DUNDEE CITY

SIGNIFICANT CASE REVIEW PROTOCOL

1. Authority of the CCPC, ASPC and DVAWP to conduct a SCR

1.1 The Child Protection Committee (CPC), Adult Support and Protection Committee (ASPC) and Violence Against Women Partnership (VAWP) are not constituted as statutory bodies, but are comprised of membership drawn from statutory and voluntary agencies. Hereafter these groups will be collectively referred to as 'the Committee(s)'.

1.2 In line with local arrangements for integrated working and strategic planning across public protection this is a joint protocol supporting Significant Case Reviews (SCRs) in any of the above Committees. It is recognised that there may be complex, interconnected events where a joint SCR between 2 or more of the above Committees is appropriate, as such this protocol also supports the planning and implementation of such SCRs.

1.3 The model process for carrying out SCRs within MAPPA arrangements is set out in section 20 of the Multi-Agency Public Protection Arrangements (MAPPA): national guidance (Scottish Government, 2016). The considerations set out in steps 7, 8 and 9 of this protocol will apply to the governance of MAPPA SCRs commissioned by the Dundee Chief Officers Group (COG) and are fully complaint with MAPPA national guidance.

1.4 This protocol replicates the model described in 'National Guidance for Child Protection Committees: Conducting a Significant Case Review' (Scottish Government, 2015) and the National Framework for Adult Protection Committees for Conducting a Significant Case Review.

2. What is a Significant Case Review?

2.1 In the context of public protection, a Significant Case Review is a multi-agency process for appraising practice and learning lessons from a situation where a person has died or been significantly harmed. Significant Case Reviews should be seen in the context of a culture of continuous improvement and should focus on learning and reflection on day-to-day practices, and the systems within which those practices operate.

2.2 The overarching objectives of Significant Case Reviews are to:

- keep under review the procedures and practices of the public bodies and office-holders required to cooperate within the safeguarding of individuals at risk present in the council's area
- give information or advice, or make proposals, to relevant services on the exercise of functions which relate to the safeguarding of individuals at risk present in the council's area
- share learning with relevant agencies and make recommendations for action (immediate action to improve service or professional shortcomings need not await the outcome of a formal review)
- consider how any recommended actions and learning will be implemented
- address the requirement to be accountable, both at the level of the agency/agencies and the occupational groups involved
- increase public confidence in public services, providing a level of assurance about how those services acted in relation to a significant case.
- recognise good practice
- identify national implications (where appropriate) including good practice

2.3 This protocol supports the achievement of these objectives by helping those responsible for reviews to:

- Undertake them at a level which is necessary, reasonable and proportionate;

- Adopt a consistent, transparent and structured approach;
- Identify the skills, experience and knowledge that are needed for the review process and consider how these might be obtained;
- Address the needs of the many different people and agencies who may have a legitimate interest in the process and its outcome; and
- Take account of the evidence base.

2.4 It sets out:
- The criteria for identifying whether a case is significant;
- The procedure for undertaking an initial case review (ICR);
- The process for conducting a significant case review including reporting mechanisms and dissemination of learning; and
- Agreed templates to support the process of conducting an ICR and an SCR.

2.5 In line with good practice principles SCRs conducted within Dundee under this protocol will:
- Be objective and transparent.
- Have a clear remit.
- Be completed to set timescales.
- Be sensitive to parallel processes.
- Be sensitive to the needs and circumstances of children, young people, adults and their families.
- Be sensitive to the needs of staff.
- Deliver clear findings to support the Committee(s) to improve outcomes.
- Not be escalated beyond what is proportionate taking account of the severity and complexity of the case.

2.6 The assumption throughout this protocol is that the relevant Committee(s) should proceed as speedily as feasible at all stages of an ICR and SCR, and that agencies should do the same. This is important in reducing stress on the child or adult (if they are still living); their family or carers; and on the staff involved. However, the complexity or circumstances of certain cases may result in preferred timescales not being met.

2.7 Regardless of whether, or when, an SCR takes place, it is important that any obvious areas for improvement of practice are addressed as soon as possible. Following the death of a child/adult or the identification of serious concerns about a child/adult, agencies should assess the circumstances of the case to identify if any immediate actions need to be taken. If action is required, it should be proportionate and taken at local level as far as possible.

3. Status of SCR relative to other linked investigations

3.1 Depending on the case, a number of processes could be driven by considerations wider than learning lessons across agencies. These can include a criminal investigation, report of death to PF, a FAI, and a review into the death of a looked after child. Further details of these processes are at A**ppendix 7.**

These processes may impact on whether a review can be progressed or concluded – criminal investigations always have primacy.

3.2 To help establish what status an SCR (including the ICR) should have relative to other formal investigations there should be ongoing dialogue with Police Scotland, COPFS, SCRA, HSE or others to determine how far and fast the SCR process can proceed in certain cases.

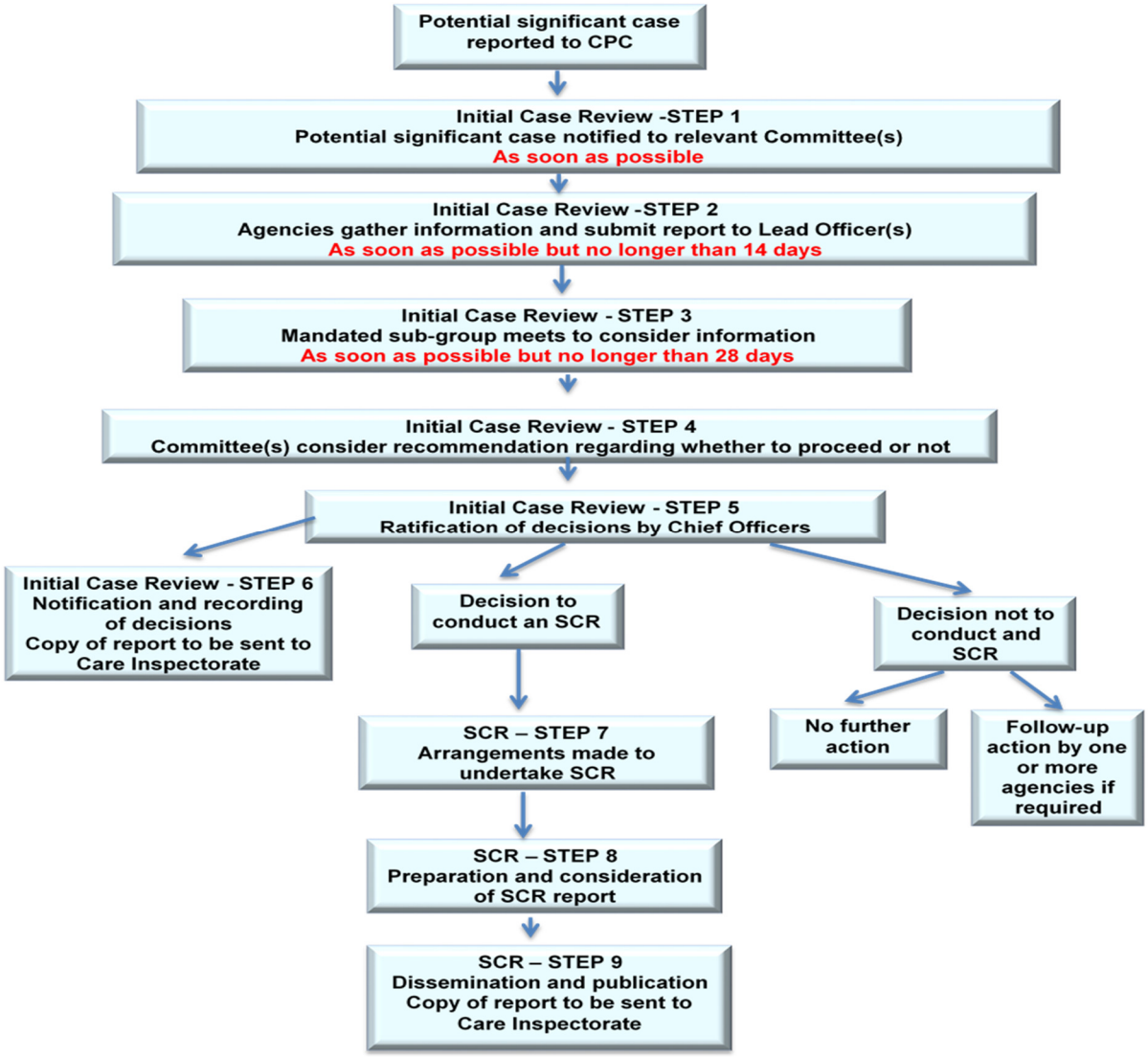
3.3 Any linked process should be notified to the Lead Officer(s) as early as possible in the ICR process (see below). Lead Officer(s) will be responsible for ensuring good liaison with relevant organisations during the ICR process, in consultation with their Committee(s). Should any case progress to an SCR this responsibility will pass to the lead reviewer(s) and review team.

