social care
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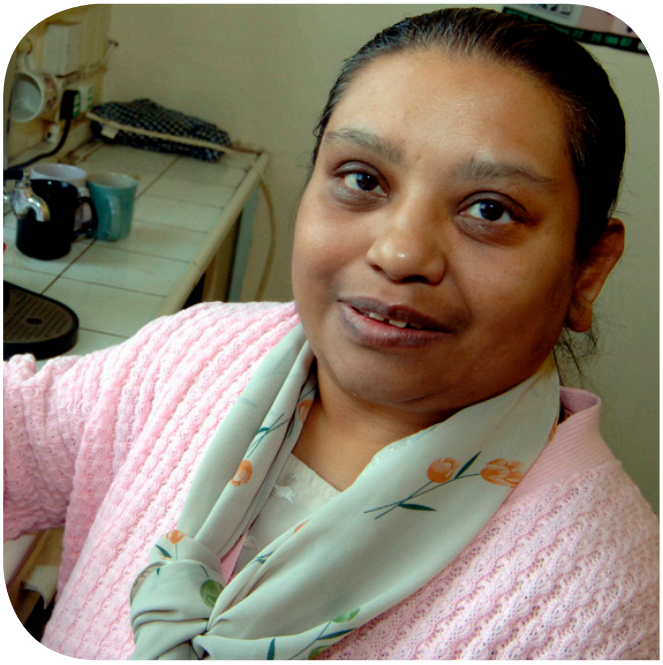
ADULTS SERVICES WEB RESOURCE

Protecting adults at risk: Good practice guide



Major investigations and reviews

At any time, front-line practitioners and managers from a range of organisations may become involved in one of the many investigation and review processes that can be triggered when an adult at risk dies, is seriously harmed, or where an adult at risk narrowly avoids being killed or seriously harmed. The key processes are listed below.

Serious case reviews

A serious case review (SCR) is called by a local safeguarding adults board (LSAB), and is a multi-agency review looking into the circumstances surrounding the death of or injury to an adult at risk. While SCRs are not mandatory in adult safeguarding, ADASS recommends that one is considered when:

- a vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death
- a vulnerable adult has sustained a potentially life-threatening injury through abuse or neglect, serious sexual abuse or sustained serious and 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
- serious abuse takes place in an institution or when multiple abusers are involved. (**9**)

SCRs are explicitly not designed to be a reinvestigation of a case, but to review whether there are lessons to be learned about multi-agency working and if procedures are effective. They are designed to improve local practice and inter-agency working. An SCR will report in writing to the LSAB.

Management reviews

In a typical SCR, the agencies involved will each contribute an individual management review (IMR), which should openly and critically explore their role in the case under review. The term ‘management review’ is also sometimes used for any single-agency review of a case, whether or not it forms part of an SCR

Large-scale investigations

When an investigation involves a number of adults at risk, whether in an establishment or because a particular alleged abuser or group of alleged abusers are involved, a number of different agencies may be part of the investigation. Careful coordination and planning are essential, so that the individuals and agencies involved are aware of their respective roles and responsibilities.

If several referrals are made in relation to one alleged abuser or to a particular setting or service, the possibility of implementing a large-scale investigation must be considered. Senior managers within each agency involved in the investigation should be informed at the point the investigation becomes large scale.

Domestic homicide reviews

Introduced by the Home Office in 2011, domestic homicide reviews (DHRs) are designed look at what lessons can be learned about agency and inter-agency practice and procedures when the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by (a) a person to whom they were related or with whom they were or had been in an intimate personal relationship, or (b) a member of the same household (**10**).

As with SCRs, the purpose is not to apportion blame but to reflect on what happened with a view to preventing domestic homicides in the future. A DHR will be called by the local Community Safety Partnership for the area in which the person lived, and will in turn have been informed of the case by the local police.

Critical incident reviews

The Metropolitan Police define a critical incident as 'Any incident where the effectiveness of the police response is likely to have a significant impact on the confidence of the victim, their family, and/or the community' (**11**). Where a critical incident has occurred, the police will review what happened and why. While these are usually internal reviews, if an incident relates to social care, particularly its statutory functions, then social care staff may become involved.

Serious incident reviews

A serious incident requiring investigation is defined as one that occurred in relation to NHS-funded services and care resulting in one of the following:

- unexpected or avoidable death of one or more patients, staff, visitors or members of the public
- serious harm to one or more patients, staff, visitors or members of the public, or where the outcome requires life-saving intervention or major surgical/medical intervention, results in permanent harm or will shorten life expectancy or cause prolonged pain or psychological harm. This includes incidents graded under the National Patient Safety Agency (NPSA) definition of severe harm
- a scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver health care services - for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or information technology failure
- allegations of abuse
- adverse media coverage or public concern about the organisation or the wider NHS
- one of the core set of 'never events' as updated on an annual basis (**12**).

Serious incident reviews are therefore led by the NHS, but will often involve people from a range of agencies.