management review authors will present key findings.
- This meeting provides the opportunity for omissions to be clarified, discrepancies in reports to be addressed and any other questions to be answered.
- Panel members should take this opportunity to fully understand all the issues central to this review.
- It is the first point at which key inter agency practice issues begin to emerge.
- In certain circumstances it may be appropriate for Officers presenting their IMR to remain to allow discussion between individual authors

Step 3 – Debating the findings and agreeing the issues

The purpose of this meeting is for Panel members to discuss and debate the findings and agree the overall issues and make recommendations. At the conclusion of this meeting, it is essential that the Chair is clear on the overview of the case, lessons learned and recommendations for the Board.

Step 4 - Agreeing the Overview Report

The purpose of this meeting is for the Panel to approve the draft overview report for presentation at the SSAB.

A copy of the draft Overview report should be sent to all agencies involved in the process for them to comment on any inaccuracies or concerns within seven days. This is to ensure that contributing agencies are satisfied that their information is fully and fairly represented. If an agency/organisation disputes the contents of the report the Panel will need to be reconvened to consider their representation. If the Panel decides not to change the report a note must be

made in the report of which organisation disagrees with the report, what they are disputing and why changes were not made to the final report.

Overview Report

The Overview Report, written by the Independent Author, is compiled using the template within the appendices on behalf of the SSAB and:

- summarises the case
- identifies lessons to be learned
- sets out recommendations
- contains an Executive Summary

The Overview Report aims to bring together the management reports and critically analyse the information and judgements within those reports.

The Overview Report should provide sufficient information for the reader to understand the sequence of events. It is vital that the recommendations in the Overview Report are few, focussed, and SMART (Specific, Measurable, Achievable, Realistic and Timely). These should fundamentally be multi agency recommendations and the severity of the recommendations will be identified by the timescales.

10 Executive Summary

The Executive Summary will be a public document and must be short, anonymous and based on the Overview Report. It should contain

- Purpose and scope of review
- Outline of review process including organisations involved
- A brief outline of the circumstances which led to the review
- A succinct account of inter agency practice issues identified
- Intended actions

STAGE 3 MUST BE COMPLETED WITHIN EIGHT WEEKS AFTER STAGE 2

STAGE 4 - Safeguarding Adults Board Meeting

It is the responsibility of the Chair of the Protection sub-Group to inform the chair of the SSAB in advance when the overview report is likely to be final so that a Board meeting can be set up to consider the findings.

It is likely an Extraordinary Board Meeting will need to be set up to consider the report and agree actions.

It is the responsibility of the Independent Author of the Serious Case Review to formally present the report in a draft form to the Safeguarding Adults Board. This would allow the main Safeguarding Adults Board to make comments and indicate actions they would recommend as a result of the Serious Case Review.

This meeting must allow sufficient time for discussion amongst Board members on the case and to secure their commitment to implementing the reports recommendations.

After the Main Safeguarding Board has met and made a decision about the recommendations representatives of the Protection sub-Group will write the Action Plan based on the Overview report and any additional comments made by the Main Safeguarding Board. These representatives will form the Action Plan Group and are likely to be the same Officers that comprised the SCR Panel. This Action Plan Group would be responsible for the overseeing of the Action Plan and to ensure that Officers carry out actions in the specified time period. The Action Plan should indicate:-

- Who will be responsible for various actions
- Timescale for completion of actions
- The intended outcomes of various actions and recommendations
- The means of monitoring and reviewing intended improvements in practice and/or systems (use of traffic light system)
- Clarify to whom the reports or parts of the report should be made available and indicate the means by which this will be carried out
- Dissemination of the report and/or key findings to partner agencies.
- The SSAB will ensure that all recommendations are actioned and will request updates from agencies.
- The action plan will remain on the SSAB Agenda until all actions have been implemented.

The Protection Officer in the Safeguarding Team will be responsible for co-ordinating this Action Plan, chairing the subsequent meetings, reporting to the Main Safeguarding Board and ensuring actions are completed.