3.4 The National Protocol for the Police Service of Scotland, COPFS, and Child Protection Committees helps with liaison and the exchange of information when there are simultaneous SCRs and criminal proceedings, an FAI or investigations that may result in further proceedings. No equivalent document exists for other protection areas.

4. The SCR Process

4.1 Any agency can ask for a case to be considered for review by a relevant Committee(s) but a family cannot ask for a review. Concerns raised by families should be addressed through relevant agencies' normal complaints procedures. Further information on family involvement in SCRs is available at http://www.baspcan.org.uk/report.php.

4.2 The review process is summarised in Figure 1 below and explained throughout this protocol.



4.3 Where time limits are referred to it is important that they are adhered to. If there is good reason for delay, the reasons for this must be clearly recorded.

4.4 Criteria for establishing whether a case is significant

4.4.1 A significant case need not be about just one significant incident. In some cases, for example, neglect, concerns may be cumulative.

4.4.2 *Criteria*

When an adult or child dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional and/or service involvement or lack of involvement, and ***one or more of the following apply:***

- Abuse or neglect is known or suspected to be a factor in the death;
- The child is on, or has been on, the Child Protection Register (CPR) or a sibling is or was on the CPR. This is regardless of whether or not abuse or neglect is known or suspected to be a factor in the child's death unless it is absolutely clear to the Child Care and Protection Committee that the child having been on the CPR has no bearing on the case;
- The adult meets the definition of an adult at risk as defined by the Adult Support and Protection (Scotland) Act 2007;
- The adult has been subject to a Multi-agency Risk Assessment Case conference in the 12 months preceding their death;
- The death is by suicide or accidental death;
- The death is by alleged murder, culpable homicide, reckless conduct, or act of violence;
- At the time of their death the child was looked after by, or was receiving aftercare or continuing care from, the local authority,

When a child or adult has not died but,

- has sustained **significant** harm or risk of significant harm as defined in the National Guidance for Child Protection Scotland;
- the adult meets the definition of an adult at risk as defined by the Adult Support and Protection (Scotland) Act 2007 and has sustained harm or risk of serious harm, under one or more of the categories of abuse and neglect set out in the Adult Support and Protection (Scotland) Act 2007;
- the adult has sustained serious harm or risk of serious harm, under one or more of the categories of violence against women set out in Equally Safe: Scotland's strategy for preventing and eradicating violence against women and girls;

and in addition to this, the incident or accumulation of incidents (a case) gives rise to serious concerns about professional and/or service involvement or lack of involvement, and the relevant Committee(s) determines that there may be learning to be gained through conducting a Significant Case Review.

4.4.3 *Definition of a child*

For the purpose of this document a child is generally a person under the age of 18 but a comprehensive definition is provided in the National Guidance for Child Protection in Scotland (Part One).

4.4.4 *Definition of an adult at risk*
For the purposes of this document an adult is generally a person over the age of 18. However, there will be specific circumstances where a person aged 16 or 17 will require to be treated as an adult (see above).

An adult at risk meets the criteria set out in the Adult Support and Protection (Scotland) Act 2007 when:

- They are unable to safeguard their own wellbeing, property rights and other interests; and
- They are at risk of harm; and,
- They are affected by disability, mental disorder, illness or physical or mental infirmity, such that they are more vulnerable to being harmed than adults who are not so affected.

All 3 elements of the definition must be met. The presence of a particular condition does not automatically mean an adult is an 'adult at risk'.

In terms of the Act harm is defined as:

- Another person's conduct is causing or is likely to cause the adult to be harmed; or,
- The adult is engaging in conduct that is causing or is likely to cause harm.

4.5 Step 1: Potential significant case notified to the relevant Committee(s) as soon as practicable after the event or when a series of events suggests an SCR may be appropriate.

4.5.1 The Committee(s) may not immediately appreciate that a case is significant. An Initial Case Review (ICR) is, therefore, an opportunity for the Committee(s) to consider relevant information, determine the course of action and recommend whether an SCR or other response is required.

4.5.2 An ICR should not be escalated beyond what is proportionate, taking account of the severity and complexity of the case and the process and its timescales should not detract from agencies taking whatever urgent action is required to protect any other person who may be at risk.

4.5.3 The initial case review notification form must be used (**Appendix 1)**. All parts must be completed as fully as possible given the information available at the time. The ICR notification form must be quality assured by an appropriate senior manager prior to submission.

When complete, the initial case review notification form should be passed to relevant Lead Officer(s) who notifies all agencies or individuals known to be involved with the person using the ICR report template (including housing if relevant) (**Appendix 2, PART A**).

4.5.4 At this time the relevant Lead Officer(s) will also notify the Chief Social Work Officer where there has been Social Work involvement in the case. If the involvement of Social Work professionals is not immediately apparent but then emerges at a later stage the Chief Social Work Officer will be notified as soon as possible.

4.5.5 Where the case is one involving death by suicide the relevant Lead Officer(s) will notify the Chair of the Tayside Multi-Agency Suicide Review Group. Where the case is one involving death related to drug use the relevant Lead Officer(s) will notify the Chair of the Tayside Drugs Death Review Group.

4.6 Step 2: Agencies gather information and submit a report(s) to the Lead Officer(s) as soon as possible but no longer than 14 calendar days using the ICR Report template (**Appendix 2, part B**).

