



Hampshire Safeguarding Adults Board

# Safeguarding Adult Review Policy

May 2015

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This document provides guidance on the Hampshire Safeguarding Adults Board Safeguarding Adult Review Policy. This document will assist people to decide when to refer a case for consideration as a Safeguarding Adult Review, as well as providing guidance on the Safeguarding Adult Review Process itself.

## Foreword

This document provides guidance on the Hampshire Safeguarding Adults Board (HSAB) Safeguarding Adult Review Policy. It is designed to assist people to decide when to refer a case for consideration as a Safeguarding Adult Review, as well as providing guidance on the Safeguarding Adult Review Process itself.

Safeguarding adult reviews are complex, detailed and lengthy reviews, undertaken for the purpose of understanding and learning from individual cases to continuously improve the effectiveness of the wider system. They are reserved for situations where there is potential for extensive systemic learning due to serious questions about the multi-agency system as a whole. Safeguarding adult reviews are commissioned and managed by the Hampshire Safeguarding Adults Board and are only undertaken in circumstances involving the death or serious injury of a vulnerable adult or adults known to numerous agencies when it is believed that the death was caused by abuse or neglect or that abuse or neglect contributed to the death or serious injury.

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## I. Introduction

- I.1 The Care Act 2014 comes into force in April 2015 and creates a new legal framework for Adult Safeguarding. Section 44 of the Act requires local safeguarding adult boards (SAB) to arrange a safeguarding adult review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the person at risk. It places a duty on all Board members to contribute in undertaking the review, sharing information and applying the lessons learnt.
- I.2 The Care Act 2014 also enables SABs to carry out reviews in other cases where it feels this would be appropriate in order to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. These may be cases which provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults but which may not meet criteria for a safeguarding adult review for example.
- I.3 The Hampshire Safeguarding Adults Board has developed a Learning and Review Framework which offers a range of reviews and audits processes that can be used to capture learning from other cases to improve the effectiveness of the wider system using resources proportionately. The Policy outlined in this document however, relates solely to conducting safeguarding adult reviews. Please refer to the overarching Learning and Review Framework for more information about the other types of review.
- I.4 The Policy outlined in this document reflects and builds on the six safeguarding principles outlined in the Government's Statement on Adult Safeguarding published in May 2013. These not only should be the basis upon which judgements are made about events and practice but also are the principles underpinning the review process itself. These principles are:

| Principle              | What this means in practice                                      |
|------------------------|--|
| <i>Empowerment</i>     | Presumption of person led decisions and informed consent         |
| <i>Prevention</i>      | It is better to take action before harm occurs                   |
| <i>Proportionality</i> | Proportionate and least intrusive responses appropriate to risks |
| <i>Protection</i>      | Support and representation for those in greatest need            |
| <i>Partnership</i>     | Local solutions through services working with their communities  |
| <i>Accountability</i>  | Accountability and transparency in delivering safeguarding       |

## **2. Guiding Principles**

2.1 The safeguarding adult review processes outlined in this document is underpinned by the following principles:

- ❖ The Care Act 2014 provides a statutory basis for undertaking the learning and review processes described in this Framework.
- ❖ This Policy recognises that there are other forms of statutory reviews (such as domestic homicide reviews, mental health homicide reviews, MAPPA reviews, children's serious case reviews, etc.) and the importance of managing the interface between these.
- ❖ The safeguarding adult review should be proportionate according to the scale, significance and level of complexity of the issues and concerns highlighted.
- ❖ Adults and their families must always be offered the opportunity to contribute to the review process and receive feedback on the learning outcomes achieved.
- ❖ All agencies involved in the case should be fully engaged in the safeguarding adult review process and have the opportunity to contribute their views.
- ❖ The central focus of the safeguarding adult review will be to gain insight and understanding of how effectively agencies were working together to support and safeguarding the person at risk and to identify any actions needed to improve future practice and partnership working.
- ❖ The safeguarding adult review process should be fair and balanced and not used to allocate blame. It should take account of what practitioners knew or could have reasonably have been expected to have known at the time. Consideration should also be given to the capacity of the person at risk and their views and choices at the time.
- ❖ A safeguarding adult review is not a disciplinary process and should be conducted in a manner which facilitates learning and allows for reflection.
- ❖ Where necessary, an independent advocate will be arranged to support and represent an adult who is the subject of a safeguarding adult review.