Once the Draft Overview Report has been presented to the Main Safeguarding Board and recommendations accepted the Chair/Author will be responsible for writing the Final Overview Report and an Executive Summary which is a public document. Once both reports have been presented to the Main Safeguarding Board by the Chair /Author the Executive Summary will be made available on the Safeguarding website.

De-briefing

All organisations must arrange for practitioners directly involved in the case to receive feedback once the SSAB has approved the report and action plan in advance of wider dissemination.

It is also important that the victim/family should be notified of the outcome even if they did not want to be involved in the process initially. This may involve the arrangement of meetings between a Senior officer from an Organisation with a relative/s.

It is vital that as much time is spent on the above process as is on the work in the preparation of the Overview Report. The purpose of carrying out a SCR is to learn lessons locally for Sandwell and possibly nationally. It is essential that the main Safeguarding Board takes full responsibility for learning lessons from the outcomes of a Serious Case Review.

ALL STAGE 4 MUST BE COMPLETED WITHIN FOUR WEEKS OF STAGE 3

Communications Strategy

The SSAB should consider carefully who might be interested in the outcome of reviews – elected members, staff, victims and their families, the public and media – and what information should be made available to each of them.

In making decisions about this, the board will need to balance the following considerations.

- The need to maintain confidentiality in respect of information contained within reports.
- The accountability of public services and the importance of maintaining public confidence in the process.
- The need to secure full and open participation from the different agencies and professionals involved
- The responsibility to provide relevant information to those with a legitimate interest.
- Constraints in sharing information when criminal proceedings are outstanding. Some information will not be able to be shared. It is therefore important to anticipate requests for information and plan in advance how they should be met.

In all cases the SSAB Overview Report should contain an Executive Summary that will be made public, which includes as minimum, information about the SCR process and key issues that have arisen from the case and recommendations that have been made. Such publication will need to be timed in accordance with the conclusion of any related court proceedings. The content will need to be suitably anonymised in order to protect the confidentiality of relevant family members and others.

It is vital that as much time is spent on the above process as is on the work in the preparation of the Overview Report. The purpose of carrying out a SCR is to learn lessons locally for Sandwell and possibly nationally. It is essential that the main Safeguarding Board take full responsibility for learning lessons from the outcomes of a Serious Case Review.

The Main Safeguarding Board will ensure that there is a clear communications strategy and if there is public interest in the case a statement should be prepared in advance of publication of the Executive Summary. Some cases that are subject to a SCR may attract media attention and it is essential that all Agencies on the Main Safeguarding Board are clear regarding the content of the Executive Summary, its recommendations, and actions taken

Referral – Serious Case Review

Any agency or professional can request a Serious Case Review by completing this form in full and sending it to:

Chair of the Sandwell Safeguarding Adults Board	Copy to Sandwell Safeguarding Adults Manager

Person/Organisation making referral:
Person/Organisation name and contact details: Name: Address: Email/Tel:

Vulnerable adult(s)/service user details: Name: Address: Date of Birth:

Criteria for review– please tick box

☐ Vulnerable adult experiencing abuse or neglect dies

☐ Vulnerable adult has sustained a potentially **life threatening** injury or sustained serious or permanent impairment

☐ Multiple vulnerable adults or from multiple perpetrators

☐ Concerns about the way in which local professionals and services work together

☐ Public interest issues.

Detail reasons for request

Team(s)/organisation(s) known to be involved

Signature:
Date:

Serious Case Review letter template to request IMR

Date

Dear >>>

Re: Serious Case Review – >>>

I am writing to inform you that the Sandwell Safeguarding Adults Board decided that a Serious Case Review should take place regarding the above named person.

A decision was made by the Sandwell Safeguarding Adults Board on >Date> to undertake a Serious Case Review to see what lessons could be learned by all agencies. Preliminary investigations suggest there were some general concerns about the standard of care >>>> and multi agency working.

As you may be aware, that unlike the safeguarding of children, there is no statutory guidance about Serious Case Reviews for adults but holding a Review is regarded as good practice. We are keen in Sandwell that we follow best practice guidance and use this opportunity to learn how to do things better. We hope you will join us in this learning process. Please find attached a copy of Sandwell's Serious Case Review procedures.

