Safeguarding Adults Review Policy

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Author	**Helen Wakeling**

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The purpose of this document is:

- To ensure that local practice is in line with the Care Act 2014 statutory requirements for the Safeguarding Adults Board to undertake Safeguarding Adults Reviews.
- To provide a framework that enables safeguarding adults reviews to be undertaken in a proportionate way.
- To recognise that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPA reviews, children's serious case reviews) and the importance of managing the interface between these.
- To recognise that the adult and their family must always be offered the opportunity to contribute to the review process and are provided with the necessary support to do so. This may include involving a Care Act advocate.

1. Introduction

1.1. The Care Act 2014 introduced a number of new duties with regard to Safeguarding Adults. One of these duties is that the Safeguarding Adults Board must undertake a Safeguarding Adults Reviews (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is reasonable cause for concern about the way agencies worked together to safeguarding the individual (s44).

1.2. The Safeguarding Adults Board can also undertake reviews in other situations, if it feels that doing so would strengthen multi-agency working.

1.3. Members of the Safeguarding Adults Board are required to co-operate and contribute to the carrying out of a review by sharing information and applying the lessons learnt. The Care Act (s45) also enables the Safeguarding Adults Board to request relevant information from anyone in order to support it in undertaking a review.

1.4. Every review should take into account what was known to practitioners working with the individual or could have been reasonably been expected to be known by them at the time. Consideration should also be given to the capacity of the person at risk and their views and choices.

1.5. Safeguarding Adults Reviews are not enquiries into how an adult at risk died or who is culpable. They are an opportunity to consider how agencies worked together, to share lessons learnt so that we can further improve the way we work together with adults at risk of abuse or neglect.

1.6. This policy reflects the six key safeguarding principles that underpin all adult safeguarding work:

Empowerment	People being supported and encouraged to make their own decisions and informed consent
Prevention	It is better to take action before harm occurs
Proportionality	The least intrusive response appropriate to the risk presented
Protection	Support and representation for those in greatest need
Partnership	Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
Accountability	Accountability and transparency in delivering safeguarding

2. When should a Safeguarding Adults Review be undertaken?

2.1. A Safeguarding Adults Review can only be commissioned by the Safeguarding Adults Board.

2.2. There is a statutory duty on the Board to arrange a review of adult (aged 18 plus) in its area with needs for care and support (it is not relevant to this duty for these needs to have been met by the provision of care and support funded by the individual or other public bodies) if:

- **a.** There is reasonable cause for concern about how the Safeguarding Adults Board, members of it or other organisations worked together to safeguard the person. **And**
- **b.** The person has died and the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died). **Or**
- **c.** The person is still alive and the Safeguarding Adults Board knows or suspects that they have experienced serious abuse or neglect. In these situations serious abuse or neglect would be indicated if:
  - The individual would have been likely to have died had there not been some form of intervention or they have suffered permanent harm
  - The person has experienced reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

2.3. Safeguarding Adults Reviews undertaken under these criteria are described as statutory reviews in this guidance.

2.4. The Act also gives a Safeguarding Adults Board the opportunity to arrange a review in other situations involving an adult in its area with needs for care and support if it is felt there would be learning to be obtained. The Bath and North East Somerset Safeguarding Adults Board will consider requests to undertake a non-statutory review in situation where:

a) An adult has received support through the Safeguarding Adult's process due to concerns of abuse or neglect **and**
b) Whilst there are no concerns about the way that individuals within agencies have worked together, there is evidence that the policies and procedures of one or a number of the agencies involved did not support this joint working. This may include issues around the sharing of information or the use of resources **or**
c) There are examples of good practice that could be used to identify lessons that could be applied by agencies when working with adults at risk in the future.

3. What is the purpose of a Safeguarding Adults Review?

3.1. The statutory Guidance for the Care Act describes the purpose of a Safeguarding Adults Review as being to "to promote effective learning and improvement action to prevent future deaths or serious harm occurring again". The aim of every review should, therefore, be to learn lessons from the case and to make sure that those lessons are applied to future cases, by all agencies in Bath and North East Somerset, to prevent similar harm occurring.

3.2 It is not the role of a Safeguarding Adults Review to hold any individual or organisation to account. There are other processes that exist for this purpose which include criminal proceedings, disciplinary processes, employment law and regulations systems for both services and professional including the Care Quality Commission, the Nursing and Midwifery Council or the Health and Care Professionals Council.

4. Requesting a Safeguarding Adults Review

4.1. A request for a review can be made by:

- Any organisation/agency working with adults in Bath and North East Somerset
- Any professional from the Board's partner agencies
- The individual concerned, a family member or another interested partner such as the Coroner, Member of Parliament or an Elected Member of B&NES Council.

4.2. The following considerations should be made when deciding whether to request a statutory review:

- The concern relates to an adult with needs for care or support – whether or not they are/were in receipt of services
- Abuse, neglect or acts of omission is known or strongly suspected to have contributed to the harm caused
- There are concerns about failings relating to 2 or more organisations working with the individual and the potential to identify and improve multi-agency practice and partnership working.

4.3. There will be situations where an incident has triggered an internal or organisational process (e.g. a RCA). This organisational investigation should take

place without delay – but as part of their internal mandatory investigation or review process the organisation should consider:

- Has the investigation highlighted concerns about another organisation or how people worked together?
- Has information come to light during the investigation that identifies abuse or neglect that was not previously recognised?

