Stockport Safeguarding Boards

Combined Serious Case Review/Safeguarding Adults Review Protocol

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1. Introduction

This document sets out the arrangements by which Stockport Safeguarding Boards will conduct its case reviews. It highlights its statutory duties, overall process for running a Serious Case Review or Safeguarding Adults Review, and how the Safeguarding Boards will commission such work.

The core process that the Stockport Safeguarding Children Board (SSCB) and Stockport Safeguarding Adults Board (SSAB) will utilise for all case reviews is set out in the attached document.

The SAR process will be flexible depending on the nature and complexity of a case, and the same processes will apply for any recommendation received by Community Safety Partnership (CSP) in relation to a Domestic Homicide Review (DHR).

It should also be noted that both Safeguarding Boards are concerned with reviews of significant cases, some of which will become SCRs/SARs and others may become reviews that will not meet the threshold but will be commissioned by the Board when considered necessary.

The key aim of any review remains as set out in the following legislation:

- Working Together 2015
- Care Act 2014.
- Domestic Violence, Crime and Victims Act (2004)

A SCR or SAR should be conducted in a way which:

- Recognises the complex circumstances in which professionals work together to safeguard children/adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings.

Deciding whether to convene a SCR/SAR

Each Serious Case Review Sub Group is made up of representatives from either SSCB and/or SSAB partner agencies. There is an expectation that all Sub Group members will ensure that they attend the meeting to share initial information and to assist in the shared decision making.

It is the responsibility of the Serious Case Review Sub Group members to consider whether the presenting information meets the criteria for SCR/SAR as set out in Working Together 2015 and the Care Act 2014.

The final decision on whether to conduct a SCR/SAR rests with the Independent Chair of the SSCB or SSAB.

Subsequently, the Serious Case Review Sub Group will quality assure the work of the SCR/SAR as the review progresses and will ratify the final report before presentation to the SSCB/SSAB.

2. Types of Case Reviews

Safeguarding Adult Reviews – Section 44 of **The Care Act 2014** sets out the explanation of the circumstances in which Safeguarding Adults Boards are required to undertake a Safeguarding Adults Review.

Domestic Homicide Reviews – were established on a statutory basis under Section 9 of the **Domestic Violence, Crime and Victims Act (2004)**

3. The purpose of a Review

The purpose of having a SCR/SAR is not to reinvestigate or to apportion blame, it is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together to safeguard children and/or adults.

Pam points from page 12

SARs are not disciplinary proceedings, and should be conducted in a manner, which facilitates learning, and appropriate arrangements must be made to support staff.

SARs are not enquiries into why an adult has died (or been significantly injured), or who is culpable. These are matters for criminal courts and coroner's courts.

4. Procedure for a SCR/SAR

Once a referral is received, the Chair of the Serious Case Review Sub Group, supported by the Safeguarding Board Business Manager, will discuss with members of the panel to consider whether the criteria is met.

Agencies can be asked for additional information by the Board Manager to inform a decision as to whether a review should take place. The Chair of the Safeguarding Boards is responsible for deciding whether to undertake a review or not, based on the recommendations of the Serious Case Review Sub Group.

The methodology for undertaking a SAR will be discussed and agreed by the Serious Case Review Sub Group and the Chair of the Safeguarding Boards.

The Safeguarding Board Business Manager on behalf of the SAB will inform the lead representative of the referring agency of the decision.

If the decision is to undertake a SAR, the Board will arrange to notify the individual, their family, friends or carers (where appropriate), of the outcome of the decision.

Recommending the Overall Approach to the SCR or SAR

The Serious Case Review Sub Group will recommend:

- Which agencies should be asked to participate in the SCR/SAR
- Whether the agencies concerned are required to secure their files
- Which methodology should be used to facilitate learning in the case
- The Terms of Reference for the SCR/SAR
- The required output from the SCR/SAR (e.g. a report)
- The timescales for completion of the SCR/SAR. This should be within 6 months if possible.
- Recommendations relating to an independent facilitator/chair
- Recommendations relating to the commissioning of an independent author

5. Notification of a serious safeguarding incident

The Safeguarding Adults Board is the only body that can undertake a Safeguarding Adult Review.