4.6.1 If agencies cannot reasonably complete the ICR Report for the Committee(s) within the suggested times, the reasons for this must be recorded and a expected date of submission agreed within the original 14 day timescale.

4.6.2 All ICR Reports must be quality assured by an appropriate senior manager within the individual agency completing them prior to being returned to the Lead Officer(s).

4.7 Step 3: The mandated sub group meets to consider the information as soon as possible. Within 28 days of the Lead Officer(s) receiving the initial notification, the mandated sub group convenes to consider agency/service information.

4.7.1 The Lead Officer(s) will collate a chronology and multi-agency report for this stage to support decision making and identifying information gaps. The output of the meeting will be either:

- Further information required to enable a recommendation – set actions, timescale for completion and supplementary meeting; or
- Sufficient information available to enable recommendation to progress to SCR or not (recording rationale).

The meeting will also consider what actions may be required immediately to ensure the ongoing safety of any person considered by the ICR.

4.7.2 The mandated sub-group will comprise of a Committee member from each of the involved agencies and will be approved by the Chair of the relevant Committee(s). The sub group will be chaired by the Chair of the relevant Committee. Where the case is cross-Committee the Chairs of all involved Committees will agree who will chair the mandated sub-group; where agreement cannot be reached the matter will be referred to chief officers for a final decision.

4.8 Step 4: The mandated sub group recommend whether or not to proceed to a significant case review (SCR):

- An SCR should only be undertaken when the criteria are met; where there is potential for significant multi-agency learning; and where an SCR is in the public interest and in the best interests of children and young people / adults and their family.
- The mandated sub group may recommend that no SCR is needed but follow-up action by one or more agencies is required. Follow-up action should be agreed and scheduled into work programmes of relevant agencies / groups.
- Where the mandated sub group is satisfied there are no concerns and there is no scope for significant corporate/multi-agency learning or it is clear that appropriate action has already been taken they may recommend to take no further action.

If there is no clear consensus within the mandated sub group as to whether or not to progress to an SCR, the final decision rests with the Chair(s) of the relevant Committee(s).

The Lead Officer(s) will maintain a register of all potentially significant cases referred to Committees for consideration on the format in **Appendix 2, Part C.**

4.9 Step 5: Ratification of decision

4.9.1 The chair of the mandated sub group will report the recommendation of the ICR to relevant Committee(s) for agreement. The decision of the Committee(s) should then be reported to the Chief Officers Group for full ratification.

4.9.2 Where a case is not progressed to a SCR the Committee(s) may direct that further appropriate and proportionate steps are taken to identify any learning from the case. These steps will not fall under the scope of this protocol.

4.10 Step 6: Notification and recording of decisions

4.10.1 All decisions (including no further action) and the reasons for these decisions must be recorded by the Committee(s) within their minutes and also **Appendix 2, Part C** and the **Significant Case Register.**

4.10.2 A written record of the decision should be sent to all agencies directly involved with the child/adult and recorded in the child/adult's case files and the case files of relevant third parties (for examples, siblings and parents of a child) **(Appendix 2, Part C).**

This format should also be used, if appropriate, to inform other relevant parties conducting parallel processes (for example, Crown Office and Procurator Fiscal Service (COPFS).

4.10.3 If a decision is made to proceed to an SCR, the Committee(s) should make appropriate arrangements to advise the child/young person, adult and/or family/carers of the intention to conduct an SCR, unless directed otherwise by Police Scotland, COPFS, SCRA, HSE or other body with similar authority.

4.10.4 For cases being considered under the authority of the Child Protection Committee notification should be sent to the Care Inspectorate.

4.11 Step 7: Arrangements made to undertake the SCR

4.11.1 The arrangements made to progress each SCR will vary depending on the circumstances of the case, agencies involved, level of public interest etc. Key points to be considered are highlighted below. Please refer to 'National Guidance for Child Protection Committees: Conducting a Significant Case Review' (Scottish Government, 2015) and Framework for Adult Protection Committees for Conducting a Significant Case Review (Draft 2016) for more detailed guidance.

4.11.2 For all aspects of arrangements, unless otherwise specifically stated below, Committee(s) will be responsible for developing proposals for consideration by chief officers.

4.11.3 *Governance*

- Chief Officers have a collective responsibility to ensure their public protection Committees have the resources, including staff time and finances, to fulfil their roles and responsibilities, including conducting SCRs. Chief Officers will, therefore, agree proposals from Committee(s) regarding how the review team will be financed and how its expenditure will be managed.
- Administrative support will also be agreed, as will practicalities such as accommodation, secure storage of any records shared, and secure access to electronic records. Committee(s) will make recommendations on these matters to chief officers for approval.
- The Committee(s) will seek to inform all those who will input and who have a legitimate interest in the SCR at each stage of the process. As each significant case will be different, the names and roles of those with an interest might vary. It is important to be

clear who needs to be aware of the review, what information they need, and when and how this will be provided.

- Each Committee will agree with local agencies who their contact points will be and their role in the process. Everyone should be clear about whether they have been contacted 'for information' or for decision making.
- Arrangements should be put in place for secure storage and filing of confidential information and files. These arrangements should also include retention schedules and processes for destruction of the information when it is no longer necessary to hold. NHS will wish to seek Caldicott approval in respect of access to any patient files where this is required by the lead reviewer as part of the review process.

4.11.4 During the course of an SCR any evidence of criminal acts or civil negligence relating to the case which come to the attention of the lead reviewer or review team will be reported to the Committee Chair(s).

4.11.5 During the course of any SCR any evidence of staff actions or inactions of sufficient seriousness which come to the attention of the lead reviewer or review team will be reported to the Committee Chair(s). The Committee Chair(s) will provide this information to the employer. It is solely a matter for the employer to decide what, if any, action it takes as a result.

4.11.6 If an agency has decided to undertake its own single agency review in addition to the SCR, it must ensure that this is done in parallel with the SCR. Normally, the officer(s) assigned to the review team from that agency should be the same as the person leading the single agency review. Information should be clearly communicated between both processes to minimise duplication of effort and disruption to those involved. There will be a presumption that findings from single agency reviews will be shared in full with the SCR lead reviewer / review team, any exception to this must be approved by chief officers.

4.11.7 *Methodology*

Committees should always consider and agree the methodology to be used in undertaking the SCR. Whilst each case will be considered individually, the public protection Committees covered by this protocol have expressed a preference for the Social Care Institute for Excellence (SCIE) Learning Together approach.