## **3. The purpose of a safeguarding adult review**

3.1 The purpose of conducting a safeguarding adult review to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local professionals and agencies work together safeguard adults at risk. The safeguarding adult

review brings together and analyses the findings from individual agencies involved in order to make recommendations for future practice where this is necessary. Specifically, the purpose of the safeguarding adult review is to:

- ❖ Determine what might have done differently to prevent the harm or death;
- ❖ Identify lessons and apply these to future cases to prevent similar harm again;
- ❖ Review the effectiveness of multi agency safeguarding arrangements and procedures;
- ❖ Inform and improve future practice and partnership working;
- ❖ Improve practice by acting on learning (developing best practice) and
- ❖ Highlight any good practice identified.

3.2 Its purpose is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as CQC and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

#### **4. Criteria for conducting a safeguarding adult review**

4.1 The Safeguarding Adults Board is the only body that can commission a safeguarding adult Review. The HSAB must arrange a safeguarding adult review of a case of an adult in its area with needs of care and support (whether or not the local authority was meeting those needs) if:

- a) There is reasonable cause for concern about how the SAB, its members or organisations worked together to safeguard the adult

AND

- b) The person died and the SAB knows/suspects this resulted from abuse or neglect (whether or not it knew about this before the person died)

OR

- c) The person is still alive but the Safeguarding Adults Board knows or suspects they've experienced serious abuse/neglect, sustained potentially life threatening injury, serious sexual abuse or serious/permanent impairment of health or development.

4.2 The Care Act 2014 Statutory guidance clarifies that SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support. The SAB should be primarily concerned with weighing up what type of 'review' process will promote effective learning and improvement action to prevent future deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults. SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

## **5. Making a referral for a safeguarding adult review**

5.1 This section outlines the process for making a referral. Following a serious incident, active consideration should be made as to whether or not a referral for a safeguarding adult review is necessary. To support this, organisations should consider including an appropriate trigger question to include on internal incident reporting, investigation and/or review templates.

5.2 It is important to note that if the nature of the incident triggers a mandatory investigation or review within the organisation concerned (e.g. Serious Incident Requiring Investigation), this should take place without delay and in line with the organisation's internal policy requirements. Internal governance processes and safeguarding adult reviews are not mutually exclusive and indeed, the multi-agency perspective may provide invaluable insights to inform internal review processes. Key questions to consider as part of internal processes include:

- ❖ Was the incident reported internally?
- ❖ Has an internal investigation been carried out?
- ❖ Has the investigation highlighted concerns about any other organisations?
- ❖ Has information come to light indicating abuse or neglect as a contributory factor?
- ❖ Based on findings, are criteria for making a referral met?

5.3 Section 45 of the care Act 2014 establishes the importance of organisations sharing with the SAB information relating to the abuse or neglect of people with needs of care and support. If the SAB requests relevant information from a body or person (for example, in the context of a safeguarding adult review) then section 45 of the Act creates a legal duty for that body or person to share what they know with the SAB. The test is that the information requested by the SAB must be for the purpose of enabling or assisting the Board to perform its functions of which carrying out safeguarding adult reviews form part.

5.4 The following considerations should be made when deciding whether to make a referral for a safeguarding adult review:

- ❖ The concerns must relate to a person with needs of care and support – whether or not 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 systemic failings relating to multiple organisations and so there is potential to identify to improve multi agency practice and partnership working.

5.5 Some cases referred may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children's serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible.

5.6 There may also be parallel processes in place such as a criminal investigation or coroner's inquest, which whilst not preventing a referral being made, will need to be taken account of in terms of the timing and management of any subsequent multi agency review.

5.7 The family should be informed of the concerns and that a safeguarding adult review referral is planned and so providing an opportunity for them to give their view about the referral and to discuss how they might want to be involved.

5.8 If it is decided that the circumstances of the case may benefit from a safeguarding adult review, the organisation's HSAB representative and/or Learning and Review Subgroup representative must be briefed on the case and notified of the intention to make a referral.