What is requested from you is the production of an Individual Management Review Report (IMR). We attach a template for completion, some guidance notes on how to complete an IMR, the Terms of Reference and the Chronology template. When completing your Individual Management Review Report you should take this opportunity to evaluate your services involvement with >>> and identify any learning for your service.

If you would like to discuss this further you can talk to ..... – Safeguarding Adults Manager, Tel: 0121 569 5410 or email ..... Or if you would prefer you can talk to >NAME> who is the Independent Chair of this Serious Case Review, Tel: >>>>

All Individual Management Review Reports must be completed and returned to ..... before **>DATE>** by e-mail to ,,,,,,, or under confidential cover to .....

You are then invited to give a brief presentation of your findings to the Serious Case Review Panel on >DATE> and answer any questions of clarification from the panel. You are asked to keep this day free and I will confirm your presentation time and the venue closer to the date.

Once we have all the Individual Management Reports these will be collated by the independent chair who will bring all the information together in an Overview Report. This report will be presented to the Safeguarding Adults Board and an Executive Summary report will be made public. We will ensure that you receive feedback from the Panel on the outcome of the Review including recommendations.

All documents other than the Executive Summary produced as part of this SCR remain confidential and the Sandwell Safeguarding Adults Board has no intention to make any documents like IMR's publicly available. The Executive Summary will be anonymised. This is to ensure that the focus of SCRs remains as providing an opportunity for agencies to reflect on their practice and learn the lessons from such incidents, rather than become an investigation of possible culpability.

Please confirm receipt of this letter to either ..... or ..... (Details above) which will enable us to forward to you the IMR and Chronology template to you electronically.

Yours sincerely

Chair of the Sandwell Adults Safeguarding Board

Attached: Sandwell Serious Case Review procedure and flowchart
Individual Management Report – Guidance
Individual Management Report Template
Chronology Template
Terms of Reference

CC:

SERIOUS CASE REVIEW

Individual Management Report – Template

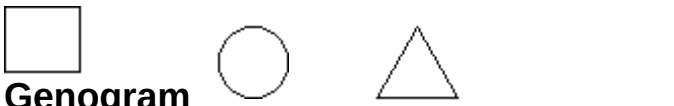
Person(s) this report relates to:	Name:>>> DOB: >>> DOD: >>>
Agency preparing this report:	
Report prepared by:	
Signed off by:	
Date report requested:	
Date report submitted:	

REPORT
Terms of Reference
1. **2.** **3.** **4.** **5.**
Methodology Who the author in within the organisation, how records were secured, which records were scrutinised, which files read, which staff interviewed etc.
Genogram and Family Details (see guidance below)
Agency Context Any significant issues re: structure, staff turnover, sickness, unallocated cases, management and supervision etc.

History of Agency Involvement with the Person / Family Include dates
Key Findings and Issues Identify good practice as well as concerns
Conclusions against the Terms of Reference What lessons the agency has learnt and actions the agency has taken or intend to take.
Recommendations Recommendations must be few, focused and SMART (Specific, Measurable, Achievable, Realistic and Timely)

A genogram is a way of representing a family tree and relationships within the family.

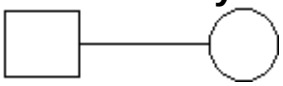
The following symbols are used to represent the gender of family members



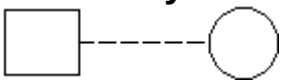
Genogram Male **Female** **Gender unknown**

If a family member is deceased, this is indicated by placing a cross inside their symbol:

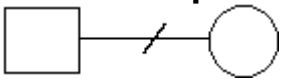
Enduring relationships, such as marriage and cohabitation, are illustrated by a single unbroken line:



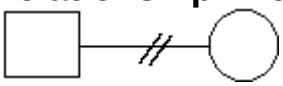
Transitory relationships are illustrated by a single broken:



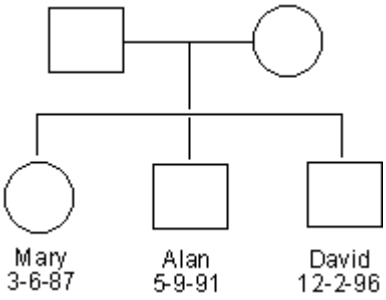
Separation is shown by a single short diagonal line across the relationship line:



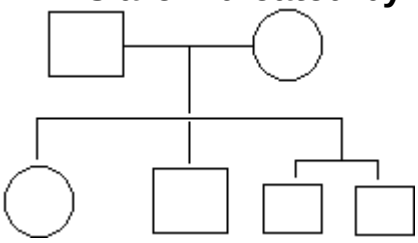
Divorce is shown by two short diagonal lines across the relationship line:



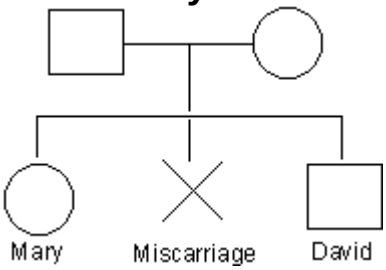
When there are a number of children from a relationship the eldest child is placed on the furthest left, followed by the second eldest and so on, with the youngest child appearing on the right.



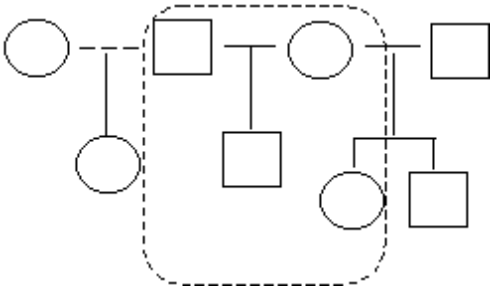
Twins are indicated by two symbols coming from a single 'stalk'



A miscarriage or abortion is indicated by a diagonal cross. In the genogram the miscarriage or abortions should be placed in the diagram in the same order as other children. So for example if a couple had a daughter, Mary, followed by a miscarriage, followed by a son David, their genogram would look like this:



The family members who are part of the same household are indicated by dotted line which is placed around the household members.



Using a Genogram

Completing a genogram can fulfil a number of functions: identifying intergenerational patterns within families; finding out about the family's history and how much of the history individual family members know.

Further information on genograms can be found on page 29 of Assessing Children in Need and their Families: Practice Guidance (Department of Health, 2000).

Using the genogram as a tool to assess family relationships is detailed in the Family Assessment: Family Competence, Strengths and Difficulties (Bentovim and Bingley Miller, 2001).

Individual Management Reports – Guidance

Individual Management reports:

- Should be completed by a senior officer. Where this creates difficulties, particularly for smaller organisations, the Senior Officer should be independent of the case and the Practitioner. This should be made clear in their IMR and document their efforts to provide some independence into the process.

- Must be signed off by the Chief Officer/Nominated person of each organisation.

- Will be written using the template provided. Using the template will make it easier for the Panel to compare information under the headings provided.

- Should look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made, and if so, to identify how those changes will be bought about.

- Should provide sufficient information for the reader to understand the significant events of the case – who did what, when and why.

- Should be evidence based. Evidence can come from many sources such as case records, electronic records, staff supervision records, documented interview records, reports such as Health Trust 'Serious Incident Reports', complaint reports or photos etc.

- However some details in the report can be included without evidence and whilst this will be considered the lack of evidence will be noted. Such incidents may include: inspections, staffing issues such as disciplinary measures or high sickness, for the police service any serious criminal matters such as a murder etc if it is thought they impacted on the service during the time of the review period.

- IMR Reports should also highlight any discrepancies identified such as – a referral should have been made but wasn't or it took 2 weeks, the care plan was reviewed late, staff supervisions were not taking place, information should have been shared but wasn't.

- Must include a conclusion with identified lessons the organisation has learnt from the review and the actions they have taken or intend to take to address them.

The Terms of Reference:

The Terms of Reference are set to focus all agencies to consider the key aspects. Better outcomes can be achieved if all the individual management reviews address the same questions and issues relevant to the case review being undertaken.