4.11.8 *Identifying and appointing a Lead Reviewer(s)*

- The Committee(s) will need to consider whether an SCR should be led internally or externally or with some external overview. Committee(s) needs to ensure that the lead reviewer and the review team, between them, have the necessary skills and competencies to undertake an SCR **(see Appendix 3).**
- The Committee(s) may decide to appoint an **internal lead reviewer** if the circumstances of the case, based on the evidence of the ICR, suggest that any findings are likely to have mainly local impact.
- The Committee(s) may decide to commission an **external lead reviewer** if: there are likely to be national as well as local findings; local findings are likely to be multi-agency rather than single agency; the case is high profile, or is likely to attract media attention; elected members, NHS Board members and MSPs have voiced their concerns; and / or the child/adult's family/carers or significant adults have expressed concerns about the actions of the agencies.
    - Where an external review is commissioned, the SCR continues to be owned by the Committee(s).
    - The Chief Officers Group/Committee(s) will agree any formal contractual arrangements that may be required, along with appropriate legal advice. They will consider which agencies will enter into the contract and ensure that

individuals have professional indemnity cover. Consideration should be given to involving legal services in drawing up formal contracts covering areas like timescales, fees and confidentiality.
    - Any contract will also include explicit instructions on the access to, storage of, transport of, transmission of, and disposal of sensitive personal information as required by the Data Protection Act. (see National Guidance for further detail of the status of an external lead reviewer).
- Regardless of whether the lead reviewer is internal or external, the Committee(s) will set out clear expectations in respect of timescales, milestones in the process and deadlines for completion of reports.
- The lead reviewer (internal or external) must be briefed by the Chair of the Committee(s) (or person with designated responsibility). The lead reviewer must be given access to the initial reports prepared by agencies for the ICR, to help them identify which agencies need to come to the initial SCR meetings (in the case of an external reviewer this will be once an MOU has been agreed between the parties to the review).

4.11.9 *Cross-authority SCRs*
In the case of a potential cross-authority SCR the relevant Committee(s) should agree a way of joint working and, if required, joint commissioning of a lead reviewer. It may be worth considering a lead reviewer who is independent of the Committee areas involved.

4.11.10 *Cross border (UK) SCRs*
Children, young people, adults and their families/carers do become involved with services across borders. Depending on individual circumstances such cases could be considered for an SCR involving two or more countries.

It is not possible to provide definitive guidance, as each case will be unique. However, building on the experience and learning of those Committees who have done cross border SCRs the following points are suggested for consideration:

- Early contact with the equivalent bodies in England, Wales or Northern Ireland to identify a link person there and provide that body with a link person within the local Committee(s).
- Make available the remit of the SCR and request the remit of the equivalent Committee(s).
- Enter into a memorandum of understanding or data sharing agreement which should be explicit in its terms about access to records, staff, family members etc.
- Consider having a member of the equivalent Committee(s) as a member of the review team for specific meetings and tasks.
- Agree a communication strategy, which should be clear about media handling and what information may be made available in any report. It must be borne in mind that in England and Wales there is a duty to make public every SCR concerning a child and in Northern Ireland, case management review (CMR) executive summaries are published.
- Consider joint contact with the family (or other significant persons) to make them aware of the cross border nature of the SCR and establish what arrangements will be carried out for feedback.

4.11.11 *Chronology*
A multi-agency chronology of significant events will have been prepared as part of the ICR process. This chronology will be circulated to agencies and professionals to check for accuracy and further updated information.

4.11.12 *Remit*

A template for the agreement of a remit is in **Appendix 4**.

- The clearer the remit the easier it will be to manage people's expectations about the outcomes of the SCR.
- The remit must include a deadline for production of reports, taking account of the circumstances and context of the case. Where deadlines have to be extended, for example in circumstances where other proceedings intervene, this should be recorded and a new deadline agreed by the Committee(s) and reported to the chief officers.
- The remit must be agreed in writing between the chair of the Committee(s) and then referred to chief officers for final agreement.
- The degree of complexity and the question of who to involve might not become clear until some initial work has been undertaken, especially in the case of an external SCR. Consequently, the remit may need to be reviewed at a later stage. If changes are made, they should be agreed and appropriately documented by the Committee(s) and reported to the chief officers.

4.11.13 *Identifying and appointing a review team*

- It is important to establish a team to support the lead reviewer(s) so that agencies feel confident their specialist issues are understood. The Committee(s) should ensure there is sufficient multi-agency representation on the review team in order to reflect the particular case.
- No one should be involved in a review team if they were directly involved in the case in a professional capacity, including in a management or supervision capacity
- In the case of an internal review the team will probably be drawn mainly from local agencies but should always consider using external expertise for part of the process in the form of a consultant, professional advisor or critical friend – a trusted, impartial person whose functions can include reviewing data, providing guidance or challenge and critiquing an individual's work.
- Consideration should be given to the skills required in the review team. This will vary according to the case and agreed responsibilities of the team but Committee(s) will wish to consider ensuring that the review team has the following skills:
    - A broad knowledge of children's and / or adult's services;
    - Investigation skills;
    - Listening and communication skills;
    - Analytical and evaluation skills;
    - Ability to make sound judgements on information collected;
    - Ability to critically analyse all factors that contributed to the significant case and the wider impacts for practice and service delivery where appropriate;
    - Ability to liaise with others and establish a good working relationship;
    - Ability to demonstrate sensitivity to national and local level issues; and
    - Appreciation of the need to be clear about the difference between an SCR's remit and task as opposed to other ongoing proceedings relating to the case (for example, a criminal investigation).
- Training or information requirements for the team should be considered.
- Agreement should be reached at the outset as to roles and responsibilities, who should undertake tasks such as document analysis and individual / group conversations, and how disputes will be resolved.

4.11.14 *Involvement of the child/young person/adult/family/carers*

- The family/carers of the child or adult should be kept informed of the various stages of the review as well as the outcomes where appropriate. Every effort should be made to involve children/young people/adults/families/carers.

- There will be occasions where the child/young person/adult/family/carers could be subject to investigation or have otherwise triggered the SCR. In these cases, information may need to be restricted. Close collaboration with Police Scotland, the Procurator Fiscal, and possibly SCRA will be vital.
- There may also be cases where families are considering taking legal action against an agency or agencies that are the subject of the SCR. Individual agencies' complaints procedures should be made available to the family at the outset of their involvement with the family, and throughout any SCR investigation, as deemed necessary and appropriate. This is *not* the responsibility of the Committee(s) or of the review team.
- It may be useful to assign a member of staff as a single point of contact for the child/young person/adult/family/carer throughout the review. Committee(s) will wish to consider whether it is preferable for this person not to be involved in the SCR process. The person carrying out this liaison role should be fully aware of the sensitivities and background of the case. This person's role could include advising the family of the intention to carry out an SCR and making arrangements to interview the child, adult, family/carers or significant adults involved. Any briefing would normally be an oral discussion.
- Diversity issues should be considered and support should be provided to ensure that a child, young person or adult, family/carers are able to participate.
- Care should be taken about where and when conversations with a child/young person or adult, or their family/carers are held, and if any special measures are needed to support this (for example, the use of advocacy or interpreter services, with particular care given to those with impaired communication). In particular if there are, or are likely to be, criminal proceedings or if there is, or likely to be a fatal accident inquiry, the review team must consult with the local COPFS, police and/or SCRA prior to any interviews.

