Interim National Framework for Adult Protection Committees for Conducting a Significant Case Review

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Contents

Foreword

The implementation of the Adult Support and Protection (Scotland) Act 2007 placed a duty upon Local Authorities to establish Adult Protection Committees. The Guidance for Adult Protection Committees states that, 'joint consideration of individual cases may help Adult Protection Committee members to develop greater joint understanding of service user concerns and professional practice.' It then further encourages Adult Protection Committees, 'to evaluate and learn from critical incidents'.

The Public Bodies Act 2014 created Integrated Joint Boards for health and social care and defined the vision for the reform of Scotland's health and care services with an aspiration to be 'seamless from the point of view of those who use them'. Significant Case Reviews are important, firstly, for those individuals and families who have been directly affected by a critical incident, and secondly, to ensure that we learn across the adult protection system. The learning from Significant Case Reviews needs to inform the way in which agencies work together to deliver joined up safeguarding and support and care to those who need it.

Many areas have now carried out Significant Case Reviews. They have proven to be a key tool in satisfying the Committees' statutory duties around reviewing procedures, cooperation, quality assurance of practice and improving skills and knowledge.

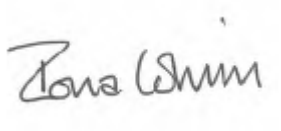
It is anticipated that this new national framework will provide a baseline for consistency in carrying out Significant Case Reviews. In turn, this will provide the opportunity in future to analyse and share the learning across Scotland to further assist Adult Protection Committees. To support consistency further, consultation on changes to the relevant sections in the current guidance for Committees on learning from significant incidents will be required.

This framework is not the last word in how Significant Case Reviews should be completed but provides a framework that will offer a level of consistency as we move forward in the development of this complex and important area of work. Drawing the learning from these reviews is important as we strive to embed that learning in procedures and practice. This will support Adult Protection Committees in their ongoing efforts to enhance the support and protection we offer to adults at risk of harm.

We also expect each individual agency and Health and Social Care Partnership to ensure this learning is directed through their clinical and care governance or quality assurance and standards arrangements.

Sincere thanks are due to all those who contributed to the development of this interim framework. Their expertise and insight was crucial to its development, and is an example of partnership working in practice.

The Scottish Government's Programme for Government for 2019-20 includes a commitment to improve the support and protection given to adults at risk of harm, through the delivery of a three year Improvement Plan. The publication of this framework is one of the first actions to be delivered as part of these improvements, and there are more to come. We need to keep working together to make Scotland a safe and supportive place for adults at risk of harm to live.



Iona Colvin
Chief Social Work Advisor to the Scottish Government

Introduction

The purpose of this framework is to support a consistent approach to conducting Adult Protection Significant Case Reviews and improve the dissemination and application of learning both locally and nationally. Supporting and protecting adults at risk of harm is an inter-agency and inter-disciplinary responsibility supported strategically by an Adult Protection Committee. This framework is for all partners.

Significant Case Reviews should be seen in the context of a culture of continuous improvement and will focus on learning and reflection around day-to-day practices, and the systems within which practice operates. Consideration should always be given to the involvement of staff in reviews and subsequent feedback to them at the conclusion of the review.

Adult Protection Committees should carry out Significant Case Reviews in certain circumstances and this Framework sets out those circumstances. Other case review and legal processes, may need to be considered when planning to undertake an Adult Support and Protection Significant Case Review [please see **Annex 1**].

This national framework should be viewed as guidance to:

- assist in the protection of adults at risk of harm
- assist decisions about the effectiveness of the particular route adopted and help manage the overall process
- complement the protocols and procedures that have been approved by adult protection committees
- support the development of local protocols and procedures or inform the review of existing protocols and procedures
- help identify how processes can be managed through other suggested routes and review structures – including commissioning reviewers
- provide sample templates

Roles and responsibilities

The Adult Support and Protection (Scotland) Act 2007 (‘the Act’) was passed by the Scottish Parliament in February 2007. ‘The Act’ was implemented in October 2008 and specified the powers and duties in relation to protecting adults at risk of harm.

Under ‘the Act’, local authorities (or those with delegated duties) have a statutory duty to make inquiries about the well-being, property or financial affairs of an individual if they know or believe that the person is an adult at risk and that they might need to intervene to take protective actions. ‘The Act’ provides powers available to council officers to carry out investigations as deemed appropriate for the

purposes of inquiry into the circumstances of an adult in order to protect them from harm.

Sections 5.1, 5.2 and 5.3 of ‘the Act’ place a duty on those agencies named that when they know or believe an adult is at risk of harm they must report the facts and circumstances of the case to the relevant council. Furthermore the agencies named must also co-operate with inquiries made by the council in relation to adults at risk of harm.

Section 42(1) of ‘the Act’ states that each local authority has a duty to establish a multi-agency Adult Protection Committee with the following functions:

(a) to keep under review the procedures and practices of the public bodies and office-holders to which this section applies which relate to the safeguarding of adults at risk present in the council's area, including, any such procedures and practices which involve co-operation between the council and other public bodies or office-holders.

(b) to give information or advice, or make proposals, to any public body and office-holder to which this section applies on the exercise of functions which relate to the safeguarding of adults at risk present in the council's area,

(c) to make, or assist in or encourage the making of, arrangements for improving the skills and knowledge of officers or employees of the public bodies and office-holders to which this section applies who have responsibilities relating to the safeguarding of adults at risk present in the council's area.

The conduct of Significant Case Reviews by the Adult Protection Committees under these functions will help to reduce harm to adults at risk by identifying areas for improvement and sharing learning.

Governance

The Adult Protection Committee is responsible for deciding whether a Significant Case Review is warranted using the criteria in this framework, and for agreeing the manner in which the review is conducted on behalf of the Chief Officers Group or equivalent. The Convenor of the Adult Protection Committee advises and makes a recommendation to the Chief Officers’ Group when a Significant Case Review is required. As such, the Chief Officers’ Group is the commissioner of any Significant Case Review with an interest in its findings and the ownership of the process and any reports generated belong to the Adult Protection Committee.

Each Adult Protection Committee will have approved procedures for managing referrals about potential Significant Case Reviews. This should include:

- decision-making about the appropriateness of the referral
- how the referral should proceed
- arrangements for commissioning a Significant Case Review

Some Adult Protection Committees may have an established group whose role is to oversee on behalf of the Adult Protection Committee matters relating to Significant Case Reviews. Where there is an established group, local arrangements should outline the key roles and responsibilities of the group. Key agency representatives should be identified to attend the group meetings. In this framework, a reference to an Adult Protection Committee could mean such a group where local delegation allows.

Following the death of an adult, or the identification of serious concerns about an adult, who was subject to adult support and protection processes or should have been, agencies should assess the circumstances of the case to identify if there are any immediate actions that need to be taken. Regardless of whether or when a Significant Case Review takes place, it is important that any areas for improvement of practice identified by the immediate evidence should be addressed as soon as possible.

Who can request a Significant Case Review?

Any agency with an interest in an adult's wellbeing and safety can request that a case be considered for review by an Adult Protection Committee where they consider the criteria for a review is met. It should be noted that concerns raised by families and addressed through the relevant agencies' normal complaints procedure may also be a trigger for a Significant Case Review where the agency considers the criteria for a review is met. The agency addressing the complaint would refer the circumstances to the Adult Protection Committee for their consideration at the earliest opportunity.

Definition of an adult at risk of harm

'The Act' refers throughout to an "adult", and at Section 53, the term "adult" means a person aged 16 or over, and an Adult at Risk is defined in Section 3(1) as those who:

- are unable to safeguard their own well-being, property, rights or other interests
- are at risk of harm
- because they are affected by disability, mental disorder, illness or physical or mental infirmity are more vulnerable to being harmed than adults who are not so affected

Definition of harm

S 53 of ‘the Act’ states harm includes all harmful conduct and, in particular, includes:
(a) Conduct which causes physical harm
(b) Conduct which causes psychological harm (for example: by causing fear, alarm or distress)
(c) Unlawful conduct which appropriates or adversely affects property, rights or interests (for example, theft, fraud, embezzlement or extortion)
(d) Conduct which causes self-harm

The Code of Practice to ‘the Act’ explains that the definition is not exhaustive and no category of harm is excluded because it is not explicitly listed. In general terms, behaviours that constitute 'harm' to a person can be physical, sexual, psychological, financial, or a combination of these. The harm can be accidental or intentional, as a result of self-neglect or neglect by a carer or caused by self-harm and/or attempted suicide. Domestic abuse, gender based violence, forced marriage, human trafficking, stalking, hate crime and 'mate crime' will generally also be harm.