Each agency is required to consider each of the Terms of Reference set by the Serious Case Review Panel and answer the question or comment on the issue from their perspective and from the evidence they have.

The Chronology

The chronology must detail all the involvement the agency initiated or was involved in specific to the identified person. The Chronology is brief factual events and references. Individual Management Review Reports will include the detail and explanation in relation to the detail of the Chronology.

Chronologies should include:

- Actions the service took – for example referrals to other agencies or professionals, assessments, contacts with people, seeking guidance for other professionals, regulatory notifications to the regulator etc. Contact with families and significant others.

- All assessments completed such as risk assessments, capacity assessments, pressure ulcer assessments, nutrition assessments etc.

- Key decisions made – such as referring a person to the GP, social care, district nurse, police, CQC or accessing specific equipment, changing care plan etc.

- Reference can be made in brief to other processes such as complaints procedures, Serious Untoward Incident reports, staff disciplinary work etc if they are relevant to the Review.

Some points to help when completing an Individual Management Report and Chronology and analysis of involvement
• Consider the events that occurred, the decisions made, and the actions taken or not. • Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why it happened. • Were practitioners sensitive to the needs of the vulnerable 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 service have in place policies and procedures for safeguarding vulnerable adults and 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 vulnerable adult and family and/or representative (if appropriate)? Do assessments and decisions appear to have been reached in an informed and professional way? • Did the actions accord with assessments and decisions made? Were appropriate services offered / provided, or relevant enquiries made, in the light of assessments? • Where relevant, were appropriate adult protection or care plans in place, and adult protection and/or looked after reviewing processes complied with? • When, and in what way, were the vulnerable adult's wishes and feelings ascertained and considered? Was this information recorded? • Was practice sensitive to the racial, cultural, linguistic and religious identity of the vulnerable adult and family and/or representative (if appropriate)? • 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 the policy and procedures for protecting and supporting vulnerable adults, and wider professional standards?
What Do We Learn From This Case?
• Are there lessons from this case for the way in which this agency works to protecting and supporting vulnerable adults and promote their welfare? • 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 inter-agency); management and supervision; working in partnership with other agencies; resources?
Recommendations for Action
• What action should be taken by whom, and by when? • What outcomes should these actions bring about, and how will the agency review whether they have been achieved?

Chronology template

The following is a word version of the Chronology which will be provided to organisations and agencies in Excel Spreadsheet format.

Person this chronology relates to							
Agency preparing this chronology							
Chronology prepared by							
Date of chronology							
Date /Time dd/mm/yyyy	**Service user or family**	**Professional person involved**	**Event**	**Decision reached / action taken** Very brief	**Service user seen Yes / No**	**Source of evidence** e.g. case file, interview etc	**Comments**
Example 30/07/2009	SU	Home manger name to District nurse name	Phone call to district nurses to report pressure sore.	DN Name visited and treated pressure sore.	yes	Case records and DN records	

Serious Case Review Overview Report Template

In respect of:	
Primary agency:	
Chair	
Author	
Panel members	

Introduction	Summarise the circumstances that lead to the review being undertaken in this case.
Terms of Reference	Detail the Terms of Reference
Agencies involved	List agencies involved and their contribution (***It may be appropriate to include an integrated chronology of involvement with the vulnerable adult and family on the part of all relevant agencies, professionals and others who have contributed to the review process. Note specifically in the chronology each occasion on which the vulnerable adult was seen and views sought/expressed)***
Genogram and Family Details	
Key findings	Good Practice Examples Issues of concern, learning and improvement
Analysis / Evidence	This part of the report should look at how and why events occurred, decisions were made and actions taken or not taken. This is the part of the report where the author can consider, with the benefit of hindsight, whether different decisions or actions may have led to an alternative course of events.
Conclusion	This part of the report should summarise, in the opinion of the Panel, what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action.

Recommendations	Recommendations should include, but should not simply be limited to, the recommendations made in individual reports from each organisation. Recommendations should be few in number, focused and specific, and capable of being implemented. If there are lessons for national as well as local policy and practice, these should also be highlighted.

Attachments	Chronology ***(see Agencies involved)***