4.11.15 *Support for staff involved in a review*

- During the review process staff who have been involved in the case should feel informed and supported by their managers and those involved in the review. There may be parallel processes running (such as disciplinary proceedings) as well as the SCR so sensitive handling is important.
- Each organisation should have its own procedures in place for supporting staff, but the following should always be considered:
    - The health and wellbeing of staff involved;
    - Provision of welfare or counselling support;
    - Communications with staff and keeping people informed of the process in an open and transparent way;
    - Access to legal/professional guidance and support; and
    - Time to prepare for interviews and for follow up.
- Staff involved in a review should be given this protocol and be supported to fully understand it.
- When the review is complete, staff involved in the case should be debriefed before the report and findings are published.

4.12 Step 8: Preparation and consideration of the SCR report

4.12.1 The lead reviewer will present the final report (and executive summary) to the SCR review team before it is sent to the Committee chair(s) for consideration by the Committee(s). This includes both internally- and externally-commissioned reports. The Committee(s) should deliver the report to the Chief Officers Group. The Committee(s) may ask the lead reviewer to present the report at the Chief Officers/CPC meetings.

- Committee(s) and the review team will wish to consider arrangements for correcting factual errors or misunderstandings in drafts of the report.
- The review team will consider what mechanisms are to be used to enable contributors to check the accuracy of what is recorded as it is drafted for the interim and/or final report.
- SCR reports should say whether or not the child, young person or adult and families/carers were informed and involved. If not, they should record a reason. If they were involved, reports should record the nature of the involvement and document how their views have been represented.
- Depending on the particular case and sensitivities, consideration should be given to arrangements for feedback to the family. This may also include how they can input to check the accuracy of what is recorded in the interim and/or final report.
- The Committee(s) should ensure that the review team and lead reviewer take account of the requirements of the Freedom of Information (Scotland) Act 2002 and the Data Protection Act 1998 in both the conduct and reporting of the review. **See Appendix 5**

4.12.2 The Committee(s) and chief officers will be responsible for considering the findings of the SCR report and developing these into appropriate recommendations / actions.

4.13 Step 9: Dissemination and publication

For each individual SCR, the Committee(s) – in conjunction with the Chief Officers – should have a dissemination strategy that best serves the public interest and the purpose of improving service delivery. The following points should be considered:

4.13.1 *Dissemination*

- Committee(s) should agree timing of local dissemination which involves all agencies and which ensures the spread of any identified good practice as well as learning, particularly to front-line practitioners.
- In order to promote national learning, the findings from all SCRs should be shared among Committee(s) and National Convenors' groups. This should include any good practice identified.
- SCRs which include a specific finding with national implications should be shared with the relevant organisation and with the Scottish Government
- The Care Inspectorate, on behalf of the Scottish Government, acts as a central collation point for all SCRs carried out by Child Protection Committees since 1 April 2012. Equivalent arrangements do not exist for SCRs led by Adult Support and Protection Committees or Violence Against Women Partnerships as yet.
- The Committee(s)' first responsibility is to report to the chief officers group. But the Committee(s) must also consider the wider reporting requirements and distribution of the report/executive summary. A list of potential organisations and people to whom the report/executive summary can also be sent to is at **Appendix 6.**

4.13.2 *Publication*

- It is for the Committee(s) (with chief officers' approval) to decide whether to publish the repot in full, the executive summary or not at all. There will be a presumption of publication of the report (with appropriate safeguards) in order to promote and support national learning and improvement activity, unless Committee(s) can demonstrate there are exceptional circumstances that justify not publishing.
- Influencing this decision will be considerations about the need to restore public confidence, protections within the Data Protection Act 1998, sensitivities and balancing interests in terms of the right to respect private and family life detailed in Article 8 of the European Convention on Human Rights. Where redactions have been made, an explanation of the legal basis for these will be given.

- It is imperative that the child/adult's right to privacy and the child/adult's right to be protected are at the forefront of all decisions and communication relating to publication of a SCR report.
- Family/carers and/or other significant adults in the child/adult's life should get a copy of any report in advance of publication except if they are subject to any criminal proceedings in respect of the case.
- Publication of the report may need to be delayed until the conclusion of criminal or FAI proceedings. Where criminal, FAI or children's hearings proceedings are ongoing the publication of any report should always be discussed with COPFS and/or SCRA.
- Reports will normally be published on the www.dundeeprotects.co.uk website for a minimum period of 12 months, unless agreed otherwise by the COG. Following removal from the website and for the benefit of national and shared learning published reports will be made available on request via the Lead Officer(s).

4.13.3 *Other considerations*

- Whether an oral briefing for relevant parties in advance of publication is required. This is particularly the case where there is likely to be interest in the case amongst the wider public and may avoid misrepresentation.
- How publishing the SCR report will provide evidence of learning.
- Liaison with COPFS/police/SCRA where criminal proceedings have taken, or are taking, place.
- Whether all parties have been informed and their views taken into account
- Whether staff integrity has been respected and duty of care considered.

4.14 Step 10: Completing the learning cycle

The Committee(s) should consider how the analysis and findings from an SCR can best inform learning and practice. Types of learning that can be shared, exchanged or disseminated from significant case reviews include:

1. Learning about undertaking a review – What are the key challenges? How have Committee(s) overcome these? What changes or provisions could be made to support this process?
2. Learning from the analysis and findings produced during the course of the review – What issues are evident in the documentation of the case? What challenges for practice are evident? What findings were reached and why?
3. Learning relating to the follow-through and implementation of the findings from a review – How are single and multi-agency findings implemented? How is this measured and monitored – have they been fulfilled and have they made an impact on practice (outcomes for and / or adults children)? What are the enablers and barriers to facilitating this process?

The Committee(s) / chief officers should agree mechanisms by which to consider the above potential aspects of learning and develop appropriate responses. The implementation of these responses will be monitored by the Committee(s) and a final report submitted to chief officers once also actions have been satisfactorily completed and evidence of impact/outcomes is available.

Appendix 1 - Initial case review notification

OFFICIAL-SENSITIVE-PERSONAL (once completed)
Once complete this form should be sent electronically by e-mail to the relevant Lead Officer(s) Protecting People Team **as soon as possible and in any case within 7** calendar days of first informing the Lead Officer(s).

Name(s)/identifier:	
CHI/URN	
Date of birth	
Gender	
Name of parents/carers/ relevant third parties	
Parent/Carer/third party address	
Sibling names/DOB/ Gender/Address	
Home address	
Current residence	
Current legal status	
Is the individual currently involved in protection processes?	**YES/NO**
Are any family members involved in protection processes?	**YES/NO**
Has the individual previously been involved in protection processes	**YES/NO**
Grounds on which the criteria for an SCR may have been met	
Evidence on which this is based	
Are there any immediate concerns? If so, what are these and have these been passed to the relevant agency for consideration/action?	
What action has been taken?	
Are there any general concerns? If so what are these and have they been passed to the relevant	

agency/service for consideration?	
Summary of the case	
Name of service/agency/professionals involved with the child	
Any other statutory proceedings underwa:	
Is another local authority involved, including cross border?	

List and attach any relevant documents.

Appendix 2 – INITIAL CASE REVIEW REPORT

OFFICIAL-SENSITIVE-PERSONAL (once completed)

PART A

When asked to do so, agencies/services should complete this initial case review report and send it electronically by e-mail to the relevant Lead Officer **as soon as possible and in any case within 14 calendar days**.