4.4. Some requests may relate to people that are also subject to other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children's serious case review. See Appendix 5 for further information on these statutory review processes. In these circumstances, a request should be made with the links to the other reviews highlighted. The Board Business Manager will then discuss the request with the Chair of the Safeguarding Board and the Chairs of any of these other reviews to agree how the interface should be managed.

4.5. There may also be a criminal investigation in progress or a coroner's inquest due to be held. This should not prevent a request being made, but it will be taken into account when considering the timing or scope of any agreed review.

4.6 The adult or their family should be made aware of any intended request by the referring organisation/individual and provided with the opportunity to give their views about the request.

4.7. Safeguarding Adults Reviews do not form part of any disciplinary process. However, if there are disciplinary matters in progress regarding the situation being requested for consideration this information should be noted on the referral form?

4.8. We use an online hosting system to make notifications and manage the information required for four review types and these are:

1. Serious Case Review (SCR) for children
2. Local Case Review/Learning Lessons Review
3. Best Practice Review
4. Safeguarding Adult Review (SAR)

To submit a notification to the Board the link is:

https://www.qes-online.com/BATHNES/ECR/Live/m/ecr/public/newnotification

Guidance for completing a notification or submitting requested information is available: SCR/SAR Guidance

5. Who makes the decision to undertake a Safeguarding Adults Review?

5.1. When a request has been received the Chair of the Safeguarding Adults Board will inform the Board Business Manager and ask the Business Manager to convene a meeting of the SAR sub group.

5.2. To assist with the decision making, organisations identified in the request as

having worked with the individual may be approached to complete an initial overview form and brief chronology. Guidance for completing a notification or submitting requested information is available: [SCR/SAR Guidance]

5.3. The sub group will consider the information provided and submit a recommendation to the Chair of the Safeguarding Adults Board as to whether the request meets the requirements for a statutory review.

5.4. The sub group will also consider requests for non-statutory reviews using the criteria outline in paragraph 2.4 to make this decision. If the sub group feel the request meets the criteria for a non-statutory review they will make a recommendation to the Chair of the Safeguarding Adults Board that a review is undertaken.

5.5. The final decision as to whether to proceed to a review will be made by the Chair of the Safeguarding Board.

5.6. The Chair of the Safeguarding Adults Board will inform the following people, in writing, of the request for a SAR and the decision taken as to whether to proceed or not.

- the person/organisation that requested the SAR
- Members of the safeguarding Board
- Members of the SAR sub group.
- The Strategic Director, People and Communities, Bath and North East Somerset.
- For reviews that are to be undertaken under the statutory requirement the Chair will also notify the Care Quality Commission and NHS England if regulated services or health services are involved.

6. <u>The SAR Sub Group's responsibilities for Safeguarding Adult Reviews</u>

6.1. The SAR Sub Group will comprise of a representative from the three Core Members of the Board:

- the local authority
- the clinical commissioning group (CCG)
- the police

Plus a Lay Representative or a representative from Health Watch.

6.2. When a SAR has been agreed by the Chair of the Safeguarding Adults Board the SAR sub group will:

- Agree a provisional Terms of Reference for the SAR, which would include the period of time to be considered by the review.
- Identify the agencies that should be involved in the SAR
- Agree who will be responsible for communicating with the adult and/or their family or advocate.
- Consider if it would be appropriate to communicate with the person who is alleged to have caused the abuse or neglect.
- Agree a timescale for completion of the SAR

- Identify which methodology should be used to facilitate learning from this SAR.

6.3. The Chair of the SAR Sub Group will, in conjunction with the Board Business Manager identify an individual to lead the review. The Board has agreed that for reviews that met the statutory requirements the person leading the review must be external to any of the agencies/organisations on the Bath and North East Somerset Safeguarding Adults Board.

6.4. For non-statutory reviews an external person may be appointed or it may be appropriate to use an individual working for an organisation in Bath and North East Somerset, if they:

- Have the skills required to undertake the review
- Work for an organisation or agency that is not involved in the review.

6.4. It has been agreed by the Local Authority, CCG and Police that the cost of employing an external person to lead and write the review report will be shared equally between these organisations.

6.5. The Chair of the Safeguarding Adults Board will be asked to confirm that they are in agreement with the Terms of Reference for the SAR, the timescale for completion and the person identified to lead the process, or make adjustments as required.

6.6. The sub group will receive regular updates on the progress of the review as agreed in the terms of reference.

6.7. The Chair of the SAR sub group will ensure that progress updates are provided to the Safeguarding Adults Board at its scheduled meetings.

6.8. The draft final report together with a draft action plan will be presented to both the sub group and the Chair of the Safeguarding Adults Board.

6.9. The Chair of the SAR sub group together with the Board Business Manager will ensure that the final report is presented to the Board as soon as possible after its completion. If the timescales prevent the report from being presented at a scheduled Board meeting an exceptional meeting of the Board will be arranged.

6.10. The Chair of the SAR sub group will also agree with the Review Chair how the draft report is to be shared with the individual/ or their friends or relatives.

6.11. The sub group will be responsible for identifying which sub group will take responsibility for obtaining assurance on each aspect of the plan. This assurance will include confirmation that the required steps have been taken and the lessons learnt have been shared across organisations in Bath and North East Somerset. These actions will be monitored by the Business Manager through the Board's Business Plan.