Inter-related investigations, reviews and other processes

There are a number of other processes, including criminal investigations and NHS Significant Adverse Event reviews, that could be running in parallel with a Significant Case Review [please see **Annex 1**] and this raises a number of issues including:

- relationship of the Significant Case Review with other processes, such as criminal proceedings and Health Board reporting and reviewing frameworks
- securing co-operation from all agencies, including relevant voluntary sector interests in relation to the release and sharing of information
- minimising duplication through the integration and coordination of these processes wherever possible
- ensuring a sufficient degree of rigour, transparency and objectivity

Depending on the case, there could be a number of processes which come into play which are driven by considerations wider than service failure or learning lessons across agencies. These can include a criminal investigation, report of a death to the Procurator Fiscal or a Fatal Accident Inquiry. In addition to this, agencies should ensure that the areas for improvement identified and shared learning are directed through the relevant clinical and care, or quality assurance, governance arrangements.

These processes may impact on whether a review can be easily progressed or concluded; criminal investigations always have primacy. To help establish what status a Significant Case Review should have relative to other formal investigations there should be on-going dialogue with Police Scotland, COPFS or others to

determine how far and fast the Significant Case Review process can proceed in certain cases. Good local liaison arrangements are important. Issues to be considered include:

- how to link processes
- how to avoid witness contamination
- how to avoid duplicate information being collected
- whether to postpone a Significant Case Review until determination of a parallel proceeding

There could be cross-cutting issues, for example, gender based violence, human trafficking, problematic alcohol and drugs use or young people in transition from children's services. On occasion complex interconnected events may require consideration of a joint Significant Case Review.

Processes can, and do, run in tandem, and the basic principles to follow are: check if there are other processes going on from the start; ensure good communication with each other; and ensure the relevant information is shared with the right parties. Above and beyond this, the priority is that the adult is, and remains, safe, regardless of other ongoing investigations (including criminal investigations). Consideration should be given to the safety of other adults who could also be at risk of harm. The rights of staff or others, who are under investigation, but have not been charged or found guilty, is another factor to be taken into account.

Cross-authority cases

A Significant Case Review in one Adult Protection Committee area may involve agencies from a different local authority, health board or police division; care home residents may be placed out of district from the commissioning authority for example. Delay in making contact should be avoided.

In the case of a potential cross-authority Significant Case Review, the relevant Adult Protection Committees should agree a mechanism for joint working, including which Adult Protection Committee should take the lead, and if required joint commissioning of a lead reviewer. It will also be important that clear channels are identified for how information is shared across local authorities. This should be authorised by the Adult Protection Committee Conveners and coordinated through the Adult Protection Committees, with authority delegated to Coordinators or Lead Officers. They should advise the Chief Officers' Group or equivalent. Any disputes (between local authorities) should be escalated to the Chief Officers' Group or equivalent for consideration and Chief Social Work Officers should be kept informed.

Where a dispute is not resolved and one Adult Protection Committee wishes to progress, the other Adult Protection Committee should make all the information that they hold on the case available to support the review. The detail of their decision not to proceed should be noted within the Significant Case Review.

Cross-UK cases

Cross-UK Significant Case Reviews have been rare, but it is possible that adults at risk of harm and their families/carers could become involved with services across borders and a Significant / Serious Case Review involving two or more countries may be considered.

It is not possible to provide definitive guidance, as each case under consideration will be unique. However, building on the experience and learning of those Adult Protection Committees who have undertaken such Significant Case Reviews the following points should be considered:

- early contact with the Local Adult Safeguarding Board (England), Area Adult Protection Committees (Wales), and the equivalent in Northern Ireland to identify a link person and provide that body with a link person within the Adult Protection Committee

- make available the remit of the Significant Case Review and request the remit of the appropriate Safeguarding Adults Board or equivalent

- enter into a memorandum of understanding, which should be explicit in its terms regarding access to records and staff and liaison with family members, for example

- consider having a member of the Safeguarding Adults Board, or its equivalent, 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 publish every Serious Case Review for public dissemination and in Northern Ireland Case Management Review (CMR) executive summaries are published. As there is no legal requirement to publish Significant Case Reviews in Scotland any references to data from Scotland may have to be redacted

- consider joint contact with the adult at risk of harm and their family/carers (or other significant persons) to make them aware of the cross-UK nature of the Significant Case Review and establish what arrangements will be carried out for

feedback, and for informing the family/carers of the publication of the Significant / Serious Case Review outcome

The purpose of a Significant Case Review

An Adult Support and Protection Significant Case Review is a means for public bodies and office holders, with responsibilities relating to the support and protection of adults at risk, to learn lessons from considering the circumstances where an adult at risk has died, or been significantly harmed. It is carried out by an Adult Protection Committee under its functions of keeping procedures and practices under review, giving information and advice to public bodies and helping or encouraging the improvement of skills and knowledge of employees of public bodies as set out in section 42 (1) of 'the Act'.

A significant case review should seek to:

- understand the full circumstances of the death/serious harm of the adult (where parallel processes like a criminal investigation are in place, it may not be possible to gather and report full information);
- examine and assess the role of all relevant services, relating both to the adult and also, as appropriate, to relatives, carers or others who may be connected to the incident or events which led to the need for the review;
- explore any key practice issues and why they might have arisen;
- establish whether there are areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults at risk;
- identify areas for development, how they are to be acted on and what is expected to change as a result;
- consider whether there are issues with the system and whether services should be reviewed or developed to address these; and
- establish findings which will allow the Adult Protection Committee to consider what recommendations need to be made to improve the quality of services.

The overarching objectives of review are to:

- keep under review the procedures and practices of the public bodies and office-holders required to cooperate with councils to which section 43 (3) of 'the Act' applies which relate to the safeguarding of adults at risk present in the council's area
- give information or advice, or make proposals, to any public body and office-holder to which section 43 (3) of 'the Act' applies on the exercise of functions which relate to the safeguarding of adults at risk present in the council's area
- share learning with relevant agencies and make recommendations for action

- consider how any recommended actions and learning will be implemented
- address the accountability, both 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 about an adult at risk of harm.

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

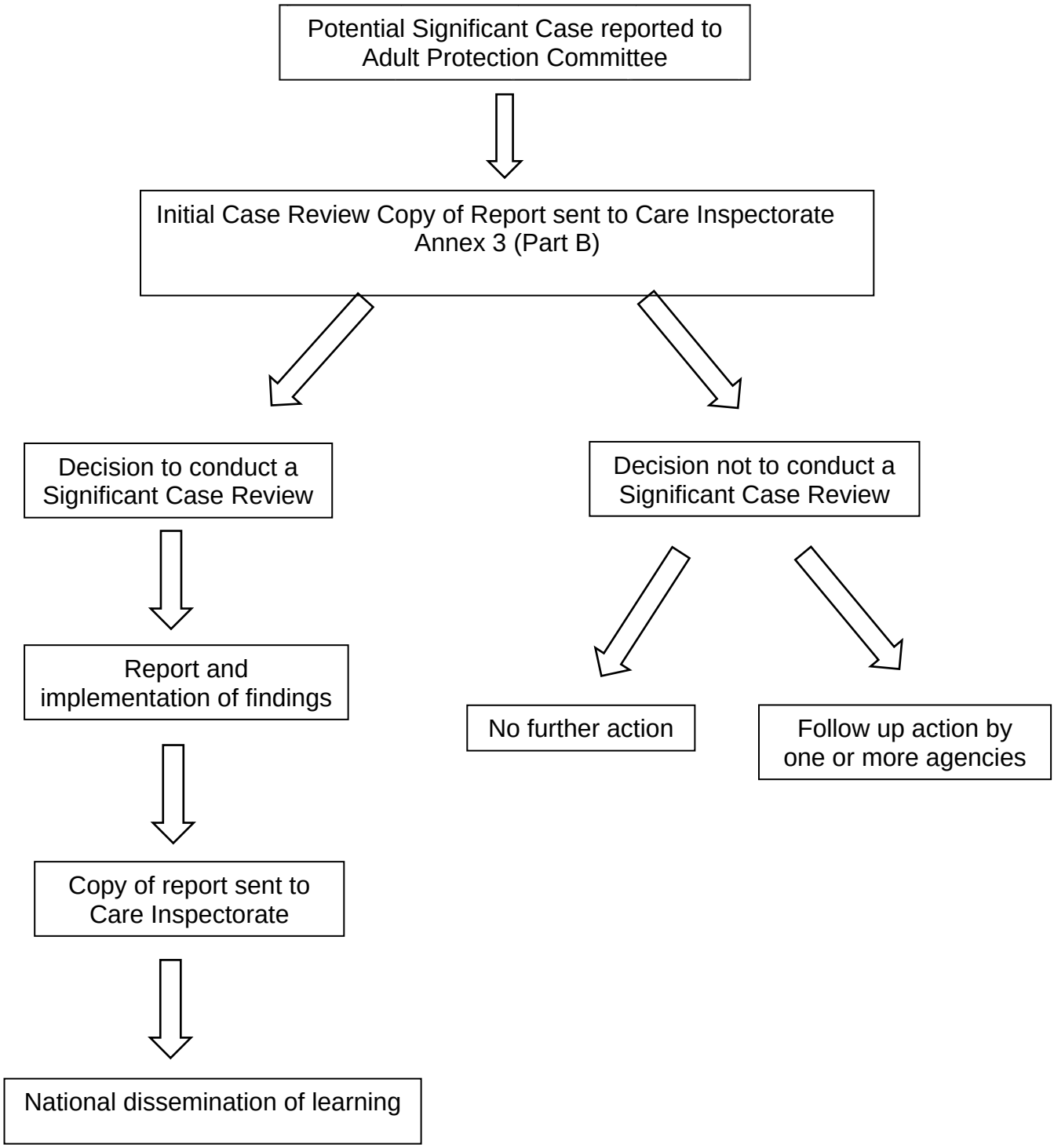
- undertake them at a level which is necessary, reasonable and proportionate
- adopt a consistent, transparent and structured approach
- identify the skills, experience and knowledge that are needed for the review process and consider how these might be obtained
- address the needs of the many individuals and agencies who may have a legitimate interest in the process and outcome

