HAMPSHIRE SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review Protocol

May 2014

This document provides guidance on the Hampshire Safeguarding Adults Board Safeguarding Adult Review Protocol. 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 Safeguarding Adult Review Protocol. 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.

The Hampshire Safeguarding Adults Board has developed a Learning Framework which seeks to develop a range of reviews and audits to ensure lessons are learned from individual cases to improve the effectiveness of the wider system using resources proportionately.

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. They are 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.

Introduction

The responsibility to undertake a Safeguarding Adult Review comes from the document 'Safeguarding Adults' published by the Association of Directors of Social Services (ADSS) published in October 2005. This document provides a National Framework of Standards for good practice and outcomes in adult safeguarding work. One of the standards in this document states that as good practice Safeguarding Adults Boards should have in place a Safeguarding Adult Review Protocol.

The Care Act 2014 also places a responsibility for Safeguarding Adults Reviews, in section 44 as outlined:

(1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the SAB 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).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

1. Purpose

The purpose of having a Safeguarding Adult Review is not to reinvestigate or to apportion blame, it is:

- 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 to safeguard vulnerable adults
- To review the effectiveness of procedures
- To inform and improve local inter-agency practice
- To improve practice by acting on learning
- To highlight good practice

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.

Safeguarding Adult Reviews are not disciplinary proceedings and should be conducted in a manner which facilitates learning and appropriate arrangements must be made to support staff.

Safeguarding Adult Reviews are also not enquiries into why an adult dies or who is culpable. These are matters for Criminal Courts and Coroners Court.

2. Criteria for a Safeguarding Adult Review

A Safeguarding Adult Review should always be considered if:

- A vulnerable adult dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death

or

- A vulnerable adult has sustained a potentially life threatening injury through abuse or neglect, serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect

or

- Serious abuse takes place in an institution or when multiple abusers are involved

AND

- The case gives rise to concerns about the way in which local professionals and agencies work together to safeguard adults at risk.

3. Procedure for making a referral for a Safeguarding Adult Review

The Safeguarding Adults Board is the only body that can commission Safeguarding Adult Reviews.

Any professional can make a referral for a Safeguarding Adult Review and referrals may be made by the Coroner, MPs and Elected Members.

Staff will usually find it helpful to discuss their concerns with their agencies representative on the Safeguarding Adults Board prior to making a referral.

Other parties, such as agencies who are not members of the Safeguarding Board, family members, carers or members of the public should raise their concerns with the member agency of the Safeguarding Adults Board they have direct contact with.

Referrals are made via secure email to safeguarding.account@hants.gcsx.gov.uk using the referral form in Part A&B Appendix 4. Discussions regarding the appropriateness of referring a case are welcomed by the Hampshire Safeguarding Adults Board Manager.

4. Procedure for commissioning a Safeguarding Adult Review

Once a referral is received, the Chair of the Learning and Review Sub Group (a sub group of the Hampshire Safeguarding Adults Board) supported by the Hampshire Safeguarding Adults Board Manager will discuss with members of the sub group or convene a meeting of the sub group to consider whether the criteria are met.

Agencies will be asked for additional information by the Board Manager in order to inform this decision.

The Chair of the Safeguarding Adults Board is responsible for the deciding whether to commission a review or not, advised by the recommendations of the Safeguarding Adult Review Sub Group.

The Safeguarding Adult Review Sub Group will decide which 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.

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

5. Interface with other proceedings or investigations

It may be necessary to consider whether the case meets the criteria for other multi-agency reviews. In this case, statutory reviews will always take priority.

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

MAPPA Serious Case Reviews

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

1. 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

2. 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:

1. A level 1 offender is charged with murder, manslaughter, rape or an attempt to commit murder or rape OR

2. An offender being managed at any level is charged with a serious offence listed in PI 10/2011 – (Appendix 6 of MAPPA Guidance), OR

3. 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).

These criteria 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.

The responsibility for the management of these reviews now rests with NHS England.