6.13. The Chair of the SAR sub group will provide updates to the Board on the progress of the action plan and will request that a review is closed once all the actions have been completed.

7. Role of Person leading the Safeguarding Adults Review

7.1. The person leading the Safeguarding Adults Review will be accountable to the SAR sub group during the period of the review.

7.2. It is expected that a person leading/Chairing a review will have the appropriate skills and experience to lead a review process, as outlined in the Care Act guidance. These include:

- Strong leadership and ability to motivate others
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
- Collaborative problem solving experience and knowledge of participative approaches
- Good analytic skills and ability to manage qualitative data
- Safeguarding knowledge
- Inclination to promote an open, reflective learning culture
- Independence from the case under review and of the organisations involved.

7.3. During the review the person leading the review will be responsible for:

- Achieving consensus of opinion about the key areas of learning and/or areas of change identified
- Ensuring that agency representatives work together positively
- That an appropriate level of challenge is provided throughout the process
- Considerations of good practice as well as areas of development are considered during the review and included in the report.
- Agreeing with agencies and the Chair of the SAR sub group who will be the named individual responsible for in contact with the individual or family members and how the individual or their families/friends will contribute to the review.
- Keeping the SAR sub group Chair updated on the progress of the review.

7.4. The person leading the review is also responsible for:

- Writing the review report ensuring that it:
  - ➢ Is in plain English
  - ➢ Clearly identifies the learning points and recommendations being made.
  - ➢ Is suitable for publication without needing to be amended or redacted.
- Seeking agreement from all contributing agencies that they are satisfied that the report reflects the information shared and discussions held as part of the review.
- If it is not possible to obtain agreement the person leading the review has the final decision on what is written. The Chair of the Safeguarding Adults Board

should, however, be notified that agreement has not been obtained from all agencies.

- Agreeing with the SAR sub group Chair and the Chair of the Safeguarding Adults Board how the report will be shared with the Board members as well as the individual/ the family.
- Participate in any agreed communication arrangements regarding the report, including public information.

8. Safeguarding Adults Review – Methodologies.

8.1. There are many ways that learning can be obtained, but a review must be proportionate in the approach it takes. The methodology to be used for a review will be discussed by SAR sub group and a provisional recommendation about the most appropriate learning method for the case under consideration will be identified before the review begins.

8.2. A summary of the approaches that may be used are contained in Appendix 2. It is recognised that the list provided in the appendix is not exhaustive and the SAR sub group may wish to use its collective expertise to recommend an alternative approach.

9. Undertaking a Safeguarding Adults Review

9.1. The person leading the SAR will be supported in this task by the Board Business Manager and administrative support.

9.2. The methodology used for a review will affect the level of multi-agency meetings required to complete a Review.

9.3. Each involved agency will provide information as required by the methodology being used for the review.

9.4. The person leading the SAR will agree with all agencies involved how records will be presented during the review process. This may require reports that are anonymised through redaction, and an agreement made on the abbreviations to be used by all agencies. It may be that consent is obtained from the individual that their information can be shared in an un-redacted form during the review process.

9.5. Agencies must be aware that there could be public scrutiny of information provided to the Review. All agencies should therefore ensure that their submissions are approved by their organisation before they are shared with the review. This may, if considered appropriate, include obtaining legal advice prior to submission.

9.10. The report produced at the conclusion of the Safeguarding Adults Review will be anonymised with regard to individuals – including the individual/ or their families and professionals. Agency names and job roles will however be included.

9.11. The final draft report will include draft recommendations which should be reflected in the Action Plan provided together with the report.

10. Timescales for a Safeguarding Adults Review

10.1. A review must be undertaken in a timely manner. The process should be completed within six months of the decision being made by the Chair of the Safeguarding Adults Board that a review is to be undertaken.

10.2. It is recognised that there may be occasions when the issues being considered by the review may mean that a longer timescales is needed. In these situations the person leading the review must agree the revised timescale with the Chair of the Safeguarding Adults Board.

10.3. If during a review, issues regarding criminal actions or the issues regarding the safety of a service are identified this should be immediately shared with the appropriate authority. The person leading the review must inform the Chair of the SAR sub group and the Chair of the Board and agree any changes required to the timescale or the scope of the review.

11. Sharing information during a Review

11.1. The Care Act contains two new duties that will need to be considered by all agencies asked to participate in a review.

11.2. Organisations represented on the Safeguarding Adults Board in Bath and North East Somerset are required under the Care Act (s44.5) to co-operate in and contribute to the carrying out of a review with a view to:

- Identifying the lessons to be learnt from the adult's case, and
- Applying those lessons to future cases.

11.3. Section 45 of the Care Act places a legal duty on any organisation or individual asked to provide relevant information to the Board to share what they know with the Board or the person identified by the Board (i.e. the person leading a review). This section applies if the information being requested by the Board is to enable or assist it to perform its functions. As a Safeguarding Adults Review is a function of the Board this section will apply to requests for relevant information made as part of a Safeguarding Adults Review.

12. Use of an independent advocate

12.1. An independent advocate must be provided to support and represent an adult (where the adult is still alive), who is subject to a safeguarding review if

- It is considered the person would experience substantial difficulty in participating in the review person **and**
- They do not have an appropriate person (friend or family) that could support their involvement in the review.