5.9 To make a referral for a multi-agency review, the referral form should be completed and submitted to the HSAB Learning and Review Subgroup via the following link:  
<https://www.qes-online.com/Hampshire/ECR/Live/m/ecr/public/newnotification>

## **6. Decision-making**

6.1 Each referral will be considered by the Learning and Review Subgroup. Involved agencies may be contacted by HSAB Business Unit to request completion of a scoping chronology to inform decision making about next steps. The Board Chair is ultimately responsible for the deciding whether or not to commission a safeguarding adult review, advised by the recommendation of the Learning and Review Subgroup.

6.2 If it is considered that the case meets the criteria for a safeguarding adult review, the Learning and Review Subgroup will commission this on behalf of the Hampshire Safeguarding Adults Board having considered the most appropriate methodology to use, either the traditional method or the systems learning approach. Depending on the circumstances the group may also consider using a model which incorporates elements of both models as a 'hybrid' model.

6.3 The Board Chair will inform the referrer in writing of the decision and notify the Care Quality Commission (regulator of health and social care services) if regulated services are involved.

6.4 A safeguarding adult review is a statutory process for cases meeting specific criteria. For cases not meeting these criteria, the Learning and Review Subgroup may consider arranging another type of review as outlined in the Learning and Review Framework.

## **7. Interface with other proceedings or investigations**

7.1 Some safeguarding adult reviews may overlap with other statutory review processes such as a domestic homicide review, mental health homicide review, MAPPA review or a children's serious case review. In these circumstances, the chairs of the respective review processes will formally discuss and agree how the interfaces between these should be managed and to dovetail activity as far as possible. The following section outlines the legal context for other statutory reviews:

*Serious Case Reviews concerning children:* Regulation 5 of the Local Safeguarding Children Boards Regulations 2006 requires Local Safeguarding Children Boards to undertake Safeguarding Children Serious Case Reviews where:

- (a) Abuse or neglect of a child is known or suspected AND
- (b) Either the child has died;

OR

- a) The child has been seriously harmed AND
- b) There is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard a child.

*Domestic Homicide Reviews:* Domestic Homicide Reviews were established on a statutory basis in April 2011 under section 9 of the Domestic Violence, Crime and Victims Act 2004. Domestic Homicide Reviews are carried out into the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by;

- (a) A person to whom he or she was related or with whom he was or had been in an intimate personal relationship
- (b) A member of the same household as him or herself, held with a view to identifying the lessons to be learned from the death.

*MAPPA Serious Case Reviews:* The guidance published in 2012 regarding MAPPA Reviews (Multi Agency Public Protection Arrangements) states that these should be undertaken when the mandatory criteria have been met if both of the following conditions apply:

- a) The MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed AND
- b) The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

Discretionary MAPPA SCRs are also permissible. It is difficult to prescribe discretionary criteria, as much will depend on the circumstances of the particular case, and whether there has been a significant breach of the MAPPA Guidance, but MAPPA SCRs might be commissioned when:

- a) A level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape OR
- b) An offender being managed at any level is charged with a serious offence listed in PI 10/2011 – (Appendix 6 of MAPPA Guidance), OR
- c) It would otherwise be in the public interest to undertake a review, e.g. following an offence which results in serious physical or psychological harm to a child or vulnerable adult but which is not an offence listed in PI 10/2011.

*Mental Health Homicide Reviews:* In June 2005 the Department of Health issued guidance on the NHS responsibility to commission independent investigations of serious incidents in mental health settings (HSG (94) 27). The responsibility for the management of these reviews now rests with NHS England. The criteria for a mental health review are:

- (a) When a homicide has been committed by a person who is, or has been, under the care, that is subject to regular or enhanced care programme approach, of a specialist mental health service in the last six months prior to the event.
- (b) When it is necessary to comply with the State's obligation under Article 2 of the European Convention on Human Rights whenever the State agent is, or may be, responsible for a death or where the victim sustains life threatening injuries.

- (c) Where serious patient safety incidents warrant an independent investigation, for example, if there is concern that an event may represent significant systemic service failure, such as a cluster of suicides.