This report should contain information relevant to the agency/service contact/interaction with the subject or person. Each agency/service will submit details of their own involvement with the subject or person. **The form must be quality assured by an appropriate senior manager prior to submission.**

All initial case review reports received by the Lead Officer(s) will be acknowledged.

Date circulated:
Date to be completed:
Date returned to designated officer:
Author:
Service/agency:

Name(s)/identifier:	
URN/CHI	
Date of birth:	
Gender:	
Name of parents/carers/ relevant third parties:	
Parent/Carer/third party address:	
Sibling names/ DOB/Gender/Address:	
Home address:	
Current residence:	
Current legal status:	
Is the individual currently involved in protection processes?	**YES/NO**
Are any family members involved in protection processes?	**YES/NO**
Has the individual previously been involved in protection processes	**YES/NO**

PART B

1. Summary of involvement:
2. Background (include relevant issues such as health, disability, cultural, religious, sexual orientation, legal status, history, education history, previous protection concerns):
3. Outline of key issues including: • Were there strategies and actions to minimise harm? • Was there evidence of Information sharing? • Was there recognition and assessment of risk? • Was timely and effective action taken? • Was there evidence of planning and review? • How good was the Record keeping?
4. Practice issues Please identify known good practices as well as any known areas for improvement.
Any particular sensitivities (for example, from the PF or police about cases where there are likely to be disciplinary proceedings):
5. Recommendation Please highlight any areas which may require further consideration:

PART C (Lead Officer to complete following SCR subgroup)

1. Recommendation: a. Criteria are met, there is potential for significant multi-agency learning; and an SCR is in the public interest and in the best interests of children and young people / adults and their family. b. No SCR is needed but follow-up action by one or more agencies is required. (Detail) c. No further action **2. Date to Committee:** **3. Date to Chief Officer's Group:** **4. Date Information added to SCR Register by Lead Officer:** (Protecting People/Workstreams/SCR Guidance)

Name	Committee	Lead Officer	Date of ICR/SCR	Decision	Progress of Recommendations/ Trends

5. Notification of decision to all parties
(Detail)

Appendix 3 – Person specification for lead reviewer

The skills and qualities required for the lead reviewer, both internal and external, include:

Chairing

- Consider practice experience required for person chairing review – this may differ depending on the particular circumstances of the case
- Responsible for ensuring the required skills and experiences of the review team are made available
- Role of body/person setting terms of reference and providing progress reports
- No preconceived views of the case/outcome
- Quality – ability to set out ground rules

Knowledge base

- Should have an in-depth knowledge of protecting adults

Analytical skills

- Those chairing/leading reviews must have the ability to interpret and analyse complex multi-agency processes and information.
- Identify what sounding boards the group may have
- Identify where to seek knowledge specific area/profession
- Logical thinking ability to map out review process
- Need to understand the context in which services are delivered.

Person qualities

- Those conducting reviews require to be open minded, fair, a good listener and a logical thinker.
- Experience of practice at various levels across an organization
- A blend of confidence and humility (to be prepared to learn)
- Need to understand professional backgrounds of those involved and be a multi-agency team player

Skills for undertaking the review

- Approachable
- Need to have awareness of adult support and protection
- Risk Assessment/Management
- Ability to challenge constructively
- Open mindedness/fairness
- Good listener
- Fair person
- Logical thinking
- Emotional intelligence
- The interviewing of significant witnesses takes time and must be undertaken with perseverance and with sensitivity
- Consider practice experience for those undertaking review – this may differ depending on circumstances of the case being reviewed

Appendix 4 – Remit

The following example provides a framework for Committees in the development of a remit for use during an SCR.

Internal or External Significant Case Review
SCR Model
Lead Reviewer/Chair
Review Team
Support for Lead Reviewer/Review Team
Deadline for production of reports
Service User/Family Involvement
Support for staff
Media handling
Recommendation to Committee
Recommendation to Chief Officer's Group

Appendix 5 Data Protection and Reports

The following is an extract from a Significant Case Review completed in September 2013 and may be useful in considering the report structure and content:

'This document contains the conclusions and recommendations of the Significant Case Review relating to D. In the interests of transparency, every effort has been made to disclose as much of the Significant Case Review as is lawfully possible. The only editing prior to disclosure is the redaction of personal data, disclosure of which cannot be justified under the Data Protection Act 1998 ("the DPA"). Although there has been a criminal trial and extensive media coverage of this case, and a significant amount of both personal data and sensitive personal data is, as a result of this, publicly available, disclosure of the personal data contained in this report must still comply with the DPA. This means that even though some of the redacted information may already be publicly available, or it may be considered to be in the public interest to disclose, it cannot automatically be disclosed, as the DPA contains certain conditions which must first be met.

The process of redacting the Significant Case Review has involved careful consideration of:-

- The need for transparency and the overall purpose of the Significant Case Review in the identification of any lessons learned
- The public interest in disclosure

Considering whether information is sensitive personal data, (for example, because it is information about a person's physical or mental health or condition, his/her sexual life, or the commission or alleged commission of an offence) and whether its inclusion in the Significant Case Review complies with the Data Protection Act 1998.

Balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention on Human Rights, meaning that any information contained in the report relating to D himself and other people whose history was closely linked to D can only be released if it is lawful, necessary and proportionate to do so.

Following this, the review panel concluded that in the unique circumstances of this case, it would not be appropriate to release the main body of the report. The narrative of the report could not be redacted so as to remove all information carrying an identification risk or the possibility of causing harm to third parties, and it was felt that removing all such information would lead to the report being at best meaningless and at worst misleading.

The conclusions and recommendations have been included but with certain text (generally containing biographical details) redacted for the reasons set out above. Any redactions are clearly marked with the word "[Redacted]". Some minor grammatical changes have been made (not flagged) to maintain consistency of language following some redactions.

Appendix 6 - Dissemination/publication – interested parties

Those with responsibility for local service delivery and review will include:

- Public protection committees (child protection, adult protection, violence against women, offender management, alcohol and drugs);
- Chief officers: Chief Executive of Dundee City Council/Chief Executive of NHS Tayside/Police Scotland representative;
- Executive Director of Children & Families Service and Health and Social Care Partnership/Chief Social Work Officer/senior managers in the police, Health & Social Care Partnership, Children & Families Service and NHS Tayside;
- Staff involved in the review;
- Crown Office and Procurator Fiscal Service;
- Children's Reporter/Scottish Children's Reporter Administration (SCRA);
- Inspectorates – Care Inspectorate, HM Inspectorate of Constabulary, Health Improvement Scotland and Mental Welfare Commission;
- Social Work Scotland; and
- Voluntary organisations and independent providers, where they are involved in the case.

Those with wider interests in the SCR report could include:

- Child/young person/adult/family/carers and/or significant others of person involved;
- Local councillors/health board chairs/representatives of Police Scotland;
- Local authority, health board and police press officers;
- Scottish Government;
- Other public protection committees;
- COSLA;
- Professional representative bodies;
- Legal representatives; and
- Unions.