12.2. If the person already has a Care Act Advocate or an IMCA, unless inappropriate, this advocate should be used.

12.3. Bath and North East Somerset Council are responsible for arranging and funding advocacy support in these circumstances. The person leading the review should request this support through the Deputy Safeguarding Adults and Quality Assurance Lead in the Council.

13. Involvement of Families

13.1. Families should be made aware that a review has been requested and informed if a review is going to take place. They should be offered the opportunity of contributing to the review process, but how that is done will depend on the methodology used and the views of the family.

13.2. It is the role of the person leading the review to ensure that an individual is identified to be the contact between the review and the family or person. The person leading the review will also agree that if family members or friends wish to contribute to the review how this will be undertaken.

13.3 The consent of the family or individual is not however required for a review to take place.

14. Responsibility to staff

14.1. Staff directly involved in working with an individual subject to a Safeguarding Adults Review should be notified by their employing agency that the decision has been made to undertake the review.

14.2. Information about the review process and how the staff members may be involved in the review should be fully explained by their employing organisation.

14.3. Support to staff members should be provided by the agency/organisation in line with their HR requirements.

14.4. Agencies may need to additionally consider what support is required if a systems approach is used to undertake the review, as this approach requires a high level of reflection and interaction from individuals. Whilst the outcomes of this approach should be very positive, individuals can experience it as being challenging.

15. Final Report and Action Plan

15.1 All Safeguarding Adult Review reports are owned by the Safeguarding Adults Board. A report and action plan are only final when accepted by the Board Chair, the Board and the Strategic Director, People and Communities.

15.2. Before publication the Board will need to consider what impact the publication may have on the adult at risk (deceased or alive), family members or other affected by the review.

15.3. The Board will ensure that the report complies with the Data Protection Act 1998, before it is shared.

15.4. Written contributions provided by agencies to the review as part of the SAR process, such as chronology and IMRs, are owned by the B&NES LSAB. Any supporting documents from agency records submitted, such as safeguarding minutes, care plan etc, the ownership would remain with the agency for ‘their own purposes’ (i.e. the original purposes for which they were produced such as safeguarding enquiries or care planning).

15.5. All action plans will explicitly set out how agencies will evidence that an action has been completed and how the learning from the SAR will be embedded into practice.

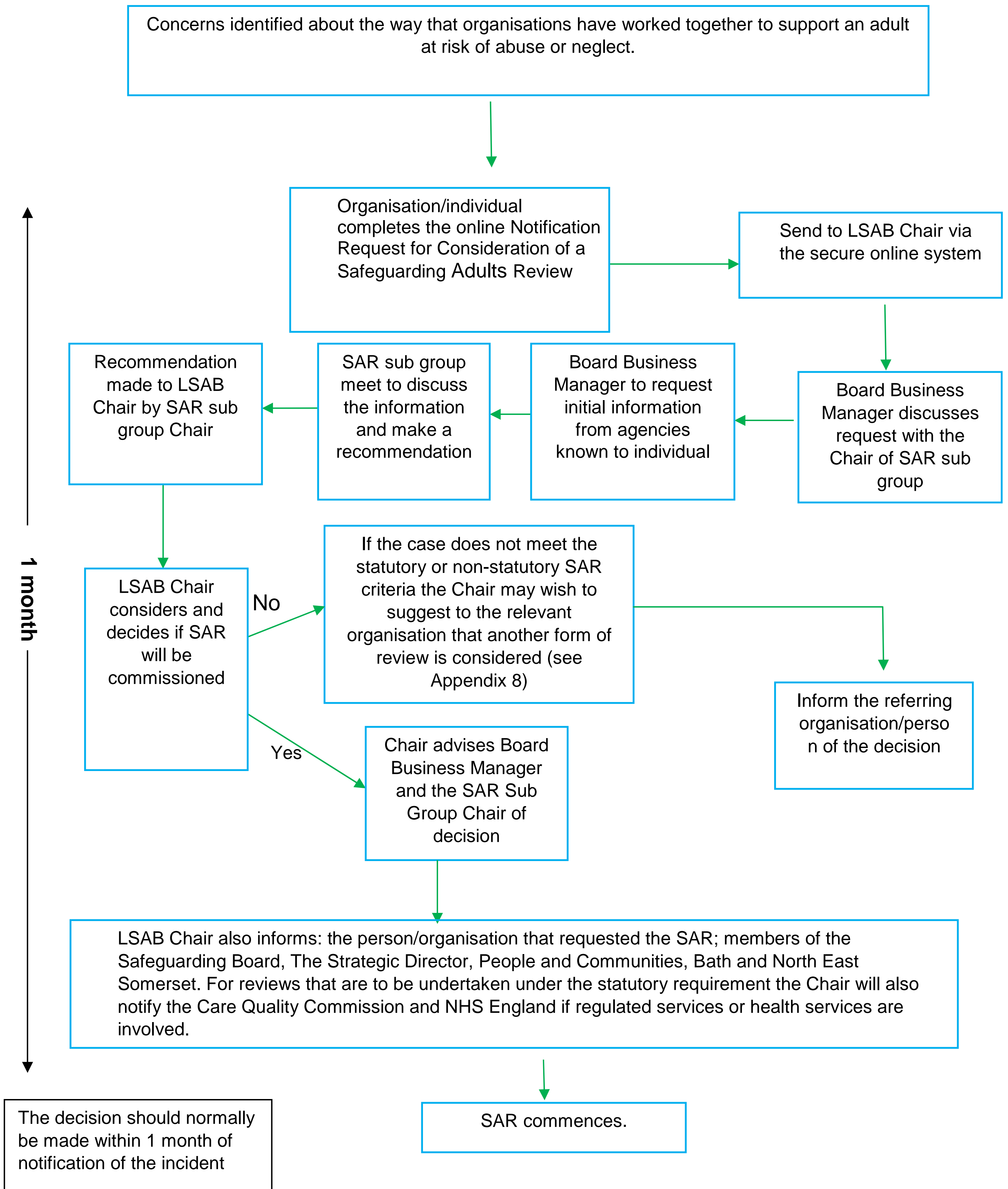
15.6. The Safeguarding Adults Board will be provided with updates on the action plan and a review will only be closed when the Board is satisfied that all the actions have been completed.