- Any professional can make a referral for a Safeguarding Adult Review.
- Staff will usually find it helpful to discuss their concerns with their organisation's safeguarding lead prior to making a referral. Using the referral checklist (Appendix 1).
- Referrals are made via secure email. See referral form A.
- Discussions regarding the appropriateness of referring a case are welcomed by the Safeguarding Adults Board Manager.

Click here for SAR referral form.

Appendix 1 shows a flowchart of SAR referral process.

Referrals should be made via secure email to the Safeguarding single point of contact (SPOC) as soon as possible after the incident via email at: lsb@stockport.gov.uk

SPOC to notify Stockport's Safeguarding Board Manager who will ensure that the Chair of the Safeguarding Boards is briefed on the circumstances.

6. Links with other reviews and investigations

There are separate statutory requirements for SCR/SAR and DHRs. However, the same process is applied when a referral has been received for either a child and/or adult of a SCR/SAR.

When running an SCR or SAR all relevant areas that need to be addressed should be established at the outset to reduce potential for duplication for families and staff.

Any SCR/SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

A SCR/SAR should also take account of any other review process e.g. Learning Disabilities Mortality Review and should inform the development of the Terms of Reference

7. Coroners

Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of a child/and or adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations;
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation;
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home);
- The Coroner or his or her officers identify deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions.

In the above situations, the Safeguarding Boards should consider instigating a SCR/SAR

8. Aim of the Serious Case Review Sub Group

- To share historical and current agency information known about the victim / perpetrator / family / household members or known significant others.
- To share information about the events surrounding the death of the victim.
- To identify any parallel review processes which may be planned or underway in relation to the incident, and the implications of these for SCR/SAR arrangements.
- To advise the Independent Chair of the Safeguarding Boards on whether the statutory criteria for undertaking a SCR/SAR have been met and accordingly whether a review should be commissioned.
- To identify those best placed to sit on the Serious Case Review Sub Group (where applicable) and its terms of reference.

Where the Serious Case Review Sub Group agrees that a situation does not meet the criteria for a SCR/SAR but agencies will benefit from a review of actions, other methodologies can be considered.

These include:

- **Serious Incident Review:** Organisations should use their own procedures if this is deemed suitable and special consideration should be given to the involvement of relevant partner organisations.
- **Single Agency Review:** A review by an individual organisation in relation to their understanding and management of a particular safeguarding issue.
- **Reflective Practice Session:** The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead or other such suitable person, including an independent facilitator.

9. Membership

Core membership of the Serious Case Review Sub Group comprises of:

- Stockport Local Authority including Safeguarding Adults and Children

- Greater Manchester Police (GMP)
- Stockport Clinical Commissioning Group
- Stockport NHS Foundation Trust
- Pennine Care NHS FT

Any other local or national agency, which had or may have been involved with the victim, perpetrator or their families and households, should also be invited to contribute to and attend the SCR/SAR panel meeting. The following examples of those who should be considered are not exhaustive:

- Registered providers i.e. Housing Associations and Social Landlords
- HM Prison Service
- National Probation Services
- Independent Health professionals, e.g. GPs and Dentists
- Schools
- Crown Prosecution Service
- The Police Family Liaison Officer
- Representatives of the Voluntary and Community Sector (VCS) with expertise in domestic violence and abuse

Servicing the meeting

The Head of Safeguarding and Learning will chair the Serious Case Review Sub Group meeting.

The Council's Safeguarding Business Unit will service the Serious Case Review Sub Group meetings. Papers will be provided at the meeting to allow panel members to be fully informed and sufficient time will be allowed to read all the relevant information.

The safeguarding business unit will:

- Notify core members that a Serious Case Review Sub Group is to take place and members will save the date in their calendar.
- Send invitations to the Serious Case Review Sub Group members and all other known agencies, which had been involved with the victim, perpetrator or their families and households to attend the Serious Case Review Sub Group meeting.
- Compile a summary for the Chair of each case in preparation for the meeting.
- Ensure that the Chair and the Serious Case Review panel members who will be attending have hard copies at the meeting.
- Prepare the agenda.
- Attend the meeting and take notes and record decisions.
- If a decision is taken to conduct a SCR/SAR, and the decision is approved by the Independent Chair of the Board, then the Safeguarding Business unit will send out the chronology template to agencies identified as being involved.