Other key interests are likely to be:

- The general public;
- Elected members, for example, MSPs, MPs and Councillors

Appendix 7 - Inter-related processes

Criminal investigations

The core functions and jurisdiction of the police in Scotland are specified by the Police and Fire Reform (Scotland) Act 2012. This includes a duty to protect life and property. The police are an independent investigative and reporting agency to both the Crown Office and Procurator Fiscal Service and to the Children's Reporter (SCRA). The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

Crimes and offences

If the police get information, by whatever means, that a crime or offence has been committed, they are duty-bound to investigate. Principally the role of the police is to establish:

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether grounds exist for referral to the Principal Reporter, under the terms of the Children's Hearings (Scotland) Act 2011 section 67;
d) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
e) Submit a report to the Procurator Fiscal and/or the Principal Reporter.

Where allegations of physical, sexual and emotional abuse are made the police consider the following – in collaboration with other agencies – before initiating the investigation:

- The immediate safety and wellbeing of the child/adult and any other children/adults;
- The need for medical attention, immediate or otherwise;
- The opportunity of access to the victim and to other people by the alleged perpetrator;
- The relationship of the alleged offender to the victim;
- The time over which the alleged abuse has occurred;
- The need to remove the child/adult or other children/adults from the home, although this will only take place after discussion between the supervisor on duty in both the police and the relevant social work departments; and
- The need to obtain and preserve evidence.

After consideration of the above, which should establish the risks and needs of the child/adult, the investigation will begin. In many such cases a senior investigating officer (SIO) will be appointed to oversee the investigation.

In matters where a serious crime or offence has been committed, the investigation will usually be conducted by specially trained officers from the Criminal Investigation Department. If the crime involves the abuse of a child, these officers will be supported by specially-trained officers from the Public Protection Unit.

The evidence of the crime or offence will be gathered in a variety of ways. These would include obtaining statements from key witnesses, gathering forensic evidence such as DNA, fingerprints, hairs and fibres and interviewing suspects.

Upon the conclusion of the investigation, the police will prepare a report and this will be submitted to the Procurator Fiscal and/or the Children's Reporter. Decisions will also be made as to whether the accused should remain in police custody pending their appearance in court, whether they should be released on undertaking which may specify certain restrictions/provisions, or whether they should be released pending report and summons.

Sudden and unexplained deaths
All sudden and unexplained deaths must be reported to the Procurator Fiscal. The death is usually reported by a doctor (either a general practitioner (GP) or a hospital doctor), by the police or a local registrar of births, deaths and marriages.

Whether or not the cause of death is known, if a doctor is of the view that a death was clinically unexpected, it is described as a 'sudden death'. When the cause of death is not known or is not clear to a doctor, this is described as an 'unexplained death'.

Once a person's death is reported to the Procurator Fiscal, it is for the Procurator Fiscal to decide what further action, if any, will be taken.

The Procurator Fiscal may decide that further investigation is required which may include, but is not limited to, the instruction of a post mortem examination to determine the cause of death and/or instructing the police to carry out further enquiries and provide a report.

While some investigations may conclude once a cause of death is known, others may require further detailed and sometimes lengthy investigation, for example, those involving complex technical and medical issues which may require the instruction of independent experts to provide an opinion. At the conclusion of the Procurator Fiscal's investigation, it may be necessary for a fatal accident inquiry (FAI) to be held.

Once a death has been reported to the Procurator Fiscal, they have legal responsibility for the body, usually until a death certificate is issued by a doctor and given to the nearest relative. The Procurator Fiscal will usually surrender legal responsibility for the body once the nearest relative has the death certificate.

In a small number of cases, the Procurator Fiscal may need to retain responsibility for the body for longer to allow for further investigations to be carried out. This happens with only a very small number of deaths, most likely where the death is thought to be suspicious. If this is necessary, nearest relatives will be advised by the police or the Procurator Fiscal.

Post mortem examination
The Procurator Fiscal will instruct a post mortem examination for all suspicious deaths; all deaths which remain unexplained after initial investigation; and in a number of other situations where there are concerns about the circumstances or cause of the death.

Suspicious deaths
Where circumstances suggest that criminal conduct may have caused or contributed towards the death, this is described as a 'suspicious death'. The Procurator Fiscal will instruct the police to investigate the circumstances and consider whether criminal charges should be brought which may lead to a prosecution. All deaths where the circumstances are thought to be suspicious must be reported to the Procurator Fiscal.

In circumstances where the death is considered to be potentially suspicious, the Procurator Fiscal may direct a two-doctor post mortem examination to corroborate the finding. This would be an essential element in the chain of evidence, particularly where criminal investigations and/or proceedings were to be instigated later.

Normally, a senior investigating officer (SIO) will be appointed to investigate suspicious deaths and specially trained officers would carry out these investigations. These investigations may well identify criminality and also those who may be responsible, and in these circumstances the police would follow their established investigative procedures.

Good practice would always suggest that a family liaison officer acts as the single point of contact between them and the police.

In child death cases, the procedures applied and followed are in fact the same, albeit, the services of a paediatrician and/or paediatric pathologist would be sought, often along with a forensic pathologist.

Fatal accident inquiry (FAI)
An FAI is a public court hearing which publically inquires into the circumstances of a death. It will be presided over by a sheriff and will usually be held in the Sheriff Court. If the death occurred as a result of an accident while the deceased was in the course of employment or where the person who died was at the time of death in legal custody (for example in prison or police custody) an FAI is mandatory. The Lord Advocate has discretion to instruct an FAI in other cases where it appears to be in the public interest that an inquiry should be held into the circumstances of the death. An FAI would not automatically be held in respect of a child death.

The purpose of an FAI is to ascertain the circumstances surrounding the death and to identify any issues of public concern or safety and to prevent future deaths or injuries. The Procurator Fiscal has responsibility for calling witnesses and leading evidence at an FAI, although other interested parties may also be represented and question witnesses.

At the end of an FAI, a sheriff will make a determination. The determination will set out:

- where and when the death and any accident resulting in the death took place
- the cause of death, or any accident resulting in the death
- any reasonable precautions that might have meant the death and any accident resulting in the death could have been avoided
- any defect in system/working practice which caused or contributed to the death or any accident resulting in the death
- any other facts relevant to the circumstances of the death

The court has no power to make any findings as to fault or to apportion blame between individuals. A sheriff has the power to recommend steps which ought to be taken to prevent a death occurring in similar circumstances in future. While there is no compulsion on any person or organisation to take such steps it would be unusual for such a recommendation to be disregarded.

Death of a looked after child (LAC) review
This review is triggered by the death of a child who is, or has previously been, looked after by a Scottish local authority. The purpose is for the local authority to assure itself and others, including Ministers, that it acted promptly and competently in the particular case and to identify any necessary improvements. Public interest may needs to be taken into account.

This inquiry is internal to local authorities and is based on this guidance. The expectation is that Scottish Ministers and the Care Inspectorate would get a report as soon as possible (and not more than 28 days) after the death.

Ministers may:

- Examine the arrangements made for the child's wellbeing during the time they were looked after;
- Assess whether action taken by the local authority may have contributed to the child's death;
- Identify lessons which need to be drawn to the attention of the authority immediately concerned and/or other authorities or other statutory agencies;
- Review legislation, policy and guidance in the light of a particular case or any trends emerging from deaths of children or young people being looked after, or previously looked after.