15.7. A report from every review undertaken by the Board, will be published on the Bath and North East Somerset Council website – within the Safeguarding Adults Board SAR webpages, unless there are exceptional circumstances agreed for not doing so.

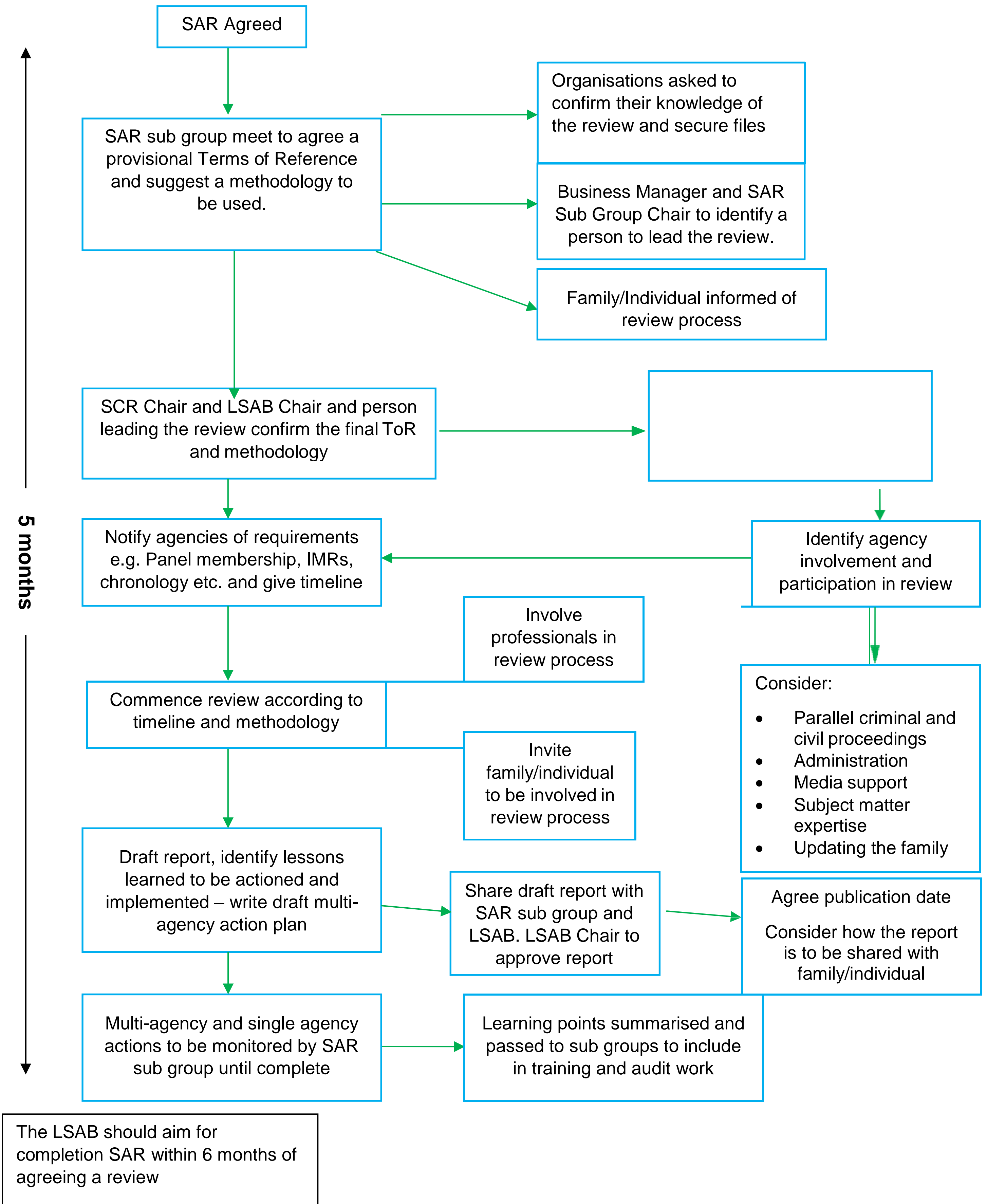
15.8. At the point of publication the Safeguarding Adults Board Chair will co-ordinate the writing of a Board Response outlining the reasons for the review, the key learning and the actions required.

Appendix 1

SAR Process Flowchart



Safeguarding Adults Review Flowchart



Appendix 2

Methodologies for Reviews

There are many ways to achieve learning and a proportionate response needs to be given to each review. When the SAR sub group is considering which methodology would be most appropriate for a review they may want to consider the approaches detailed below. It is recognised that this list is not exhaustive and the sub group will use the expertise available to it to recommend the most appropriate learning method for the review.