10. Timescales

All requests will be submitted to the Serious Case Review Sub Group with the authority to consider the referral. The Serious Case Review Sub Group will be established within **20 working days** of the notification.

The Serious Case Review Sub Group will consider the criteria for the undertaking of a SCR/SAR. The conclusions of the Serious Case Review Sub Group and their recommendations should be provided in writing **within 10 working** days of the meeting to the Independent Chair of Stockport's Safeguarding Boards, who will make the decision on whether there should be a review **within 15 working days.**

Stockport's Safeguarding Board Manager, on behalf of the Independent Chair, must inform the victim's family, in writing, of the Safeguarding Boards position regarding whether a SCR/SAR will be conducted.

Once the decision to undertake a SCR/SAR has been made, it is good practice for it to be completed within six months.

It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues, which emerge from the review and need to be considered immediately, should be brought to the attention of the Board.

11. Conducting the review

Once a decision has been made to conduct a review, the Chair and members of the Serious Case Review Sub Group will be responsible for preparing draft Terms of Reference, which are proportionate to the circumstances of the case.

12. Appointment and Role of the Review Panel Chair and Report Author

The Review Panel Chair should be an experienced individual who is not directly associated with any of the agencies involved in the Review.

The Review Panel Chair will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the Individual Management Reviews (IMRs – see below) and any other evidence the Serious Case Review Sub Group decides is relevant.

Consideration should be given to the skills and expertise required to effectively Chair a SCR/SAR. They should have the appropriate core skills including:

- Strong leadership and ability to motivate others;
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics;
- Collaborative problem solving experience and knowledge of participative approaches;
- Ability to find and evaluate best practice;
- Good analytic skills and ability to manage quantitative and qualitative data;
- Knowledge of safeguarding adults;
- Ability to write for a wide audience and
- An understanding of the complexity of the health and social care system

The Review Panel Chair is responsible for the final decision on the suitability of the SCR/SAR terms of reference and they are to be agreed at the first meeting of the Panel.

The Terms of Reference may, however, need to be revisited as the Review progresses and as new information is identified. The Review Panel Chair will agree any amendments to the Terms of Reference with the Review Panel.

The Review Panel Chair will establish an agreed timetable of Review Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of IMRs.

As part of the terms of reference, the Chair should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the Review in conjunction with Stockport Council's corporate communications team.

The Review Panel Chair should as far as possible, ensure that the review process is a learning exercise in itself for all those involved in the case.

The Review Panel Chair will regularly update the Independent Chair of the Stockport Safeguarding Boards on progress with the SCR/SAR.

The Review Panel Chair will maintain contact with the Safeguarding Board Business Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

The Chair of the Review Panel should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

Where there is an on-going criminal investigation the Review Panel Chair will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

13. Methodology

SCR/SARs can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies, led by an independent overview report author. With this method, individual agencies are asked to review the practice within their organisation through Individual Management Reviews (IMR) and Chronologies, which then form part of an Overview Report.

Other methods considered are:

- Action Learning Approach
- Peer review approach
- Thematic Reviews
- Single Agency Review

Stockport Safeguarding Boards will endorse the approach best suited to the circumstances of each individual case, and the Serious Case Review Sub Group will decide on the most appropriate method.

14. Involvement of Family Members, Friends, and other Support Networks

Family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the Review Panel have opportunities to listen to family experiences and perspectives and that these contribute meaningfully to the final report.

Family members can include:

- Siblings
- Parents
- Carers
- Grandparents
- Other significant family members identified from the Family Association Network/ Genogram.

As a minimum, family members should:

- Be notified of the review process, what that means for them and how they can access support – including impact of media coverage
- Agree the level and frequency of contact with family members to ensure they are kept informed
- Supported to contribute to the review process – either in writing, by meeting with the review panel, sharing views via a third party or by other means identified by the Review Panel
- Included in feedback about the learning identified by the Review Panel
- Informed and prepared for the publication of the report in a timely manner – again including the likelihood of media interest
- Provided with a read only copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version – A 'hard' copy of the report should not be provided until the report is in the public domain.