There should be discussion between the Chair of the Board as advised by the Board Manager as to the interface with other review processes.

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 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.

It is also acknowledged that all agencies will have their own internal / statutory review procedures to investigate serious incidents. This protocol 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.

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 Board Manager.

6. Methodology

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 through Individual Management Reviews and Chronologies which then form part of an Overview Report produced by an Independent Overview Report Author. It is permissible for the Panel Chair and the Overview Report Author to be the same person.

More recently, 'systems learning' (e.g. A model introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011), has been introduced 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.

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 Sub Group will decide on the most appropriate method.

7. Governance

Safeguarding Adult Reviews are 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 competition of Safeguarding Adult Reviews, for decision making in respect of commissioning reviews, formally accepting reports and agreeing sign off of the report for publication.

Responsibility for the management of Safeguarding Adult Reviews is delegated to the Learning and Review Sub Group which is a sub group of the Hampshire Safeguarding Adults Board.

The Learning and Review Sub Group is responsible for ensuring the smooth running of the process, ensuring timely completion of reviews, keeping the Board updated and making recommendations to the Board as required.

Safeguarding Adult Review findings will be presented to the Board once they have been agreed by the Learning and Review Sub Group.

Involved organisations should 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.

All involved agencies will be asked to submit an Impact Assessment at the end of the process to demonstrate how practice has improved within the agency as a result of the Safeguarding Adults Review.

8. Timescales

Safeguarding Adult Reviews must be completed in a timely manner. Once the decision to commission a Safeguarding Adult Review has been made, it should be

completed, reviewed by the Learning and Review Sub Group and presented to the Hampshire Safeguarding Adults Board within 6 months, unless agreed by the Chair of the Board. Any urgent issues which emerge from the review and need to be considered earlier should be brought to the attention of the Chair of the Board. It is acknowledged that where a Safeguarding Adult Review relates to serious institutional abuse or where multiple abusers re involved then such reviews are likely to be more complex and may require more time.

9. Media/communication and publication

Since Hampshire Adult Services are the lead agency media and communication issues will be co-ordinated by the Hampshire County Council Communications Team in collaboration with the communications teams of the other agencies involved.

Publication will be managed through publication on the website of the Hampshire Safeguarding Adults Board. At the point of publication the Chair of the Safeguarding Adults Board will release a statement outlining the reasons for the review, key findings and required actions.

10. Responsibilities to families

It is vital that families are made aware that the Safeguarding Adult Review is taking place and offered the opportunity of contributing to the review process.

The Chair of the Hampshire Safeguarding Adults Board will contact the family and carers of the adult at risk as they think is reasonable to invite them to participate in the Safeguarding Adult Review, but their consent is not required for the Review to go ahead. (See Part A & B Appendix 2 for standard letter template).

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.

11. Responsibilities to staff

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 a Safeguarding Adult 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.

At the end of the process staff should be invited to a feedback session, co-ordinated by the Board Manager.

Particularly with the systems methodology 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.

12. Review

This protocol will be reviewed in 12 months time to take account of developments and new legislative requirements.

If using the traditional method Part A of this procedure should be followed.
If using the systems learning approach Part B of this procedure should be followed.

Part A

Safeguarding Adult Reviews using the traditional method

Process

The Safeguarding Adult Review Panel

The Chair of the Learning and Review Sub Group will appoint an Independent Chair and an Independent Overview Report Author with an appropriate level of experience, expertise and knowledge. This responsibility can be carried out by the same person.

A Safeguarding Adult Review Panel will also be commissioned consisting of at least Health, Police and Local Authority representatives. The Chair of the Learning and Review Sub Group will write to the Chief Officers of the organisations involved for nominations to the Safeguarding Adult Review Panel and will request the production of a full chronology of agency involvement and Individual Management Reviews (See Part A Appendix 5). The letter will enclose terms of reference and timescales for the Safeguarding Adult Review.

Each agency will nominate a representative who has the appropriate level of experience and knowledge and who has had no direct involvement in the case or line management responsibility for anyone who has.