1. **Significant Event Analysis**

This approach brings together people from the agencies involved to consider significant events within the situation under review and together analyse what went well and what could have been done differently.

The approach has been used for many years in the NHS to analyse a significant event in a systematic and detailed way to ascertain what can be learnt by the overall quality of care and to indicate changes that might lead to future improvements.

The organisations involved are asked to provide agency reports or chronologies that detail their involvement with the individual. This information is then used to support the discussion during the multi-agency learning event that forms the central aspect of this approach.

The person leading the review will be required to undertake a facilitation role, bringing people together and encouraging an open discussion on the support that was provided to an individual. This will require the person leading the review to have the ability to handle multiple perspectives together with sensitivity to complex group dynamics.

Taking part in the learning event should be:

- Frontline practitioners including those involved with the individual as appropriate
- Line Managers
- The authors of the agency reports/chronologies
- Professional Leads/experts (as required)

Ground rules should be agreed before the meeting starts to reinforce the educational spirit of the process and ensure opinions are respected and individuals are not ‘blamed’. Minutes of the meeting should be taken and action points noted.

The analysis and discussion during the review will be supported by having the following available:

- Policies and procedures – both multi-agency procedures such as the LSAB policy and individual agency policy/procedures that are relevant to the review.

- Chronology or agency reports completed by each organisation. These should contain all key events and highlight key areas of learning or good practice from each agency.

This material should be circulate to all attendees before the learning event

The event should consider

- What happened
- Why did it happen in this way
- Is it consistent with the agency policies/ procedures
- What are the areas of good practice
- Areas for improvement
- Lessons learnt.
- What has already been changed or actioned as a result of this situation

After the learning event the person leading the review will need to consolidate all the information provided into an overview report that contains: an analysis of key issues, lessons learned and recommendations.

A further meeting with all involved in the learning event should be held to consider the draft report and action plan and make any adjustments required to agree the report.

Family members can be involved in this process by considering the initial outcomes from the learning event, identifying any areas that require clarification and offer their perspective on areas for improvement and areas of good practice.

To obtain further guidance on Significant Event Audits go to www.npsa.nhs.nrls/gp

2. Individual Management Reviews

Individual Management Reviews (IMR's) are a way of enabling organisations to reflect and critically analyse their involvement with key individuals in the case under consideration. Every organisation's IMR should identify good practice alongside the identification of areas where systems, processes, or individual/ organisational practice could be improved.

Individual Management Reviews can be used for a desk-based review or a review that involves a multi-agency panel review. The IMRs would be provided by each organisation for consideration by the review group. The role of the review group is to ensure areas of uncertainty or conflicting accounts in agency recording is explored, areas of good practice identified and issues identified that could enhance multi-agency working in the future. The person leading the review would be responsible for writing an overview report based on the individual IMR's and the panel discussions.

Individual Management Reviews can also be used as one of the sources of information for a traditional Safeguarding Adult Review.

The involvement of family members or families in an Individual Management Review can be challenging. The person leading the review may wish to consider how the family can contribute to the work undertaken by the review group. This should

include discussions with each organisation about the appropriateness of sharing a summary or the whole content of each organisations review.

A template for an Individual Management Review and a checklist for completing an IMR are available in Appendices 5 and 7

3. Multi-agency Combined Chronology

A chronology of events is a useful way of achieving an overview of a case from information obtained from a number of organisations. This enables a review to identify gaps in service provision or practice, missed opportunities for communication and areas of good practice. This methodology is best used when there is a focused period of multi-agency involvement. It is not well suited to a review that is considering multi-agency involvement over a number of years.

Once a combined chronology has been developed from each organisations submissions, a workshop should be held. The workshop would be facilitated by the person leading the review. Lead practitioners and managers from each agency should be invited to the workshop and the combined chronology used as the basis for a reflection on the ways agencies worked together. This will lead to the identification of:

- Gaps in service provision
- Areas where practice could be strengthened
- Organisational practice or procedures that impacted on the work undertaken
- Missed communication opportunities
- Examples of good practice.
- Recommendations for lessons learnt

An overview report based on these key areas will then be drafted by the person leading the review and shared for agreement before submission to the SAR sub group.

Family members or the individual concerned can contribute to this approach by providing their own chronology based on their understanding of support provided by organisations.

4. The Serious Case Review Model

This is the traditional approach to undertaking a serious case review in both adults and children services. Agencies involved are asked to submit both a chronology and an Individual Management Review. These provide the review with a detailed analysis of each agencies work with the individual and an overview of the level of multi-agency involvement.

A Review Panel is established with the person leading the review chairing this panel. The panel members are usually senior managers from the involved organisations and the person leading the review. The person leading the review may also wish to have a representative from an advocacy or service user organisation to ensure that there is a level of challenge to the perceptions of professionals throughout the process.

The task of the review panel is to:

- clarify through challenge the information provided in the individual reviews,
- obtain an agreed overview of the multi-agency involvement with the individual
- identify areas where there were gaps in service provision,
- highlight missed opportunities to communicate,
- consider areas of organisational/individual practice that impacted on the support provided
- comment on good practice.

The person leading the review is responsible for writing an overview report. This should be considered by the panel in draft form, with agencies confirming that they are in agreement with both the report and the recommended action plan.