15. The Final Overview Report

The SCR/SAR overview report brings together the learning, themes identified from the review and will analyse and comment on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the child/and or adult.

The Chair of the Review panel has responsibility for collating the report and the report should:

- Provide a summary of the circumstances that led to the review.

- Briefly outline the review process and methodology, including how the views and participation of key stakeholders as achieved.

- Be written in a succinct and focused manner with the emphasis on recognising and sustaining good practice as well as identifying how and where practice can be improved in the future.

- Identify action that agencies or services have already undertaken in response to learning.

- Form a conclusion as to the effectiveness of local practice to safeguard and promote the welfare of the child/and or adult.

The SCR/SAR overview report should firstly be presented to the Serious Case Review Sub Group. This provides an opportunity for the Chair of the review panel along with the Serious Case Review Sub Group to quality assure the document, reference the identified learning and to ensure an opportunity for the findings to be challenged where necessary.

Once agreed the Chair of the review panel should present the report to the Safeguarding Board, supported by the Serious Case Review Sub Group Chair.

It will be the responsibility of the Safeguarding Board and its Independent Chair to identify and agree how practice challenges or recommendations from the SCR/SAR Report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

16. Action plans

A clear SCR/SAR action plan should be developed by the Stockport Safeguarding Boards with a focus on improving outcomes for children/ and or adults at risk. The following should be included in the Action Plan as standard:

• A timeline for publication of the report should be developed and where possible a date identified.

• Action is taken by the Stockport safeguarding Boards to share the findings of the report with the practitioners who contributed to the Learning Event and with family members.

• Stockport Safeguarding Boards will identify how it will share the lessons learned, and practice impact with the wilder workforce in the Stockport area.

Once the SCR/SAR report and action plan have been agreed, the report will be endorsed and signed off by the Safeguarding Boards and copies to be available on the local council's website.

The action plan will be regularly reviewed and its impact evaluated using existing local Safeguarding Board processes.

17. Findings from SCR/SARs

The findings from any SCR/SAR should be reported in the Stockport Safeguarding Annual Report and what actions it has taken or intends to take in relation to those findings. Where the Safeguarding Board decides not to implement an action, then the Annual report must state the reason for that decision.

18. Media Strategy

The Chair of the Serious Case Review Sub Group Panel, in consultation with the Independent Chair, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

Since the Local Authority is, the lead agency, media and communication issues will usually be co-ordinated by the council's Communications Team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.

All SCR/SAR reports will be considered for publication on the website of the relevant Safeguarding Boards. In the case of publication, the Independent Chair of the Safeguarding Boards will release a statement where appropriate.

19. Learning from SCR/SAR

The value of SCR/SARs is in the learning derived from them. As much effort should be spent on acting on recommendations as on conducting the actual Review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timed.

The following should help to secure maximum benefit from the review:

- Conduct the review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with adults.
- Make sure staff and their representatives understand what can be expected in the event of a SCR/SAR.

20. Complaints & Escalation procedure

Where a complaint is received about a Board process, for example a Safeguarding Adult Review, this will initially be responded to by the Board Manager in consultation with the relevant Head of Service, with a written response within 28 days of receipt.

If the complainant is unsatisfied with the response, they should contact the Board Manager who will arrange for their complaint to be considered by the Independent Chair.

The Independent Chair will provide a further written response within 28 days of the complainant contacting the Board Manager. All written complaint responses will include details of how to contact the Local Government Ombudsman.

The Board Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation.

Appendix 1 – Flow Chart

Review Decision making process

Domestic Homicide

Notified by GMP to Head of Safeguarding and Learning

Case moves Straight to Review process

Unexpected child death, serious incident or safeguarding adult incident occurs

Head of Safeguarding and Learning and Business Manager to be notified within 1 working day)

Safeguarding Investigation would refer to Serious Case Review panel for consideration

Head of Safeguarding and Learning consults with:

- Service Director Children Social Care – Stockport MBC
- Head of Marketing and commissioning - Adult Social Care
- Inspector Public Protection Unit – GMP

Consultation and agreement to take place within 2 working days of the incident

Does a Consideration Meeting need to be convened?