7.2 There may be a criminal investigation running concurrently with the safeguarding adult review. In these situations, the criminal investigation takes precedence, although this should not delay the work being undertaken in respect of the safeguarding adult review. Any possible witnesses should be interviewed first by the police as part of any criminal proceedings before being interviewed for the purposes of their agency's individual management review (IMR). It may also be necessary to delay the publishing of overview reports until the conclusion of any criminal trial. Single agencies can however progress with implementing the learning from individual IMRs.

7.3 It is also acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents. This policy is not intended to duplicate or replace these and any opportunities to prevent duplication will be encouraged. In some cases, dependent on the specific issues in the case, internal investigation reports may provide adequate information to address the terms of reference or it may be that additional reports are required to address any outstanding areas. Careful planning and communication is required to make the most effective use of resources and avoid duplication. It may be necessary for the SAB to request information and/or reports arising from other statutory reviews to inform the safeguarding adult review process. Any such requests will be made under section 45 of the Care Act 2014 as outlined in paragraph 5.3 of this document,

7.4 Safeguarding adult reviews are not part of any disciplinary process. However, should information emerge in the course of the safeguarding adult review that may indicate that disciplinary action should be taken the agencies concerned should deal with such issues in accordance with their own procedures. If disciplinary matters are in progress at the commencement of the safeguarding adult review these should be notified to the HSAB Business Unit.

## **8. Safeguarding adult review methodologies**

8.1 Safeguarding adult reviews can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies through independent reviewers and an independent panel involving two key stages. Individual agencies are asked to review the practice within their organisations the collated findings of which then form part of an overview report usually written by an independent author.

8.2 More recently, 'systems learning' approaches have emerged. One such model was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011 as an alternative method. This approach sets out to study the whole system and look closely at what influenced professional practice. It does

this by taking account of the many factors that interact and influence individual worker's practice in a more in depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. There are also other similar methodologies such as Serious Incident Learning Process (SILP) which is recognised as less bureaucratic than the SCIE model.

8.3 Other options may also be considered such as a hybrid of the traditional and more recent methods. The Hampshire Safeguarding Adults Board can endorse the approach best suited to the circumstances of each individual case and the Learning and Review Subgroup will decide on the most appropriate method.

## 9. The safeguarding adult review process

- 9.1 The safeguarding adult review is overseen by the Hampshire Safeguarding Adults Board which is a multi-agency partnership with senior manager representation from all the key agencies in Hampshire who work with adults at risk. The Board is responsible for ensuring that effective systems are in place for the effective completion of safeguarding adult reviews, for decision making in respect of commissioning reviews, formally accepting reports and agreeing sign off of the report for publication.
- 9.2 Responsibility for the management of safeguarding adult reviews is delegated to the Board's Learning and Review Subgroup. This group is responsible for establishing an independently chaired safeguarding adult review panel to undertake the review and will maintain an oversight and co-ordination role throughout the process. The Learning and Review Subgroup is also responsible for ensuring the smooth running of the process, ensuring timely completion of reviews and for keeping the Board updated.
- 9.3 The safeguarding adult review will be undertaken in accordance with the guiding principles outlined on page five. The Learning and Review Subgroup will agree terms of reference and these will be published and openly available.
- 9.4 If the Board requests information from an organisation or individual who is likely to have information which is relevant to SAB's functions, they must share what they know with the Board in accordance with section 45 of the Care Act 2014.
- 9.5 The safeguarding adult review will be undertaken by people who are independent of the case under review and of the organisations whose actions are being reviewed. A reviewer role profile has been developed to ensure appropriately experienced and skilled people undertake this role. The core skills and experience expected of reviewers are as follows:
- ❖ Appropriate level of seniority
  - ❖ Strong leadership and ability to motivate others
  - ❖ Inclined towards promoting an open, reflective learning culture
  - ❖ Expert facilitation skills
  - ❖ Experience of more than one review methodology
  - ❖ Good analytic skills and experience of collaborative problem solving
  - ❖ Ability to manage potentially sensitive and complex group dynamics
  - ❖ Excellent interpersonal skills
  - ❖ Safeguarding experience and understanding of vulnerability and its impact.
- 9.7 When undertaking the safeguarding adult review, the records will either be anonymised through redaction or consent should be sought. Involved organisations will be provided with copies of reports for comments on factual accuracy prior to final draft. Where a Safeguarding Adult Review Panel is established it will be the role of the Panel to ensure the report is factually accurate and based on the evidence gathered during the process. Where systems methodology is used this is the role of the Review Team.