This framework sets out:

- the criteria for identifying whether a case is significant
- the procedure for undertaking an Initial Case Review
- the process for conducting a Significant Case Review including reporting mechanisms and dissemination of learning
- tools to support the process of conducting an Initial or Significant Case Review

Figure 1

Overview of the case review process



Criteria for establishing whether a case is significant

A significant case need not comprise just one significant incident. In some cases concerns may be cumulative. A case is significant when one of the following applies:

a) Where the adult is, or was, subject to adult support and protection processes

(i) When an adult at risk of harm dies and the incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional or service involvement in relation to an adult who is, or was, the subject of adult support and protection processes, **and** one or more of the following apply:

- harm or neglect is known or suspected to be a factor in the adult's death;
- the death is by suicide or accidental death;
- the death is by alleged murder, culpable homicide, reckless conduct, or act of violence.

OR

(ii) When an adult at risk of harm has not died but has sustained harm or risk of harm as defined in the Adult Support and Protection (Scotland) Act *2007* **and** in addition to this, the critical incident or accumulation of incidents (a case) gives rise to significant/serious concerns about professional or service involvement in relation to an adult who is, or was, the subject of adult support and protection processes.

b) Where the adult who died or sustained serious harm was not subject to adult support and protection processes

(i) When the findings of an inquiry or review by another organisation or court proceedings, or a referral from another organisation gives rise to significant/serious concerns about lack of involvement in relation to the Adult Support and Protection (Scotland) Act 2007.

OR

(ii) The Adult Protection Committee determines there may be learning to be gained through conducting a Significant Case Review.

Initial Case Reviews

An Initial Case Review is an opportunity for the Adult Protection Committee to consider information relating to the case, determine the course of action and recommend whether a Significant Case Review or other response is required.

An Initial Case Review should not be escalated beyond what is proportionate taking account of the severity and complexity of the case. The process and its timescales should not detract from agencies taking whatever urgent action is required to protect any other adult who may be at risk of harm. When a case meets or appears to meet the criteria above an Initial Case Review should always be undertaken. Where time limits are referred to it is important that they are adhered to. If there is difficulty with a time limit the report should record the reason for the delay. Support for staff may need to be considered.

Adult Protection Committees should develop their own local operating protocol for handling Initial Case Reviews which should identify who has delegated authority to accept the initial notification, instruct any further information-gathering and make a decision on whether to proceed to a Significant Case Review. Each local Initial Case Review operating protocol should be agreed with the Chief Officers' Group or equivalent. It should firmly reflect this national framework but retain sufficient flexibility to suit local structures.

Summary of the Initial Case Review Process

Step 1: Potential significant case notified to Adult Protection Committee as soon as practicable after the event or when a series of events suggests a Significant Case Review maybe appropriate.

The Initial Case Review Notification form should be used (**Annex 2**): This includes:

- a statement about the current position of the adult, and if they are alive, what actions have been or will be taken on their behalf
- a brief description of the case and the basis for referral
- any other formal proceedings underway or completed (see page 6 and **Annex 1**)
- a summary of agency/professional involvement
- contact details

When complete the Initial Case Review Notification Form should be passed to the Adult Protection Committee coordinator or nominated person who notifies all agencies or persons involved with the adult using the Initial Case Review template (in **Annex 3**).

Step 2: Agencies gather information and submit a report to the Adult Protection Committee or mandated sub group (this refers to the initial review and remains generic as areas may have different local arrangements; for example, a Quality Assurance Subgroup of an Adult Protection Committee) as soon as possible, but no longer than the time period agreed with the Adult Protection Committee, using the Initial Case Review Report template **(Annex 3)**.

The information gathering process should include:

- a summary of involvement including background
- an outline of key issues
- a chronology
- any identified elements of good practice
- any identified areas for improvement
- details of any inter-related processes, investigations or reviews and any particular complexities (e.g. from the Procurator Fiscal, Police or any other agency, about cases where there are ongoing, or likely to be, criminal proceedings, Fatal Accident Inquiry or disciplinary proceedings) Details of any underlying or cross-cutting issues (this may involve consideration of any other agencies that should have been involved)

If agencies cannot reasonably complete the Initial Case Review Report for the Adult Protection Committee within the suggested times, this and the reasons for this should be recorded.

Step 3: The Adult Protection Committee coordinator or nominated person liaises with other agencies where there are parallel processes taking place or the case is cross local authority or cross UK. It will be necessary to establish points of contact and to gather the most up-to-date information from these other agencies to inform the Adult Protection Committee's decision on whether, and when, to proceed or not.

Step 4: The Adult Protection Committee or mandated sub group, meets to consider the information as soon as possible, or the Convenor convenes a meeting of all the agencies to consider this and reports back to the Committee or sub group. They will either make a decision on whether or not the case proceeds to Significant Case Review or request further information from agencies to be provided as soon as possible/within an agreed time period,. Having a considered chronology and a timeline for this stage can help with decision making and identifying information gaps.

Step 5: The Adult Protection Committee or mandated sub group decide whether or not to proceed to a Significant Case Review. A Significant Case Review should only be undertaken when the criteria are met, where there is potential for significant corporate learning and where a Significant Case Review is in the best interests of adults at risk and in the public interest. Where the Adult Protection Committee cannot agree whether or not to progress to a Significant Case Review, this could be resolved by giving the Adult

Protection Committee Convener the final decision or casting vote. Following consideration there are several potential outcomes:

- a Significant Case Review should be carried out
- a Significant Case Review, or a decision on this, may be deferred until the outcome of another investigation, review or process is known, if necessary
- the Adult Protection Committee may decide that no Significant Case Review is needed but follow-up action by one or more agencies is required if, for example, local protocols need to be reinforced. The Adult Protection Committee may want to draw appropriate guidance to staff's attention or to review training or protocols around a particular theme. They may also decide to initiate local action to rectify an immediate issue or to undertake single agency action. Follow-up action should be agreed and scheduled into the Adult Protection Committee's future work programme.
- where the Adult Protection Committee is satisfied there are no concerns and there is no scope for significant corporate learning or the information provided indicates that appropriate action has already been taken, they may decide to take no further action

Step 6: Reporting the outcome to the Chief Officers' Group or equivalent
The Adult Protection Committee advises and makes recommendations to the Chief Officers Group or equivalent on the outcome of an Initial Case Review and any decision to proceed to a Significant Case Review.

Step 7: Notification and recording of decisions. All decisions (including no further action) and the reasons for these decisions should be recorded by the Adult Protection Committee. A report, using the headings in **Annex 3** and a record of decision-making should be compiled. Each Adult Protection Committee should maintain a register of all potentially significant cases referred to it in order to evidence the decisions made; monitor the progress of the reviews undertaken; monitor and review the implementation of recommendations; and identify contextual trends (e.g. prevalence of substance misuse).