The Chair of the Learning and Review Sub Group will consider the need for relevant subject experts such as substance misuse, domestic abuse, mental health or medical experts.

Terms of Reference

The Learning and Review Sub Group will be responsible for drawing up the draft terms of reference for approval by the Chair of the Safeguarding Adults Board.

The Terms of Reference will be confirmed at the first meeting of the Safeguarding Adult Review Panel.

Terms of Reference will include the following:

Details of the subject and details of concerns that triggered the Safeguarding Adult Review
Agencies to provide Individual Management Reviews
Membership of Panel, Independent Author and Chair
Areas to be considered
How the Safeguarding Adult Review will link with any parallel processes and/or criminal or Coroner's investigations and considerations of these

See Part A Appendix 1 for Terms of Reference Template.

It is important that the Panel decide on the necessary timescales to be covered in the review and how far back chronologies should start. It is possible to ask agencies to provide background on involvement prior to a certain date, rather than requiring a full chronology.

Chronologies and Individual Management Reviews

Using this approach, agencies will be asked to produce Chronologies and Individual Management Reviews.

The Chronologies and Individual Management Reviews are a vital part of the Safeguarding Adult Review process and therefore it is essential that authors are supported by their agencies in carrying out this function.

At the beginning, the Safeguarding Adult Review Panel will convene a meeting between the Panel and Individual Management Review authors to go through the process and expectations of the Individual Management Reviews.

During the Safeguarding Adult Review the Safeguarding Adult Review Panel will ask Individual Management Review authors to present their reports at the panel and this will give them the chance to elaborate and explain their report.

At the end of the Review, the Chair of the Panel will convene a meeting of the Individual Management Review authors to debrief them about the findings.

A template to be used as standard for the production of Chronologies and Individual Management Reviews in contained in Part A Appendix 2 & 3.

Responsibilities of the Safeguarding Adult Review Panel

The role of the Safeguarding Adult Review Panel is to agree the terms of reference, review the progress of enquiries, consider all data being submitted before the Panel, give consideration to the findings and conclusions and make recommendations in relation to what action is required to address the learning identified.

It is expected that all Safeguarding Adult Review Panel members attend each Safeguarding Adult Review panel meeting. Each panel member has a key role and professional responsibility within the Safeguarding Adult Review process. Agencies must be robust in selecting their nominated panel member and be clear on time commitment for the panel meetings and involvement in the Safeguarding Adult Review including preparation between and for panel meetings. It is imperative to the integrity of the Safeguarding Adult Review process to ensure it is quorate at each meeting of the Safeguarding Adult Review panel meetings and that there is continuity.

Once the Safeguarding Adult Review Panel is established, nomination of any deputy panel member is only permitted under exceptional circumstances. It is a requirement

for the panel members to prepare for each panel meeting thoroughly and input in other ways that the Chair or Overview Report Author may require.

The Safeguarding Adult Review Panel will be quorate when the police, health and local authority representatives are present, together with the Chair.

The Safeguarding Adult Review Panel will meet on average between 3 and 6 times during the course of the review.

Each Safeguarding Adult Review Panel Member must be of requisite seniority to be able to fully secure their organisation's full participation in the Safeguarding Adult Review. This includes supporting the Safeguarding Adult Review Panel Chair to convey any urgent learning points emerging from the Safeguarding Adult Review while it is in progress.

The panel member must not have been directly involved in the first line management or frontline care of the individual (s) concerned.

At its initial meeting the Panel will confirm:

- The detailed terms of reference and if necessary ask for clarification from the Chair of the Safeguarding Adult Review Sub Group
- The information required from each participant
- The support and other resources needed, any perceived deficits to be referred to the Chair of the Safeguarding Adult Review Sub Group
- Dates, times and venues for meetings
- The nature and extent of legal information required, in particular any Data Protection considerations.
- Confirm who will be responsible for liaising with family members and when this should be undertaken within the process. This is usually the Chair and one other panel member.