MAPPA significant case review
The fundamental purpose of MAPPA is public protection and managing the risk of serious harm posed by certain groups of offenders. It is understood that the responsible authorities and any partners involved in the management of offenders cannot eliminate risk – they can only do their best to minimise that risk.

It is recognised that, on occasions, offenders managed under the MAPPA will commit, or attempt to commit, further serious crimes and, when this happens, the MAPPA processes must be examined. This is firstly to ensure that the actions or processes employed by the responsible authorities are not flawed and, secondly, where it has been identified that practice could have been strengthened, plans are put in place promptly to do so.

There are five stages to a MAPPA SCR;
1. Identification and notification of relevant cases
2. Information gathering
3. Decision to proceed, or not, to an SCR
4. Significant case review process
5. Report and publication

The criteria for undertaking an SCR in MAPPA is:
- When an offender managed under MAPPA is charged with murder, attempted murder or a crime of serious sexual harm;
- Significant concern has been raised in respect of the management of a MAPPA offender which gives rise to serious concerns about professional and/or service involvement;
- Where it appears that an offender managed under MAPPA is killed or seriously injured as a direct result of their status as a sex offender becoming known.

Learning from adverse events through reporting and review: A national framework for NHS Scotland (HIS)
As per the Mental Welfare Commission report recommendation *Left alone - the end of life support and treatment of Mr. JL* (July 2014), processes should make reference to this document and consider the integration and coordination of these processes wherever possible.

Adverse Event Review for Unexpected Death
This list of Significant Adverse Events describes distinct events categorised by the organisation as ones that must always be reported when they may have resulted in:
- unexpected **death 1**
- **significant harm** (harm includes negative physical and emotional impact) to a patient and family
- may have **required intervention to save life**

These events must always be reported to the appropriate Associate Medical **and** Nurse Director who will carry out initial review of the event, inform the relevant Director and refer the event to the Executive Medical **and** Nurse Director for a decision whether to progress to Significant Adverse Event Review (SAER). This must be actioned as soon as possible based on a brief review of the event. This initial review is not an in-depth systems analysis. The AMD and AND may recommend a Directorate led system analysis following this initial review.
The record of the death should be recorded if the person:

- was an in-patient
- was on the current community caseload
- has been in contact with the service in the last 12 months
- has been referred to the service but not yet seen
- has been discharged from the service within the last 3 months

The death was:

- suicide or possible suicide
- possibly related to service (e.g. titration, delay in commencing treatment, change from usual pattern of attending appointments, non-compliance with treatment plan)
- "other" unexplained e.g. suspected or accidental overdose

The adverse event does not require review if it is clear the death is unrelated to the service or the death is attributed to a medical condition such as cancer.

Care Inspectorate
The role of the Care Inspectorate is to regulate and inspect care, social work and child protection services so that:

- vulnerable people are safe
- the quality of these services improves
- people know the standards they have a right to expect

The Care Inspectorate reports publicly on the quality of these services across Scotland, and can support and encourage the development of better ways of delivering these services.

Healthcare Improvement Scotland
Healthcare Improvement Scotland provides public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services, and independent healthcare services. HIS reports and publishes findings on performance and demonstrate accountability of these services to the people who use them. This makes a positive impact on the healthcare outcomes for patients, their families and the public, and feeds the improvement cycle by providing further evidence for improvement.

Mental Welfare Commission for Scotland
Investigations by the Mental Welfare Commission focus on one person, but have lessons for many organisations. The Commission carries out an investigation into an individual's care and treatment when it believes there are similar issues in other people's care and lessons to be learnt for services throughout Scotland.

Serious Incident Review
The purpose of a serious incident review is to ensure that local authorities and partner agencies identify areas for development and areas of good practice.

Following a serious incident the Care Inspectorate must be notified of such within 5 working days. The Care Inspectorate will forward to Scottish Government Criminal Justice division. The local authority is then required to undertake a review of the serious incident and submit this to the Care Inspectorate within 3 months of the notification. The review can be completed in two ways: firstly and initial analysis review is completed - this may be enough with the local authority concluding no further detailed review is required or; secondly following an initial analysis review a more comprehensive review is required.

A serious incident is defined as an incident involving:-
'Harmful behaviour, of a violent or sexual nature, which is life `threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible.'
(Framework for Risk Assessment Management and Evaluation: FRAME)
And includes:

- An offender on statutory supervision or licence is charged with and/or recalled to custody on suspicion of an offence that has resulted in the death or serious harm of another person.
- The incident, or accumulation of incidents, gives rise to significant concerns about professional and/or service involvement or lack of involvement.
- An offender on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

The Care Inspectorate will then provide a written response to the review and the case will then either be closed or additional information sought. DRAFT October 2016
33

Significant Adverse Event NHS
There are 3 categories of reviews for Significant Adverse Events:

- **Category I** Events that may have contributed to or resulted in permanent harm, for example death, intervention required to sustain life, severe financial loss (£>1m), ongoing national adverse publicity
- **Category II** Events that may have contributed to or resulted in temporary harm, for example initial or prolonged treatment, intervention or monitoring required, temporary loss of service, significant financial loss, adverse local publicity
- **Category III** Events that had the potential to cause harm but i) an error did not result, ii) an error did not reach the person iii) an error reached the person but did not result in harm (near misses)

The categories are based on impact of harm. A senior manager or Director is assigned to ensure the review is undertaken at the appropriate level. There are six stages of adverse event management:

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event
3. Initial reporting and notification

4. Analysis and categorisation
5. Review
6. Improvement planning and monitoring

The report outlining the findings, conclusions and recommendations from the review should be presented through local NHS management structures.

Offences under Adult Support and Protection (Scotland) Act 2007
Obstruction
Section 49 provides that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the Act. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under section 10 (examination of records etc.). However if the adult at risk prevents or obstructs a person, or refuses to comply with a request to provide access to any records, then the adult will not have committed an offence.
A person found guilty of these offences is liable on summary conviction to:

- a fine not exceeding level 3 on the standard scale; and/or
- imprisonment for a term not exceeding 3 months.

Offences by corporate bodies etc.
Where it is proven that an offence under Part 1 of the Act was committed with the consent or connivance of, or was attributable to any neglect on the part of a "relevant person", or a person purporting to act in that capacity, that person as well as the body corporate, partnership or unincorporated association is also guilty of an offence.
A "relevant person" for the purposes of this section means:

- a director, manager, secretary or other similar officer of a body corporate such as limited company, a plc., or a company established by a charter or by Act of Parliament;
- a member, where the affairs of the body are managed by its members;
- an officer or member of the council;
- a partner in a Scottish partnership; or
- a person who is concerned in the management or control of an unincorporated association other than a Scottish partnership.

An unincorporated association is the most common form of organisation within the independent and third sector in Scotland. It is a contractual relationship between the individual members of the organisation, all of whom have agreed or "contracted" to come together for a particular charitable purpose. Unlike an incorporated body the association has no existence or personality separate from its individual members.