Family members or the individual could be involved in this form of review through regular discussions with a nominated person regarding the areas being considered by the review panel. Consideration should be given to sharing the finding of the review panel verbally before the report is written so that family members or the individual can offer their perspective on the findings.

5. SCIE – Systems Review (also known as Learning Together)

This approach has been used in child protection in the last few years but has only been used to date in a small number of adult safeguarding reviews.

The central idea of this approach is that any workers performance is a result of both their own skill and knowledge and the organisational setting in which they are working. The approach looks at the quality of work produced by the combination of the worker and the tools available to them. This would include procedures, working conditions, resources and skills, as well as issues such as team and organisational cultures.

This requires the review to:

- Reconstruct how professionals saw the case at the time: speaking to staff to get their perspective on the case as it unfolded, and why they chose the actions they took.
- Identify and analyse key practice episodes, and the contributory factors behind them: looking at significant periods and aspects of the case, the practice that occurred and the factors that influenced the work the professionals did.
- Interpret the broader significance: analysing the ways in which what happened reflects wider issues in the system.

The review draws on two sources of data. The formal documentation of the different agencies involved and in-depth one-to-one conversations with key people involved in the case. The conversations are undertaken with staff, service users and families, and joint meetings of all key professionals involved in the case. The formal documentation will include records maintained by the practitioners, as well as the policies and procedures of the involved organisations.

This approach does require both the person leading the review and those involved in the review team to have some knowledge about both the methodology and how ethnographic or open enquiry research is undertaken. Unlike all the other approaches in this appendix, this approach does not propose setting Terms of Reference for the review but rather identifying issues through the enquiry process.

The final report will contain both a narrative of multi-agency perspectives and an identification of key practice episodes and their contributory factors. The report will make recommendations for strengthening future practice.

More information on this model can be found on the Social Care Institute for Excellence website www.scie.org.uk

Appendix 3

Individual Management Review Template

STRICTLY CONFIDENTIAL

Individual Management Review report from (please insert agency name and logo)

Safeguarding Adults Review for (insert agreed initials or reference)

Name and Role of Author	
Signature	
Date completed	
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Date	
Version No:	

Introduction
Family and household composition
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Appendix 4

Guidance for completion of an Individual Management Review Report Form

1. Anonymity

Throughout the report please ensure that your report is fully anonymised including names, addresses, professional names and identifiable locations e.g. names of day centres, care homes with nursing, hospitals, health centres etc. Please provide an identifying key as a separate document.

2. Introduction

This should include a:

- Brief description of your organisation and its role in relation to key individuals.
- The agreed terms of reference for the review – copied from the ToR provided by the SAR sub group.
- The sources of information that have been used to inform the review e.g. file reports, supervision records, training documents, policies and procedures, management information and interviews with staff (stating job title only not names). If you have not been able to interview staff please state the reason for this.
- Detail of related reviews and processes. If any parallel reviews (i.e. untoward incidents, mental health review, disciplinary investigations [with no identifiable details] are ongoing or completed but relevant, please make a note in this section

3. Family and household composition

Please include a description of the Adult at Risk, Person(s) Alleged Responsible and other relevant family members and significant others that your agency has had contact with.

4. Chronology of Service Provision and Involvement

This section should contain a summary of the events that occurred, information known to the agency, any assessments undertaken and decisions reached; the services offered and provided and any other action taken.

Episodes of service provision may be broken down as appropriate e.g. by periods of the case being ‘open’ with your agency, by change of keyworker and so on.

5. Analysis of involvement

The analysis should consider the events that occurred, the decisions made and the actions taken or not taken. Consideration should be given to not only what happened but why. Practice should be assessed against policies, guidance and legislation.

The following are examples of the areas that should be considered for all reviews:

Service and practitioner standards:

- Was the agency's involvement in line with organisational expectation of services and/or national expectation of this service?
- Were practitioners sensitive to the needs of the Adult(s) at Risk or the Person(s) Alleged Responsible?
- Were they knowledgeable about potential risks of abuse or neglect?
- Were they aware of what to do if they had concerns?
- Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?
- Was the level of staff supervision appropriate and did it address the issues for this case?
- Were senior managers involved at the appropriate points?

Please highlight good practice as well as that which in hindsight could have been improved

Policies, procedures and risk assessment:

- Did the agency have policies and procedures in place for dealing with safeguarding concerns?
- Were these procedures and policies effective, and agreed by practitioners to be effective and worth using?
- Did the agency have policies and procedures for risk assessment and risk management?
- Were these assessments correctly used in this case?
- What assessments were undertaken by the agency?
- Were any opportunities to undertake assessments missed?
- Do assessments and decisions appear to have been reached in an informed professional way?
- Was any threshold applied for accessing the service appropriate and in line with agency thresholds?
- Did actions or risk management plans accord with assessments and decisions made? Were appropriate services then offered or provided?
- Were appropriate statutory actions taken in line with the relevant time frames (reviews, re-assessments, visits)?

Person centred focus:

- When and in what way were the person's wishes and feelings ascertained and considered?
- Were they given enough information, options and time to make informed decisions?
- If the individual was not able to describe their views and wishes what steps were taken to obtain them?
- Was practice in accordance with the Mental Capacity Act?
- Was the individual signposted or referred to other agencies that they might prefer to work with?