9.8 The safeguarding adult reviews must be completed in a timely manner. Once the decision to commission a review has been made, the review process should be completed within six months unless otherwise agreed by the Board Chair. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Board Chair. It is acknowledged that where a safeguarding adult review relates to serious organisational abuse or where multiple perpetrators are involved, such reviews are likely to be more complex and may require more time.

## **10. Independent advocacy**

10.1 Under s 68 of the Care Act 2014, an independent advocate must be arranged (where necessary) to support and represent an adult who is the subject of a safeguarding adult review if it is judged they would experience substantial difficulty in participating in the review process. Where an independent advocate has already been arranged under s67 Care Act or under the Mental Capacity Act 2005 then, unless inappropriate, the same advocate should be used.

10.2 A person assessed as having capacity to make decisions about their care and support may be offered the support of an independent advocate if they would experience 'substantial difficulty' in being involved in the process and where there is no other suitable person to represent and support them. It will be the responsibility of the local authority to arrange and fund advocacy support in these circumstances.

## **11. Responsibilities to families**

11.1 It is vital that families are made aware that the review is taking place and offered the opportunity of contributing to the review process. The Board Chair will contact the family and carers of the adult at risk as they think is reasonable to invite them to participate in the review process. However, their consent is not required for the review to go ahead.

11.2 They should be kept updated at key stages of the review and notified of the publication of the report. It is likely that the Board Manager will fulfil this role.

## **12. Responsibilities to staff**

- 12.1 The staff directly involved in the care and support of individuals subject to a safeguarding adult review should be notified by the agency they are employed by of the decision to undertake the review and support should be provided to them. The process and their involvement should be fully explained and for those unfamiliar with the process, they should be signposted to guidance as required.
- 12.2 At the end of the process HSAB should consider whether staff should be invited to a feedback session, co-ordinated by the Learning and Review Subgroup representative of the agency concerned in conjunction with the Board Manager.
- 12.3 Particularly with the systems methodologies it is key that all agencies ensure there is internal support for those involved. This methodology is highly reflective, very interactive and while the benefits of collaborative analysis is positive, staff can feel challenged by this approach.

## **13. Reporting arrangements**

- 13.1 The Learning and Review Subgroup will provide regular updates to Hampshire Safeguarding Adults Board on the progress of the review. The safeguarding adult review will report within six months of the review being established. Once completed, the report and recommendations will be presented to the Hampshire Safeguarding Adults Board for consideration.
- 13.2 Once the report is approved, the Learning and Review Subgroup will produce a multi-agency action plan responding to any recommendations made. Monitoring of the implementation of this action plan will be undertaken by the Quality Assurance Subgroup. The norm will be to publish an anonymised version of the full report on the HSAB website. However, in exceptional circumstances and only with the agreement of the Board, this practice may vary.
- 13.3 As a means of signing off the safeguarding adult review and its resulting action plan, the involved agencies will be asked to complete an impact analysis report detailing the outcomes and difference made as a result of the actions undertaken. Collated findings from the review will be included in the HSAB Annual Report.

## **14. Media, communication and publication**

- 14.1 The Board has developed a multi-agency Safeguarding Communication Protocol which outlines how communication and publication will be managed within and across agencies. However, as Hampshire Adult Services are the lead agency for adult

safeguarding, media and communication issues will be co-ordinated by the Hampshire County Council Communications Team on behalf of the Board and in collaboration with the communications teams of the other agencies involved. [Please click here to view the HSAB Safeguarding Communication Protocol](#)

- 14.2 Publication of the safeguarding adult review will be managed through publication on the Hampshire Safeguarding Adults Board Website. At the point of publication the Board Chair will release a statement outlining the reasons for the, key findings and required actions. It has been agreed that the norm will be to publish a full anonymised report unless there are exceptional circumstances not to do so. The Website can be viewed via this link [www.hampshiresab.org.uk](http://www.hampshiresab.org.uk)