A date for the Consideration meeting is arranged and all agencies are contacted and requested to complete an Agency Contact report

Agency contact form requires completion and returning to SSCB OR SSAB within 15 working days of request being made

Consideration Meeting takes place:

All agency information is reviewed and consideration is given as to whether the incident meets the threshold for a SCR/SAR

The Consideration Meeting decision is referred to the Independent Chair of SSAB or SSCB for final decision review

Decision to hold SCR	Decision to hold Independent Learning Review	Decision to hold SAR	No further action

Head of Safeguarding to inform National Panel,DFE Ofsted or CCG

within 14 days of decision being made

Proceed to Review

See separate review process/task list

Appendix 2

Communication strategy re: SAR/SCR publication

All responsibilities for the Safeguarding Boards business manager unless otherwise stated

On completion of SAR/SCR

- In Final Panel meeting have a discussion with partners about Communication issues and agree what information needs to be communicated and to who.

In preparation for inquest

- Head of Safeguarding and/or Safeguarding Board Business manager will liaise with Communication re statements in relation to inquest - prepare statement in advance. Director of People will make a statement on behalf of Stockport Council as and when required.
- Head of Safeguarding and/or Safeguarding Board Business manager to write Communication statement in co-operation with Communication and provide this to Panel members.
- Communication to provide statement from Press on request.

In preparation for publication of SAR

- Agree a date for publication.
- Ensure Panel have had final version of Overview report
- For SCR's send copies of overview reports to National panel and Ofsted with proposed publication date two weeks in advance of publication.
- Send finalised report to SAR repository and/or NSPCC and National Association of LSCBs
- Agree publication style - pro-active press statements or publish on website.
- Liaise with Council Communication about potential for press interest re publication.
- Inform family by letter.
- Inform independent reviewer.
- Inform lead member and Chief Exec. Consider if an elected members brief is required
- Notify Website team of intention to publish on Stockport Safeguarding Boards website.
- Liaise with Panel members so that their Communication departments can be alerted - panel members to provide communication lead from their respective organisation.
    - Final version of reports to be circulated to Communication reps as required
    - Partners need to have their own statements ready and liaison should take place with Stockport Council Communication about prepared statements.
    - If partners have media, queries they **must** liaise with Stockport Council Communication link person before making a response so that the level of exposure and risk can be assessed.
- Inform Safeguarding Board partners of intention to publish any reports on either of the Stockport safeguarding websites, and what information will be provided alongside with the report. Usually this will be 7-minute briefing but it may include a summary of the changes that have taken place because of the SAR/SCR and an explanation about delays in publication.
- Report onto website - circulate link to partners

Appendix 3 – Stockport Safeguarding Partnerships Review Protocol

Stockport Safeguarding Children Partnership/Adults Board has produced a protocol that demonstrates the management arrangements of their Safeguarding learning reviews once completed.

The primary purpose of this process is to ensure the learning from reviews is embedded into practice.

Clarification of the process is provided in the stages described below:

Stage 1
A Safeguarding Review has been undertaken and approved by the Review Panel. At this stage the overview report along with recommendations have been endorsed by the Safeguarding Executive/Board.

Stage 2
The Review Panel produce an action plan based on the recommendation agreed in the overview report. The agreed action plan is then shared with the Practice Improvement Partnership who has the responsibility to oversee the delivery of the action plan. Lessons learnt from learning reviews are disseminated through safeguarding 7 minute briefing papers and the Practice Improvement Partnership has the responsibility to sign off such papers to assist in the sharing of key messages.

Stage 3
Practice Improvement Partnership will manage the performance and progress of an action plan, this will be conducted through discussion at each partnership meeting for updates/evidence on the actions. The partnership will continue to monitor the work until members are fully satisfied that all actions within the plan have been met. At this point, the action plan is signed off by the partnership and shared with the Quality Assurance Partnership for oversight.

Stage 4
On receipt of the action plan, the Quality Assurance partnership will arrange a multi-agency moderation meeting to scrutinise evidence provided, and verify that each action has been met and implemented; and there is evidence as to how the impact will be measured. Once assurance is gained the action plan is signed off and reported back through to the Safeguarding Executive/Board in the QAP standard report to the Safeguarding Executive/Board. The QAP will also consider how any of the impact of learning can be tested from a partnership perspective i.e. completion of single agency audits/multi agency audits/inclusion in the dataset.