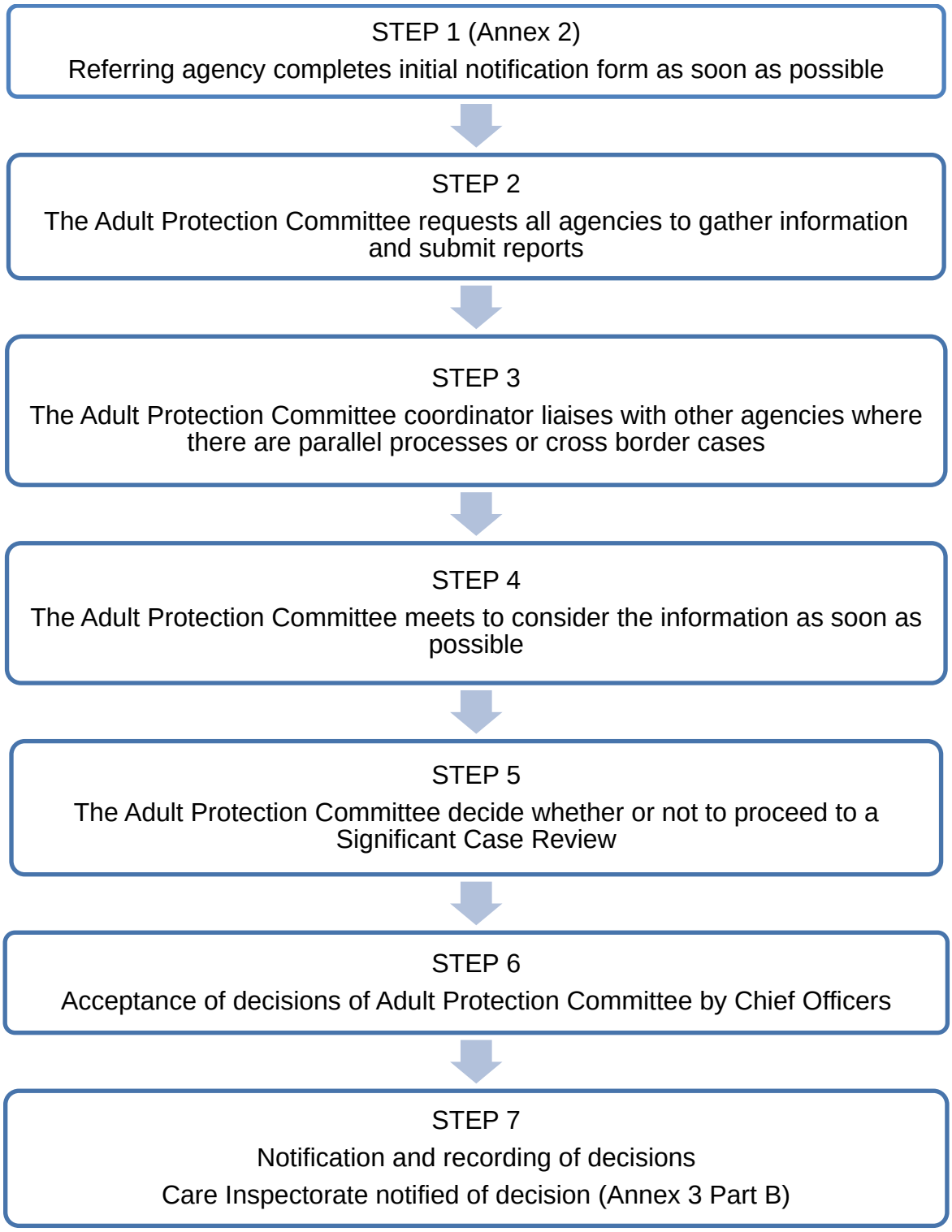
A written record of the decision should be sent to all agencies directly involved with the adult and stored appropriately. Each agency should ensure that the outcome and decisions are noted within the relevant clinical and care governance structures. If a decision is made to proceed to a Significant Case Review, the Adult Protection Committee should advise the adult and/or family/carers of its' intentions.

Notification should be sent to the Care Inspectorate, using part B of the initial case review report (**Annex 3**), and, if appropriate for parallel processes, to other relevant parties (for example, Crown Office and Procurator Fiscal Service). By receiving and collating decisions made by Adult Protection Committees in respect of Initial Case Reviews, the Care Inspectorate will be better able to understand and report on the relationship between Initial and Significant Case Reviews and factors that influence decision-making. This should help ensure that the framework is being applied effectively.

The assumption throughout is that an Adult Protection Committee should proceed as speedily as feasible at all stages of an Initial Case Review and a Significant Case Review, and that agencies should proceed likewise. It is important that reviews are carried out timeously, not least to reduce stress on the adult; their family or carers; and on the staff involved. The complexity or circumstances of certain cases may result in the preferred timescales not being met.

Figure 2

Initial case review process flowchart



Carrying out a Significant Case Review

1) Interdependencies

A potentially complex set of activities (see **Annex 1**) may be triggered by a significant case. It is important that local services do not interfere in or contaminate that activity, especially in relation to evidence gathering where there is, or might be, a criminal investigation – whether of staff involved in a case or a third party. The key requirement is to maintain good ongoing dialogue with the COPFS and/or Police Scotland to ascertain where they are in their considerations and agree what can be progressed in the Significant Case Review. Efforts should be made to minimise duplication and ensure, as far as is practicable, that the various processes are complementary albeit their purpose could be somewhat different. These inter-related processes are less likely to take place if a significant case does not involve a death. During the course of a Significant Case Review any evidence of criminal acts or civil negligence relating to the case which comes to the attention of the Lead Reviewer (see below) or Review Team should be reported to the Police.

If not already the case, Adult Protection Committees should seek to ensure they have a named contact in the Procurator Fiscal's office to be able to pursue such ongoing dialogue as is required to meet the objectives of each type of activity.

There will also be agency-specific work that is routinely undertaken, particularly on the death of an adult at risk of harm, for example, when this occurs in hospital or is unexpected such as in the case of sudden unexpected deaths. It will be important that any Significant Case Review is coordinated to dovetail with such work to avoid duplication of effort and unnecessary further review.

2) Communication

The Adult Protection Committee should seek to inform all those who will contribute and who have a legitimate interest in the Significant Case Review at each stage of the process. It may be useful to have a single point of contact and keep a log of who requests information. As each significant case will be different, the names and roles of those with an interest might vary. Throughout the process, consideration should be given as to whether there is anyone else who should be informed, or how much information should be offered to different parties on the Significant Case Review. 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 Adult Protection Committee should agree with local agencies who the contact points should be and their role in the process, i.e. whether it is communication for information or decision-making.

3) The Lead Reviewer/s

The Adult Protection Committee will need to consider whether a significant case review should be led internally or externally or with some external overview. Adult Protection Committees must ensure that the Lead Reviewer and the review team, between them, have the necessary skills and competencies[1] to undertake a Significant Case Review. These skills will differ according to the circumstances of each case and the agreed role of the review team. **Annex 4** provides a 'person specification' list for a Lead Reviewer.

The Adult Protection Committee may decide to appoint an **internal lead reviewer or two reviewers** if the circumstances of the case, based on the evidence of the Initial Case Review, suggest that any recommendations are likely to have mainly local impact. In the case of an internal review the team would probably be drawn mainly from within the Adult Protection Committee's member agencies but it should always consider using external expertise to provide impartial advice or comment in the form of a consultant, professional advisor or critical friend.

The Adult Protection Committee may decide to commission an **external lead reviewer** if:

- there are likely to be national as well as local recommendations
- local recommendations are likely to be multi-agency rather than single agency
- the case is high profile, or is likely to attract media attention
- Councillors, MSPs or other elected members have voiced concerns about local services
- the Adult Protection Committee is facing multiple reviews
- the adult's family/carers or significant others have expressed concerns about the actions of the agencies

Where an external review is commissioned, the Significant Case Review continues to be owned by the Adult Protection Committee.

The Adult Protection Committee should agree any formal contractual arrangements that may be required. They should consider which agencies will enter into the contract and ensure that individuals have professional indemnity cover. Consideration should be given to involve legal services in the drawing up of formal contracts that incorporate areas such as timescales, fees and confidentially.

Their contract should 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. As the independent chair is acting on the instructions of the Adult Protection Committee (representing the Chief Officer Group

[1] SCIE: https://www.scie.org.uk/safeguarding/adults/reviews/care-act#skill

or equivalent) they are acting as a Data Processor and not a Data Controller for the purpose of the Significant Case Review and do not require to be registered with Information Commissioner's Office.
Regardless of whether the Lead Reviewer is internal or external the Adult Protection Committee will wish to set out clear expectations in respect of timescales, key milestones in the process and for completion of reports.

4) The Review Team

The Adult Protection Committee should ensure there is sufficient multi-agency representation on the review team in order to reflect the case in question. It is important to assemble a mixed team to support the Lead Reviewer so that key agencies feel confident their specialist issues are understood. The different perspectives of a mixed review team can add to the depth of enquiry. Any training or information requirements for the team should be considered. Consideration should also be given to the knowledge, skills and experience required in the review team.

The review team should be agreed, and their roles and responsibilities, including who will undertake tasks such as file reading and interviews, tasks, and how disputes will be resolved. No-one should be involved in a review if they were directly involved in the case in a professional capacity.

For any review team, it is important to establish whom the key contacts are in all the agencies involved. These could be designated Significant Case Review contacts who can also advise on, and broker access to, relevant practitioners and information, provide any agency information that may be relevant (protocols/guidance) and generally act as a liaison point. In addition consideration should be given to who will make the links with relevant parties beyond the main statutory agencies. The team will also need to gather relevant evidence from a wide variety of sources and be prepared to negotiate if information is not forthcoming.