# **APPENDIX 10**

## **Pathway for conducting a Safeguarding Adult Review**

### **Commissioning a Safeguarding Adult Review**

- ❖ Written request for Safeguarding Adult Review submitted to Learning and Review Subgroup (please the referral form in Appendix 12).
- ❖ Agencies requested to supply scoping information in the form of a chronology.
- ❖ Learning and Review Subgroup makes recommendations to HSAB Chair on its decision.
- ❖ Learning and Review Subgroup decides on methodology and timescales.
- ❖ Chair notifies Hampshire Safeguarding Adults Board and Care Quality Commission if registered services involved.
- ❖ HSAB Learning and Review Subgroup Chair contacts families.

### **Undertaking a Safeguarding Adult Review**

- ❖ Chair of Hampshire Safeguarding Adults Board approves terms of reference, drawn up by Learning and Review Subgroup.
- ❖ Learning and Review Subgroup appoints an Independent Chair and Report Author.
- ❖ Learning and Review Subgroup seeks Review Panel Members and confirms involved lead representative. Initial Safeguarding Adult Review Panel held.
- ❖ Further Review Panels held to consider information provided by involved agencies.
- ❖ Overview Report produced by Independent Author and Recommendations presented to the Review Panel.
- ❖ Overview Report and Executive Summary presented to Hampshire Safeguarding Adults Board by the Chair of the Learning and Review Subgroup.

### **Publication**

- ❖ Feedback sessions with staff and family facilitated by the SAB Board Manager.
- ❖ Final Report published.

### **Review and Monitoring**

Action plans to be monitored by the Quality Assurance Subgroup to ensure the learning supports the development of frontline practice.

# APPENDIX 11

## Guidance for Families

### **Hampshire Safeguarding Adults Board – Information for Families about Safeguarding Adult Reviews**

#### **What is the Hampshire Safeguarding Adults Board?**

The Hampshire Safeguarding Adults Board brings together the main organisations that work with vulnerable adults and their families across Hampshire including Police, Health Trusts, District Councils, Probation and Adult Services with the aim of making sure they work in partnership to keep vulnerable adults safe.

#### **What is a Safeguarding Adult Review?**

The Hampshire Safeguarding Adults Board may carry out a Safeguarding Adult Review when a vulnerable adult has been harmed or has died and abuse or neglect is suspected and there are lessons to be learnt about how organisations have worked together to prevent similar deaths or injuries happening in the future. Safeguarding adult reviews look at how local organisations have worked together to provide services to the vulnerable adult(s) who is/are subject to review. A Safeguarding Adult Review is completely separate from any investigation being undertaken by the Police or Coroner.

#### **Who undertakes Safeguarding Adult Reviews?**

Safeguarding Adult Reviews are undertaken using different methods, involving people from the various organisations who were involved with the vulnerable adult. There will be a Chair who is independent and someone responsible for writing the final report, known as the Overview Report Author. At the end of the process the final report is produced which is agreed by the Safeguarding Adults Board.

#### **How long will the review take?**

The Review should be completed within 6 months of the decision being taken to start the Review. Sometimes this timescale needs to be extended.

#### **How are families involved?**

Families and, where relevant and appropriate, close friends and carers, will be given the opportunity to share their views and comment on the services they, and the adult at risk received. They will be contacted to offer to arrange a meeting by those undertaking the

Review. When the Review is complete there will be a follow on meeting offered to outline the findings and recommendations and families will be provided with a copy of the Executive Summary. This will also be available on the Hampshire Safeguarding Adults Board website.

### **Further information**

If you want to know more about Safeguarding Adult Reviews the Safeguarding Adults Board Manager will be happy to be approached or further information can be found on the Hampshire Safeguarding Adult Board website [www.hampshiresab.org.uk](http://www.hampshiresab.org.uk)

# **APPENDIX 12**

## **Hampshire Safeguarding Adults Board**

### **Referral Form for a Multi Agency Review**

Please use the link below for all safeguarding adult review referrals to the Hampshire Safeguarding Adults Board:

<https://www.qes-online.com/Hampshire/ECR/Live/m/ecr/public/newnotification>