A Safeguarding Adult Review is a forum for formal information sharing and all Panel members will be expected to critically analyse all the information presented.

Subsequent meetings of the panel will receive the Individual Management Reviews, request any additional information or clarifications that arise.

On the basis if the above analysis, the Safeguarding Adult Review Panel will undertake an assessment of good practice, what might have been done differently or better and recommend how to embed this learning into practice or procedures.

They will then agree the content of the Overview Report prior to its drafting, having overseen the collation of the findings.

The Safeguarding Adult Review Panel will produce recommendations as part of the Overview Report which will indicate:

- What action is required to meet each recommendation
- Who will be responsible for the various actions

- The intended outcome of the various actions and recommendations
- The means of monitoring and reviewing intended improvements in practice and/or systems

The Panel will meet to consider, amend as necessary and ratify the Overview Report prior to its submission to the Chair of the Learning and Review Sub Group.

The final Overview Report and Executive Summary will be forwarded to the Chair of the Safeguarding Adults Board for approval and presentation at the Safeguarding Adults Board for sign off.

Once the recommendations and the action plan are agreed it will be the responsibility of the Quality Assurance Sub Group to monitor the implementation of action plans.
The Overview Report Author will be independent. The Chair will also be independent or be co-opted from an adjoining Authority where there is no conflict of interest.

Responsibilities of the Safeguarding Adults Board

The Safeguarding Adults Board will consider the final draft of the Overview Report and either agree it and its recommendations or return it to the Safeguarding Adults Review Panel for further work.

Once it has agreed the Overview Report, the Safeguarding Adults Board will:

- Ensure that all recommendations are smart
- Ensure that recommendations are endorsed at a senior level by each agency
- Clarify to whom the report or parts of the report should be made available and agree the means by which this will be carried out
- Disseminate the report or key findings to interested parties as agreed
- Provide feedback and debriefing to staff and family members
- Confirm the monitoring and implementation of the recommendations

The Safeguarding Adult Review Executive Summary will then be published.

The Safeguarding Adults Board will receive updates from the Quality Assurance Group on the progress of action plans.

PART A APPENDIX 1

Safeguarding Adult Review Terms of Reference

The Board Manager and the Learning and Review Sub Group Chair will draft Terms of Reference for each Safeguarding Adult Review if using traditional methodology. These will be confirmed at the first meeting of the Safeguarding Adult Review Panel.

The purpose of the Review is to establish whether there are lessons to be learnt from the circumstances of the case about the way in which relevant professionals and agencies have or are working together to safeguard vulnerable adults to inform inter agency and multi-agency practices as they relate to safeguarding vulnerable adults.

The Terms of Reference will include:

1. Details of the person(s) subject to the Safeguarding Adult Review – name, date of birth, date of death (if relevant), address
2. Brief details of the concern that triggered the Safeguarding Adult Review
3. Specific areas of concern for the Safeguarding Adult Review to focus upon
4. Period of time the Safeguarding Adult Review is to consider
5. Agencies to provide Chronologies and Individual Management Reviews
6. Membership of Safeguarding Adult Review Panel – agencies, experts and specialists
7. Chair of the Safeguarding Adult Review Panel
8. Independent Overview Report Author
9. Strategy for involvement of family members
10. Reference to any parallel investigations
11. Start and completion dates for the Safeguarding Adult Review
12. Areas to be analysed
13. Strategy for implementation of lessons learnt
14. A strategy for publication of the Overview Report and Executive Summary
15. A strategy for managing media interest.

PART A APPENDIX 2

Safeguarding Adult Review Chronology Template

Agency Chronology of Involvement

Name of Agency:

Name(s) of Adult(s):

Name of person Completing Chronology:

Job Title:

Date:

Please complete with the information required under each heading. The last column should be used for comments on the appropriateness/quality of the intervention or whether it raises any other professional issue.

Date	Source of evidence	Name of Professional involved and role	Type of intervention	Action taken/decision made	Comment

PART A APPENDIX 3

Guidance for the Completion of Individual Management Reviews for agencies

Agencies with knowledge or contact with the vulnerable adult subject to a Safeguarding Adult Review will be requested for all records pertaining to work with the vulnerable adult to be secured and for the completion of a Chronology and Individual Management Review.