The Adult Protection Committees will want to consider ensure that the Review Team has the following:

- a broad knowledge of health and social care, criminal justice and other relevant areas, such as housing
- recent operational experience at a senior level of health and social care or criminal justice
- investigation skills
- analytical and evaluation skills
- report writing skills
- an understanding of different methodologies and why one may be more appropriate than another in particular circumstances
- ability to make sound judgments 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 other bodies and establish a good working relationship
- demonstrate sensitivity to national and local level issues
- appreciation of the need to be clear about the difference between a Significant Case Review's remit and task as opposed to other ongoing proceedings relating to that case (for example, a criminal investigation)
- where required, specialist input

5) Methodology

Adult Protection Committees should always consider and agree the methodology to be used in undertaking the Significant Case Review. This may vary according to the case and agreed responsibilities of the team.

Reviewers are expected to be able to use an established and evidence-based scrutiny methodology; for example, systems approach, root cause analysis[2] or the Social Care Institute for Excellence (SCIE) 'Learning Together' model[3]. For those conducting a Significant Case Review using this methodology, there will be no specific recommendations but findings and issues for the Adult Protection Committee to consider. The Welsh Government[4] has developed a tiered approach. This has a multi-agency professional forum for cases with a shorter process and formal review processes.

6) Chronology or timeline

The Adult Protection Committee will wish to ensure that a multi-agency chronology or timeline of significant events and contacts is prepared (this may already have been prepared as part of the Initial Case Review process) and circulated to agencies and professionals to check for accuracy.

[2] NHS (2004) Root Cause Analysis (RCA) toolkit.
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59901 or
https://webarchive.nationalarchives.gov.uk/20171030124348/http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

[3] SCIE learning together to safeguard adults and children: a 'systems' model for case reviews.
https://www.scie.org.uk/children/learningtogether/ and
https://www.scie.org.uk/safeguarding/adults/reviews/care-act#approaches

[4] https://socialcare.wales/cms_assets/hub-downloads/Working-Together-to-Safeguard-People-Volume-3-Adult-Practice-Reviews.pdf

7) Remit

Depending on the comprehensiveness of the information gathered at the Initial Case Review stage it may be possible for the Adult Protection Committee, or specially convened sub-group, to agree the remit of the full Significant Case Review at or following the initial meeting. If there are areas that require further clarification the Adult Protection Committee, or sub-group, may request that agencies undertake key tasks and report back within an agreed timeframe.

In the case of an externally led review the remit of the review and the key question(s) to be addressed should be agreed in writing by the Adult Protection Committee and the External Lead Reviewer.

The clearer the remit the easier it will be to manage the expectations of those involved in contributing to the Significant Case Review, and the wider audience, inthe outcome of the review. It is recognised that the degree of complexity and/or which people to involve might not become clear until some initial work has been undertaken, especially in the case of an external Significant Case Review. 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 Adult Protection Committee or sub-group.

A deadline for production of reports, which takes account of the circumstances and context of the case, should be included within the remit. 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 Adult Protection Committee, or sub-group.

The Lead Reviewer (internal or external) must be briefed by the Convener of the Adult Protection Committee (or person with designated responsibility). The Lead Reviewer must be given access to the initial reports and chronology prepared by agencies for the Initial Case Review, to assist in identifying which agencies need to attend the Significant Case Review meetings.

The written remit of the Review should be agreed by the Adult Protection Committee. It can be reviewed throughout the process, but changes must be agreed with the Adult Protection Committee. The review team should report on progress made to the Adult Protection Committee or Significant Case Review sub group.

The remit should:

- clarify roles and responsibilities across agencies
- set a timeframe to be covered by the review
- agree a timeline for conducting the review
- be clear and deliverable

A review may reveal staff actions or inactions which are of sufficient seriousness that they need to be brought to the attention of the employer. The review team has a duty to do this, irrespective of the Significant Case Review process.

8) Support for staff involved in a review

During the review process staff should be informed and supported by their managers. There may be parallel but distinct processes running which staff are involved in (e.g. disciplinary proceedings) as well as the Significant Case Review so sensitive handling is important. The impact on staff and the implications for human resources, regulators and others requires careful consideration.

Each organisation should have its own procedures in place for supporting staff, but the following should always be considered:

- the health and well-being of staff involved
- provision of personal, welfare, counselling or trauma-informed support
- how to engage with staff, keep people informed of the process in an open and transparent way, and provide protected feedback
- the need for legal/professional guidance and support
- time to prepare for discussions and interviews and for follow up and clarity about how the information provided will be used

This framework should be given to staff involved in a review, together with a copy of the local operational protocols in place in their Adult Protection Committee area to support this framework. Once the review has been completed staff involved in the case should be given a debrief on the review and the findings before the report is published. Adult Protection Committees will also wish to consider what mechanism will be used to enable contributors to confirm the accuracy of what is recorded as it is drafted for the interim and/or final report.

9) Involvement of the adult and their family/carers

The family/carers of the adult at risk should be kept informed of the various stages of the review as well as the outcomes where appropriate. There will be occasions where the family/carers could be subject to investigation or have otherwise triggered the Significant Case Review. In these cases, information may need to be restricted.

Close collaboration with Police Scotland, the Procurator Fiscal, and any other relevant agency will be vital.

There may also be cases where families/carers are considering taking legal action against an agency or agencies that are the subject of the Significant Case Review. Individual agencies should ensure that their complaints procedures are made available to the family/carer at the outset of their involvement, and throughout any Significant Case Review investigation, as deemed necessary and appropriate. This is not the responsibility of the Adult Protection Committee or of the review team.

Significant Case Review reports should include information about whether or not the adult and their family/carer were informed and involved. If not, reports should record a reason. If they were involved, reports should record the nature of the involvement and document how their views have been represented. Diversity issues should be considered and adequate support should be provided to ensure that the adult and family members/carers are able to participate.

Care should be taken about where and when an adult, or their family/carers, are interviewed, 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 Crown Office and Procurator Fiscal Service and police prior to any interviews.

It may also be useful to assign a member of staff to liaise with the adult or the family/carer throughout the review. This person should not be involved in the Significant Case Review process or a member of the review team. 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 a Significant Case Review and making arrangements to interview the adult, family/carers or other significant adults involved. Any briefing would normally be an oral discussion.

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 into checking the accuracy of what is recorded in the interim and/or final report.

10) Resources

Resources should be considered when commissioning a Significant Case Review. It is for each Convener to negotiate with the Chief Officers' Group or equivalent to secure appropriate resources in advance. Support, advocacy and communication needs should be considered.

11) The Report

A Significant Case Review Report should seek to:

- set out the facts on the circumstances leading to and surrounding the death/serious harm of the adult (it is acknowledged that this may be difficult if there are parallel inquiries taking place, e.g. a criminal investigation);

- examine the role of all agencies involved in providing care, support and protection services (this may be achieved by establishing a chronology of agencies' and professionals' significant events and contacts), and analyse and assess the circumstances drawing out the implications and issues

- explore any key practice issues and the reasons for these

- establish the areas for improvement and lessons to be shared, about the way in which agencies work individually and collectively to protect adults at risk of harm

- consider how lessons are to be acted on and what is expected to change as a result. Consider whether there are gaps in the system and whether services should be reviewed or developed to address those gaps. Consider whether specific recommendations are required.

It is important to have a degree of consistency in the structure and content of Significant Case Review reports. This will make it easier for people to identify and use the findings or recommendations and for read-across to other reports to be made. The report should, therefore, include the areas outlined in **Annex 5**.

Adult Protection Committees should consider the necessary arrangements for correcting factual errors or misunderstandings in drafts of the report.

In agreeing the final report, whether internally or externally commissioned, the following steps apply:

1. The Lead Reviewer will present the final report (and executive summary) to the Significant Case Review team
2. The Review team will send the final report to the Adult Protection Committee Convener for presentation to the Adult Protection Committee.
3. The Adult Protection Committee will then send the final report to the Chief Officers' Group.
4. The Adult Protection Convener may ask the Lead Reviewer to present the report to the Adult Protection Committee or the Chief Officers' Group.
5. The content and acceptance of the final report (as well as considerations regarding publication, media handling as outlined below) will be agreed

between the Adult Protection Committee and Chief Officers' Group through the stepped process above.

12) Freedom of information and data protection

The Adult Protection Committee should ensure that the review team and Lead Reviewer take account of the requirements of the Freedom of Information Act 2002 and Data Protection Act 2018 [5] in both the conduct and reporting of the review. **Annex 6** contains an extract from a Significant Case Review which may be helpful in considering the report structure and content in respect of the Data Protection Act 2018. Healthcare Improvement Scotland have developed guidance on sharing information[6]. When an independent/external lead reviewer is appointed, 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. This should be done as early as possible.

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. These details can be included in data sharing agreement.

13) Dissemination

Adult Protection Committees should timeously agree a local dissemination approach which ensures the spread of any identified good practice as well as learning, particularly to front line staff.

Adult Protection Committees may also want to consider sharing reports with interested parties such as the Scottish Adult Support and Protection Conveners' Group and Social Work Scotland Adult Protection Practice Network.