- Was the practice sensitive to the age, gender, physical and mental ability, ethnicity, culture and religion, language, sexual orientation and socio-economic status of the people concerned?
- Were any disability or vulnerability considered and responded to appropriately?
- Were services accessible for this person?

Inter-agency working:

- Did the agency comply with working protocols agreed with other agencies, including any information sharing protocols?
- What evidence was there of good inter-agency activity?
- Did anything adversely affect the inter-agency activity?

Good practice:

- Are there ways of working effectively that could be passed on to other organisations or individuals?
- Was any additional support or service provided above what would normally be offered?
- Were there any examples of good practice over and above that which would be routinely provided?

Lessons to be learned:

- Are there lessons to be learned from this case relating to the way in which this agency works to safeguard adults at risk of abuse or neglect?
- Where can practice be improved?
- Are there implications for: ways of working, training, management and supervision, working in partnership with other agencies and resources?
- If you have highlighted areas of work that were not of the required standard, please consider, what contributed to services being below expectations
- Individual workers' situations, the organisational structure culture or the political context?
- Did anything or anyone appear to interrupt the decision making process?
- Did anything adversely affect inter-agency activity?
- Have any previous reviews made recommendations about similar concerns and why weren't the lessons embedded from these previous reviews?

Terms of reference

In addition to the questions above, address any specific issues in the terms of reference.

6. Conclusions

Pull together the findings and analysis in order to comment on:

- Service provided, quality of practice and adherence to procedures
- Appropriateness of policies, procedures, guidance, training and supervision
- Decision making
- Action taken in respect of decisions made
- Resource implications, where this is directly relevant

7. Recommendations

Individual agency recommendations for action contained in the report will be considered as part of the review. The review may, however, also recommend further actions for your agency which will be included in the final overview report.

Any individual agency recommendations not included in the final SAR Report are expected to be acted on within individual agency governance arrangements Recommendations for action must flow from your conclusions. Recommendations can include changes for your agency procedure, practice, or deployment of resources. In addition you may make recommendations that may have an impact on other agencies as well as your own.

Any recommendation that suggest immediate action is required should be reported to your senior manager and the person leading the review. They should not wait until the completion of this report.

8. Learning the Lessons

Please identify how your agency intends to:

- Feedback the conclusions of the IMR to staff
- Communicate and disseminate lessons learned from the Safeguarding Adults Review.

Appendix 5

Parallel Review Process

1. NHS Serious Incident Investigations

Serious Incidents in the NHS include abuse that resulted in (or was identified through) a Safeguarding Adults Review. The revised National Health Service England (NHSE) serious incident framework, implemented from April 2015, explains the responsibilities and actions for dealing with Serious Incidents. It outlines the process and procedures to ensure that Serious Incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

See Serious Incident Framework: Supporting learning to prevent recurrence, NHS England (Updated: March 2015). https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf.

2. Domestic Homicide Reviews

When there has been a death of an individual of 16 years or over which has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related to, had been in an intimate personal relationship or was a member of the same household then a Domestic Homicide Review (DHR) or Serious Incident review will be undertaken.
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97881/DHR-guidance.pdf

3. MAPPA Serious Case Reviews

The guidance published in 2012 regarding MAPPA (Multi Agency Public Protection Arrangements) Reviews state that a review should be undertaken if a MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or any time in the 28 days before the offence was committed and the offence is murder, attempted murder, manslaughter, rape or attempted rape. Discretionary MAPPA SCRs can also be undertaken depending on the circumstances of a particular case and whether there has been a significant breach of the MAPPA guidance.
http://www.justice.gov.uk/downloads/offenders/mappa/mappa-guidance-2012-part1.pdf

4. Serious Case Reviews concerning Children.

Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 sets out the functions of Local Safeguarding Children Boards (LSCB). This includes the requirement for LSCB's to undertake reviews of serious cases and advise on lessons to be learned in specified circumstances, namely where:

(a) abuse or neglect of a child is known or suspected: **and**

(b) either – (i) the child has died; or
(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority their Board partners or other relevant persons have worked together' (p75 WT2015)

The Working Together 2015 guidance clarifies the term "seriously harmed" as:

- A potentially life threatening injury;
- Serious and/or likely long term impairment of physical or mental health or physical, intellectual, emotional, social or behavioural development.

Cases which meet one of the criteria will always trigger a Serious Case Review (SCR). In situations where a child died by suspected suicide unless there is definitive evidence that there are no concerns about inter agency working the LSCB **must** commission an SCR.

In addition, even if one of the criteria is not met, an SCR **should always** be carried out when a child dies in custody, police custody, on remand or following sentencing, in a Young Offenders Institution, or in a secure children's home. The same applies where a child dies who was detained under the Mental Health Act 1983 or where a child aged 16 or 17 years was the subject of a deprivation or liberty order under the Mental Capacity Act 2005.

Notifiable incidents and Serious Case Review Process

5. Criminal investigation/prosecution

Where a Safeguarding Adults Review is to take place and there are to be criminal proceedings, the LSAB and Police will operate within the Crown Prosecution Service suggested framework for the sharing and exchange of relevant information. This can be found on the CPS website:
http://www.cps.gov.uk/publications/docs/liaison_and_information_exchange.pdf.

The framework deals with the process of a Safeguarding Adults Review and how it may affect the conduct of the criminal investigation/prosecution.