The Individual Management Review (IMR)

Each organisation that is required to complete an Individual Management Review will need to: -

Appoint a manager from within your organisation (or an independent person) to undertake the task of completing your Individual Management Review. This person should not have been directly concerned with the vulnerable adult, or be the immediate line manager of the practitioners involved.

Ensure that all relevant files are secured and made available to the organisation IMR report writer.

Ensure that Individual Management Reviews authors are allocated adequate resources (time, admin support) to complete their report within the required timescales. It is imperative that timescales are adhered to in order that the role and actions of the agencies involved with the family can collectively be reviewed by the sub group.

Make available to the Individual Management Review report writer, the chronology template and the Individual Management Review template (which would have already been forwarded to your organisation) which must be used for the compilation of the Individual Management Review.

Notify the staff involved and ensure that any staff involved with the vulnerable adult should be given the opportunity to discuss their understanding of what has happened. It is essential that support and counselling be offered, given the possible serious impact on the professionals involved.

Role of Individual Management Review Report Author

The report writer, having reviewed the files, should be aware of the members of staff who have been involved in the case. The staff members, through their line manager, should already be aware that a Safeguarding Adult Review is being undertaken.

The report author should interview the professionals from their organisation who have had recent or relevant involvement with the vulnerable adult. This should be arranged in consultation with their line manager. The report writer should ascertain, in consultation with the line manager, that the member of staff is receiving or has

received the appropriate support in relation to that member's own welfare if this is needed.

This meeting should give the report writer the opportunity to check with the member of staff the factual accuracy of the details of the chronology. It will also be an opportunity for staff to identify good practice and any lessons they consider can be learnt from their own and their organisation's involvement. A written record of the interview should be made and should be shared with the interviewee.

The purpose of the Individual Management Review is to look openly and critically at individual and organisational practice, to see whether the case indicates that changes could or should be made and, if so, to identify how those changes will be brought about.

The Individual Management Review report writer should complete the chronology and report on the relevant template, and a copy should be sent to the senior manager in their organisation for their acceptance on behalf of the organisation, before it is forwarded to the Chair of the Safeguarding Adult Review Panel by the deadline specified.

The senior manager within the organisation will be responsible for ensuring that the recommendations contained within the Individual Management Review are acted on.

Safeguarding Adult Reviews are not part of any disciplinary process. If the report writer comes across information which he/she considers is a matter which needs to be investigated under disciplinary procedures then this should be brought immediately to the attention of the individual's line manager/senior manager.

PART A APPENDIX 4

Template for Individual Management Reviews

Prior to the Safeguarding Adult Review starting a meeting will be arranged with the Safeguarding Adult Review Panel and all Individual Management Review Authors to go through the process and expectations of the Individual Management Review.

During the Safeguarding Adult Review the Safeguarding Adult Review Panel will ask Individual Management Review authors to present their reports at the panel in order that they can elaborate on and explain their report.

This document is intended to provide an individual management review of the decisions, actions taken and services provided to xxx

The aim of the individual management review is to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.

The findings from the individual management review report should be endorsed by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

The individual management review provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the vulnerable adult.

Name of Agency:

Name of Vulnerable Adult(s):

DOB/DOD:

Name, agency and contact details of person completing chronology and management review:

Date of Request for IMR:

Date of Completion of IMR:

Terms of Reference (to be added):

Methodology:

FACTUAL/CONTEXTUAL SUMMARY

Provide a brief factual and contextual summary of your agency's involvement with the vulnerable adult for the time period identified for this Safeguarding Adult Review.

CHRONOLOGY OF AGENCY INVOLVEMENT

This will need to be completed on the chronology template provided.

Construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the vulnerable adult(s) and/or alleged perpetrator over the period of time set out in the review's terms of reference.

Where abbreviations are used, please provide a glossary at the back of this document to explain them.