The Care Inspectorate, on behalf of Scottish Government, acts as a central collation point for all Initial Case Review decisions and Significant Case Reviews completed across Scotland at the point at which they are concluded. By receiving and reviewing all Significant Case Reviews, the Care Inspectorate can better engage with Adult Protection Committees and Chief Officers to support continuous improvement locally and to disseminate common themes to support national learning.

[5] The Information Commissioner's Office publishes guidance: https://ico.org.uk/ and http://www.itspublicknowledge.info/home/ScottishInformationCommissioner.aspx

[6] http://www.healthcareimprovementscotland.org/about_us/what_we_do/freedom_of_information/our_publication_scheme.aspx

14) Publication

Whether to publish the full report or just the executive summary is a decision which should be made by the Adult Protection Committee and approved by the Chief Officers' Group or equivalent. In making this decision consideration should be given to the necessity to restore public confidence, the protections within the Data Protection Act 2018 and balancing interests in terms of the right to respect for private and family life in terms of Article 8 of the European Convention of Human Rights. Where the full report is not being published, the summary should give an explanation of the redaction that has been required. See **Annex 6** for an example.

The first responsibility of the Adult Protection Committee is to report to the Chief Officers Group or equivalent. But the Adult Protection Committee has wider responsibilities and must consider the wider reporting requirements and distribution of the Report/Executive Summary. A list of potential organisations and persons to whom the Report/Executive summary can be sent is contained at **Annex 7** but it is always up to the Adult Protection Committee in consultation with the Chief Officers Group or equivalent to decide this in each individual case.

It is imperative that the adult's right to privacy and the adult's right to be protected is at the forefront of all decisions and communication relating to publication of a Significant Case Review report.

Family/carers and/or other significant adults in the adult's life should receive 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 require to be delayed until the conclusion of criminal or FAI proceedings. Where criminal or FAI proceedings are ongoing the publication of any report should always be discussed and agreed with COPFS.
Other considerations for the Adult Protection Committee include the following.

- 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 Significant Case Review report will support learning
- whether the Significant Case Review report is set within the wider context of health and social care
- whether all parties have been informed and their views taken into account (adult, family and staff)
- has the integrity of staff been respected and duty of care been considered

15) Media handling

The media can help promote more effective prevention and intervention to protect adults at risk of harm by raising public awareness of the circumstances which can contribute to harm and what members of the community can do to mitigate these risks.

Where there is engagement with the media, the communications strategy should include a media handling plan. Most agencies will have communications officers for the agency and any protocols/handling issues should be developed in conjunction with them. Before the report is in the public domain it should be agreed who will link with the media on behalf of Chief Officers/the Adult Protection Committee, brief the relevant Communications Officer(s) and approve the wording of any quotes. No information relating to a Significant Case Review should be released to the press unless it has been approved by Chief Officers/Adult Protection Committee.

Communication with the media should focus on learning and highlight that most adults at risk of harm **are** protected. It is important to add an element of calm and focus and not to add to any sense of alarm or confusion and Adult Protection Committees should proactively offer interviews to the media where this supports their strategic objectives e.g. of raising awareness of the process of Significant Case Reviews or about the role of Adult Protection Committees.

Once the report on the Significant Case Review is published and in the public domain a high-level spokesperson, where possible, should respond to media requests

Learning from Significant Case Reviews

The Adult Protection Committee should consider how the analysis and recommendations from a Significant Case Review can best inform learning and practice. Types of learning that can be shared, exchanged or disseminated from significant case reviews include:

- considering the key challenges of the review and how these were, or could be, overcome
- reflecting on the issues identified and barriers to change, and the action that has been undertaken, or will have to be
- measuring the impact that a Significant Case Review has had

Capturing learning in relation to the process, output and follow-through of conducting significant case reviews could be achieved in different ways:

- internal/external quality assurance to appraise the process
- practice exchange/communities of expertise to share experiences, perspectives and skills
- research to critically appraise/analyse the strengths and limitations of arrangements used or to draw out messages for practice, policy and research

The Adult Protection Committee should produce a summary of cases considered by them over the course of the year and introduce these into the learning cycle, whether the decision was to undertake a Significant Case Review or not. Adult Protection Committees will determine the urgency for action planning and implementation within the learning cycle according to the significance of the issues raised.

After some Significant Case Reviews it may be necessary for other Adult Protection Committees to review their own guidance and procedures in light of the findings and recommendations. This could be facilitated through the existing groups or by specially convened meetings depending on the need for urgency.

Some recommendations from reviews may have implications for a range of bodies, and may need to be shared with agencies named in the Adult Support and Protection (Scotland) Act 2007, and other relevant bodies who have an interest in the circumstances of the case.

Significant Case Reviews are one source of information that can contribute to an agenda for learning and for practice and policy development. Other sources include the information generated through research and evaluation, inspection and audit and organisational knowledge (i.e. the understanding and awareness that exists among the staff within organisations). Together, these can provide a map of critical issues

for practice. Each also represents an opportunity to identify good practice that can be shared. Areas to consider include:

- Adult Protection Committees could report on findings from their Significant Case Reviews in their biennial reports, where published, or within their Adult Protection Committee improvement plan (or whatever report/format Adult Protection Committees consider appropriate)

- brokering of practice expertise in undertaking and implementing Significant Case Reviews

- active dissemination (i.e. presentation and discussion) of findings from quality assurance and research exercises through conferences (on Significant Case Reviews or on themes emerging from Significant Case Reviews), seminars and existing meetings (e.g. Scottish Adult Support and Protection Conveners Group, National Adult Support and Protection Learning and Development Network; local Adult Protection Committees; single-agency forums)

- dissemination (i.e. circulation) of findings from quality assurance and research exercises

The Care Inspectorate will support practice improvement as a result of national learning identified by Significant Case Reviews by holding learning events and by exploring the development of mechanisms to support better sharing of learning from Significant Case Reviews across the country.

The Care Inspectorate will undertake a retrospective review of Significant Case Reviews conducted between a period to be agreed with Scottish Government to identify national learning and support improvement in relation to both practice in implementing adult support and protection legislation and processes and arrangements for reviewing significant incidents through the Significant Case Review mechanism.

The Care Inspectorate will conduct a regular review of the Significant Case Reviews completed in Scotland, and, report nationally on the key learning points for the benefit of relevant services across Scotland and the Scottish Government.

Annex 1

Inter-related investigations, reviews and other processes or themes

Processes, which may need to be considered in addition to a Significant Case Review include:

Adverse Events (significant adverse events NHS)

In collaboration with NHS boards, Healthcare Improvement Scotland has led the development of the National Framework: **Learning from Adverse events through Reporting and Review: A National Framework for Scotland (Third edition 2018).**

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.

An **adverse event** is defined as **an event that could have caused (a near miss), or did result in, harm to people or groups of people.** The National Framework describes 3 categories of reviews for significant adverse events and a senior manager or Director is assigned to ensure the review is undertaken at the appropriate level.

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 management of adverse events should incorporate the following six stages

1. Risk assessment and prevention
2. Identification and immediate actions following an adverse event, including consideration of duty of candour
3. Initial reporting and notification
4. Assessment and categorisation, including consideration of duty of candour
5. Review and analysis
6. Improvement planning and monitoring

The report outlining the findings, conclusions and recommendations from the review should be presented through local NHS management structures. The third edition of the framework was produced following the implementation of the statutory organisational Duty of Candour legislation in Scotland on 1 April 2018.

Criminal Investigations (CI)

Within Scotland the core functions and jurisdiction of the police 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 the Crown Office and Procurator Fiscal Service. The police have a duty to investigate both crimes/offences and also any sudden and unexplained deaths.

Crimes and Offences

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

a) Whether or not a crime or offence has been committed;
b) Whether there is sufficient evidence to support a criminal charge;
c) Whether there is sufficient evidence to justify the detention and/or arrest of the alleged offender; and thereafter to
d) Submit a report to the Procurator Fiscal

Where allegations of physical, sexual and emotional abuse are made involving adults, the police consider, in collaboration with other agencies the following before initiating the investigation. Reports of Adults at Risk of Harm being received under the Adult Support and Protection (Scotland) Act 2007 include physical harm, conduct which causes psychological harm (e.g. by causing fear, alarm or distress, unlawful conduct (e.g. Theft) or conduct which causes self-harm:

- the immediate safety and wellbeing of the adult at risk
- the need for medical attention, immediate or otherwise
- the opportunity of access to the victim and to other adults by the alleged perpetrator
- the relationship of the alleged offender to the victim
- the proximity in time over which the alleged abuse has occurred
- the need to remove the adult or other adult from the home to a place of safety, although this will only take place after discussion between the supervisor on duty in both the police and the relevant Social Work Departments
- the need to obtain and preserve evidence

After consideration of the above, which should ascertain the risks and needs of the adult, the investigation will begin. In many such cases a Senior Investigation 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 of the Criminal Investigation Department.

The evidence of the crime or offence will be gathered in a variety of ways such as the obtaining of statements from witnesses who have knowledge of the events under investigation, the gathering of forensic evidence such as DNA, fingerprints, hairs, fibres, etc. and the interviewing of those person(s) suspected of being responsible.

Upon conclusion of the investigation the police will prepare a report of the circumstances and this will be submitted to the Procurator Fiscal. Decisions will also be made as to whether the accused should remain in police custody pending his/her 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.

Fatal Accident Inquiry

A Fatal Accident Inquiry is a court hearing which publically makes inquiries 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.

The purpose of a Fatal Accident Inquiry 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 a Fatal Accident Inquiry, a Sheriff will make a determination. The determination will set out:

- where and when the death occurred
- the cause of death
- any precautions whereby the death might have been avoided
- any defect in systems which caused or contributed to the death
- any other facts which are 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. The Sheriff has the power to make recommendations as to 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.

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 their 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 to, firstly, 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 Significant Case Review:

1. Identification and notification of relevant cases.
2. Information gathering
3. Decision to proceed, or not to an Significant Case Review
4. Significant Case Review process
5. Report and publication

The criteria for undertaking a Significant Case Review in MAPPA is:

- when an offender managed under MAPPA at any level, is charged with an offence that has resulted in the death or serious harm to another person, or an offence listed in Schedule 3 of the Sexual Offences Act 2003;
- significant concern has been raised about professional and/or service involvement, or lack of involvement, in respect of the management of an offender under MAPPA at any level;
- where it appears that a registered sex offender being managed under MAPPA is killed or seriously injured as a direct result of his/her status as a registered sex offender;
- where an offender currently being managed under MAPPA has died or been seriously injured in circumstances likely to generate significant public concern.

Offences

Obstruction

Section 49 of the Adult Support and Protection (Scotland) Act 2007 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.

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.

Serious Incident Review

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 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.

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

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 death 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, the Procurator Fiscal has 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, it may be necessary for the Procurator Fiscal to retain responsibility for the body for a longer period of time to allow for further investigations to be carried out into the circumstances. 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.

Suspicious Deaths

Where there are circumstances surrounding the death which 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 that a two Doctor post mortem examination be carried out for corroboration purposes of 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 well-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.

Public bodies with responsibility for scrutiny and improvement support include:

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. The Care Inspectorate has a duty to support improvement in care and social work services and promulgate good practice. The Care Inspectorate is strongly committed to supporting strategic partnerships such as adult protection committees in their continuous improvement by providing support and feedback locally and by identifying and reporting on wider themes and learning which could improve practice nationally.

The Health and Safety Executive

The Health and Safety Executive[7] is a statutory body established under section 10 of the Health and Safety at Work Act 1974. The Health and Safety Executive's main statutory duties are to:

- propose and set necessary standards for health and safety performance, including submitting proposals to the relevant SoS for health and safety regulations and codes of practice;
- secure compliance with these standards, including making appropriate arrangements for enforcement;
- make such arrangements as it considers appropriate for the carrying out of research and the publication of the results of research and encouraging research by others;
- make such arrangements as it considers appropriate for the provision of an information and advisory service, ensuring relevant groups are kept informed of and adequately advised on matters related to health and safety; and
- provide Ministers on request with information and expert advice.

[7] http://www.hse.gov.uk/enforce/index.htm

Local authorities also have a role in enforcing health and safety legislation in some privately-owned care homes. The HSE and Scottish local authorities have signed an agreement with the Care Inspectorate: http://www.hse.gov.uk/scotland/pdf/liaison-agreement-0617.pdf. The agreement has been developed to assist staff by:

- promoting co-ordination of investigations, where appropriate, into incidents that have resulted in service user deaths or serious injuries, which could have been prevented
- encouraging appropriate information to be shared in a timely manner
- establishing and maintaining liaison arrangements.

Healthcare Improvement Scotland

Healthcare Improvement Scotland, is an organisation with many parts and one purpose - better quality health and social care for everyone in Scotland. They have five key priorities. These are areas where they believe they can make the most impact and where they focus efforts and resources.

- enabling people to make informed decisions about their care and treatment.
- helping health and social care organisations to redesign and continuously improve services.
- provide evidence and share knowledge that enables people to get the best out of the services they use and helps services improve.
- provide quality assurance that gives people confidence in the services and supports providers to improve.
- making the best use of resources, we aim to ensure every pound invested in our work adds value to the care people receive.

Healthcare Improvement Scotland (HIS) 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 demonstrates accountability of these services to the people who use them. HIS also supports health and social care services to continuously improve and redesign services alongside the provision of evidence and sharing of knowledge. 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 investigations into deficiencies in an individual’s care and treatment, particularly when it believes there are similar issues in other people’s care and where lessons can be learned for services throughout Scotland. Their work is specific to individuals with mental ill

health, learning disability, and related conditions. (See Section 11 Mental Health Care and Treatment (Scotland) Act 2003).

The Mental Welfare Commission should be notified of significant events that meet the criteria referred to below:

http://www.mwcscot.org.uk/good-practice/notifying-commission

It is difficult to be prescriptive as each and every circumstance will be different.

Action 1 of the Scottish Government's report 'Review of the arrangements for investigating deaths of people of patients being treated for mental disorder' (December 2018) is:

The Scottish Government will ask the Mental Welfare Commission for Scotland to develop a system for investigating all deaths of patients who, at the time of death, were subject to an order under either the Mental Health (Care and Treatment) (Scotland) Act 2003 or part VI of the Criminal Procedure (Scotland) Act 1995 (whether in hospital or in the community, including those who had their detention suspended).

This process should take account of the effectiveness of any investigation carried out by other agencies and should reflect the range of powers the Commission has to inspect medical records, carry out investigations, and hold inquiries (as set out in sections 11-12 and 16 of the 2003 Act). The design and testing of the new system should involve, and be informed by the views of carers, families and staff with direct experience of existing systems. It should include appropriate elements of public scrutiny and should involve staff, families and carers. The new system should have clear timescales for investigation, reporting and publication.

The Commission is working to develop this system of reviews and further information and guidance will be issued to all stakeholders at an appropriate stage.

The Office of the Public Guardian

The Office of the Public Guardian[8] has statutory powers to supervise financial guardians, financial interveners and withdrawers, and powers to investigate them (and continuing attorneys) where there is a concern or risk of financial abuse.

The Office of the Public Guardian aims to ensure that these appointed proxies act in the best interests of the adult with incapacity, and that they carry out their duties properly, within the scope of their powers. If there is a concern about how an appointed proxy is acting, an investigation may be undertaken, and the incapable

[8] https://www.publicguardian-scotland.gov.uk/

adult's property or financial affairs may be appropriately safeguarded from risk from abuse or misuse.

Anyone who has concerns that an adult's funds/property are at a risk, can refer the matter to Office of the Public Guardian. They will need to provide evidence to support those concerns. Concerns might include:

- the way in which an attorney, who has authority to manage an adult's finances or property, is using that authority.
- an adult's property or financial affairs appears to be at risk, perhaps because of the involvement of a third party who has no authority to manage the adult's finances.

When investigating continuing attorneys, the Office of the Public Guardian only has a locus when the granter/adult has lost capacity; when a current and future risk has been identified (the Office of the Public Guardian does not have a remit to investigate historical matters); and, where no other proxy (joint attorney) has been appointed who could investigate and safeguard the estate.

The Scottish Fire and Rescue Service (SFRS)

The Scottish Fire and Rescue Service is a national organisation delivering front-line services locally across three Service Delivery Areas (SDAs) in the North, West and East of the country. SFRS works in partnership to reduce the incidences of fire in Scotland and, continues to play a key role in prevention, to ensure the safety and wellbeing of Scotlands' communities.

The SFRS have a specialist fire investigation units located in each SDA (Glasgow, Edinburgh and Aberdeen). The teams work exclusively on fire investigation. Their role allows them to build a comprehensive knowledge base, identify issues, track trends and understand the circumstances surrounding the fire event. The investigation process culminates in a detailed report that identifies the origin, cause and fire development. This information is shared across the organisation and partners (where appropriate) in order to learn from previous incidents and, improve community and firefighter safety. By jointly investigating fire incidents, the SFRS aim to reduce the instances of fire and reduce the number of fire deaths, injuries and trauma resulting from such incidents.

A multi-agency "Protocol" to jointly investigate fires was introduced in 2013. This protocol commits SFRS, Police Scotland and Scottish Police Authority (SPA) Forensic Services to work together and share their specialist skills and expertise when dealing with certain levels of investigations. The Protocol ensures that the approach to investigations is consistent across the organisations, and across the country.

Scottish Social Services Council

The Scottish Social Services Council (SSSC) is the regulator for the social services workforce in Scotland. SSSC register social services workers, set standards for practice, conduct, training and education and support professional development. Where people fall below standards of practice and conduct they can investigate and take action.

The fitness to practice process of a professional regulator, such as SSSC, may be running in parallel with a Significant Case Review. Where there are issues with the conduct of workers who are registered with the SSSC it would be helpful to keep them informed. This will support the coordination of activity between organisations and minimise duplication.

Annex 2

Exemplar Initial Case Review Notification

CONFIDENTIAL (when complete)

The designated person within any agency should complete this Initial Case Review Notification and send it electronically by e-mail to the local Adult Protection Committee lead **as soon as possible and in any case within ( )** calendar days of first informing the agreed lead.

The Adult Protection Committee lead, on receipt of the written notification should alert other services/agencies/practitioners who are involved that the case has been reported as a potential Significant Case Review. This alert to other services/agencies/ practitioners can be by telephone, e-mail or fax etc.

These other services/agencies will then be requested to submit an Initial Case Review Report by the Adult Protection Committee lead.

All Initial Case Review Notification Reports received by the Adult Protection Committee lead will be acknowledged.

Adult's Name/Identifier, Adult's Date of Birth and Adult's Gender;

Adult's Home Address &/or Current Residence;

Name of Adult's Next of kin/Carers and their Address/s if different;

Grounds on which the criteria for a Significant Case Review may have been met:

Evidence on which this is based:

Are there any immediate concerns? If so, who have these been passed to for consideration/action?

Are there any general concerns? If so, who have these been passed to for consideration?

Summary of the case

Name of Service/Agency/Professionals Involved with the Adult:

Any other statutory proceedings underway or completed?

Is another local authority involved, including cross border?

Annex 3

Exemplar Initial Case Review Report

CONFIDENTIAL (when complete)

PART A

As requested agencies/services should complete this Initial Case Review Report and send it electronically by e-mail to the Adult Protection Committee lead **as soon as possible and in any case within ( ) calendar days**. This report should contain relevant information pertaining to the agencies/service contact/interaction with the subject or person. Each agency/service will submit details of their own involvement with the subject or person. All Initial Case Review Reports received by the Adult Protection Committee lead will be acknowledged.

Date Circulated:
Date to be completed:
Date returned to designated officer:
Author:
Service/Agency:

Adult's Name/Identifier, Adult's Date of Birth and Adult's Gender; **Adult's Home Address &/or Current Residence;** **Name of Adult's Next of kin /Carers and their Address/s if different;**
1. Summary of involvement:
2. Background (include relevant issues e.g. health, disability, cultural, religious, sexual orientation, legal status and previous concerns or referrals re adult support and protection):
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 there evidence of planning? • How good was the record keeping?
4. Practice Issues Please identify known good practice as well as any known areas for improvement.
Any particular sensitivities (e.g. from the Procurator Fiscal or Police about cases where there are likely to be disciplinary proceedings):
5. Recommendation Please highlight any areas which may require further consideration:

PART B

6. Decisions made and reasons Case Review No: Date of review report:
7. Case review group Options to be considered: Decisions made: Reasons: Date:
8. Adult Protection Committee Date notified of decision: Note of discussion by Adult Protection Committee: Decisions made: Reasons: Date:
9. Chief Officers Date notified of above decision: Note of any comments/discussion by Chief Officers: Decisions made: Date:

Annex 4

Person Specification for Lead Reviewer/s

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

Annex 5

Exemplar Significant Case Review Report

For those conducting a Significant Case Review using the SCIE 'Learning Together' Methodology, there will be no specific Recommendations but Findings and Issues for the Adult Protection Committee to consider

Core Data – Adult	
Adult's Identifier	
Age of adult	
Gender	
Sexual Orientation	
Disability	
Health needs (including mental health and /or learning difficulties	
Education	
Living circumstances prior to incident	
Position in family/ number of siblings	
Ethnicity	
Religion	
Nature of injury/cause of death	
Legal status of adult	
Agencies/Services involved	
Family/carer factors (if applicable)	
Age	
Mental health issues	
Disability	
Health needs (including mental health and/or learning difficulties)	

Substance use (if applicable)	
Convictions (if applicable)	
Problems in childhood (if applicable)	
Domestic abuse (if applicable)	
Add antisocial behaviour (if applicable)	
Ethnicity	
Religion	
Marital/relationship status eg co-habitation	
Living circumstances	
Agencies/Services involved	
Environmental Factors	
Financial problems	
Housing	
Support from extended family/ community	
Introduction This includes the circumstances that led to the review, the purpose and focus of the review, the periods considered and agencies involved, the extent of the family's/carers' involvement. Note how long the report has taken and reasons for any delays.	
The facts This includes the family background and circumstances, and agency involvement. A chronology or timeline of significant events, (including when the adult was seen and by whom and whether the adult's views were sought) is also included. Where appropriate, the chronology may be presented in a number of distinct phases and supplemented by a written account of what happened during each phase. A genogram (a type of family tree) may be a useful format to map out key relevant person, and families. In the reviewing of the case, a full chronology will be required but for the purpose of the report, the primary aim at this stage is to highlight areas of practice or events that are considered by the review to be particularly relevant, not to provide an overly detailed account of events. As such the full chronology should not be included within the body of the report. Details of all significant others in the adult's life should also be included.	

Analysis This section critically assesses the key circumstances of the case, the interventions offered, decisions made etc. For example, were the responses appropriate, were key decisions justifiable, was the relevant information sought or considered, were there early, effective and appropriate interventions? Where the family and adult's circumstances sufficiently assessed? It should be remembered that the review is taking place with the benefit of hindsight and the analysis should consider the actions of services within the context of the circumstances of the time.
Key issues Following on from the analysis and depending on the circumstances of the case, the review should clearly identify the key areas that impacted on the adult and agency responses and then explore these further to understand how they came about. This section should assist readers to understand the "why" of what happened and a level of analysis (for example, root cause) should be applied. It would be helpful to explore key areas within a framework of cause and effect factors – for example, resourcing, organisational culture, training, policies etc.
Learning points This section highlights the key learning points from the review – again the focus here should not be on 'what happened', but the reasons why it happened as it will be these areas that services and organisations can actively take forward and address. This section should also actively address strengths and good practice identified as well as the learning that has taken place since the case, any changes in practice and policy that have been implemented and the outcome of changes.
Recommendations or if using SCIE model findings and Issues

Executive Summary

This provides a brief, possibly anonymised, account of the circumstances of the case and agency involvement. Chronologies should not be included. Analysis of the key events has to be sufficient to allow a context for the identification of the key issues and learning points but a balance has to be struck to ensure confidentiality issues are respected. The learning points, recommendations and action points should be replicated in full.

Appendices

These include, if not already within the body of the report:-

- Review Team membership
- Remit/terms of reference
- Chronology
- Files accessed/relevant documents
- People interviewed (their professional role or relationship to the adult)

Annex 6

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 (now 2018) ("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 (now 2018).

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.

Annex 7

Dissemination/Publication: Interested Parties

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

- Staff involved in the review
- The local Adult Protection Committee
- Chief Officers: Chief Executive of Local Authority/Chief Executive of Health Board/ Police Scotland representative
- Director of Social Work/Chief Social Work Officer/Senior Managers in the Police and Health Service
- Mental Welfare Commission
- Crown Office and Procurator Fiscal Service
- Inspectorates – Care Inspectorate, HM Inspectorate of Constabulary Health Improvement Scotland
- Professional regulators, for example, Scottish Social Services Council
- Voluntary organisations and independent providers, where they are involved in the case

Those with wider interests in the Significant Case Review report could include:

- Family/Carers and/or significant others of adult involved
- Local Councillors/Health Board Chairs/Representatives of Police Scotland
- Local Authority, Health Board and Police press officers
- Other Adult Protection Committees
- Professional representative bodies
- Legal representatives
- Unions

Other key interests are likely to be:

- The general public
- Elected members, e.g. MSPs, MPs and Councillors
- The media

GLOSSARY

COPFS	Crown Office and Procurator Fiscal Service
FAI	Fatal Accident Inquiry
HIS	Healthcare Improvement Scotland
SIO	Senior Investigating Officer
SSSC	Scottish Social Services Council

Membership of the Working Group (2018-19)

Jamie Aarons, Renfrewshire Health & Social Care Partnership

Colin Anderson, Glasgow City Adult Protection Committee

Maureen Berry, Healthcare Improvement Scotland

Paul Comley, ASP National Co-Ordinator

Alex Davidson, Argyle and Bute, East Ayrshire and Inverclyde Adult Protection Committees

Jean Harper, Scottish Government

Ian Kerr, Care Inspectorate

Helen King, Fife Health & Social Care Partnership

Andrew Lowe, Orkney Adult Protection Committee

Anne Neilson, NHS Lothian

Marion Sandilands, Renfrewshire Health & Social Care Partnership

Julie Stewart, South Lanarkshire Health & Social Care Partnership

Brenda Walker, North Ayrshire Health & Social Care Partnership

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