ANALYSIS OF INVOLVEMENT

The report author is expected to rigorously analyse the involvement of their agency. Consider the events that occurred, the decisions made, and the actions taken or not. Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened, but why. The Terms of Reference should be referred to as headings to analyse practice against.
Facts should not be stated without their origin.

Consider specifically:

Were practitioners sensitive to the needs of the vulnerable adults in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a concern about a vulnerable adult?

Did the agency have in place policies and procedures for safeguarding vulnerable adults and acting on concerns about abuse or neglect?

What were the key relevant points/opportunities for assessment and decision making in the case in relation to the vulnerable adult? Do assessments and decisions appear to have been reached in an informed and professional way?

Did action accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?

Where relevant were appropriate care plans in place, reviewing processes complied with and how did they involve relevant risk assessment in protecting the vulnerable adult?

Were more senior managers or other agencies and professionals, involved at points they should have been?

Was the work in this case consistent with agency policy and procedures for safeguarding vulnerable adults, and wider professional standards?

Was mental capacity considered and any formal Mental Capacity Assessment recorded?

Was practice sensitive to the racial, cultural, linguistic and religious identity of the vulnerable adult? Cite ethnicity and culture of the vulnerable adult and the relevance of this to provide an exploration.

Were relevant, appropriate safeguarding adults or care plans in place, and safeguarding adults reviewing processes complied with?

Are there are any particular features of this case, or issues surrounding the death or injury of the vulnerable adult(s), that you consider require further comment in respect of your agency's involvement?

LEARNING

Is there good practice to highlight, as well as ways in which practice can be improved?
Are there lessons from this case for the way in which this agency works to safeguard vulnerable adults?
Are there implications for ways of working?
Are there implications for management and/or supervision?
Are there implications for training (single or multi-agency)?

RECOMMENDATIONS FOR ACTION
Recommendations should be few in number, focused and specific, and capable of being implemented. Consideration should be given to the resources required to implementing the recommendations such as cost.

ACTION PLAN

Recommendation	Action Required	Person Responsible	Timescale	Success Criteria	Monitoring	Progress

IMR Completed by:
(Signed by Author)

IMR agreed by:
(Director/Head of Service/Senior Officer)
Date:

PART A APPENDIX 5

Template for standard letters

Letter requesting IMR and nominations to the Safeguarding Adults Review Panel

Dear

Re:
Name:
DOB:
Address:

I am writing to inform you that the Hampshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death. I enclose Terms of Reference for the review.

The Safeguarding Adult Review Panel will be chaired by an independent person and will require a representative of your agency. I would be grateful if you could nominate a suitable representative with suitable seniority and experience.

A separate suitably experienced officer should be identified to undertake the Individual Management Review into this case as required under the Safeguarding Adult Review protocol. The Individual Management Review author should have no line management relationship with practitioners working with the vulnerable adult or any direct contact themselves with the vulnerable adult.

In accordance with the Safeguarding Adult Review protocol please can you ensure that your agency files in respect of the above named vulnerable adult are immediately secured to guard against potential loss or interference, and to enable the Safeguarding Adult Review process to commence.

I attached information and a template relating to the individual management review and in relation to the chronology which your agency is required to complete.

There will be an introductory meeting for Individual Management Review authors to explain the process once we have the details.

The findings from the individual management review should be agreed and accepted by you as the senior officer in the organisation who has responsibility for ensuring that the recommendations are acted upon.
I would be obliged if you could confirm your Individual Management Review author and nominated panel representative to xxx Board Manager.

Yours Sincerely

Chair of the Hampshire Safeguarding Adults Board

PART A APPENDIX 6

Template - Overview Report

Content of report:
1. Introduction
2. Circumstances that led to a Safeguarding Adult Review being undertaken in this case.
3. Terms of reference
4. Process of the Safeguarding Adult Review
5. Facts of the individual case
6. Analysis of individual case
7. Conclusions & recommendations
8. Recommendations presented in a grid with SMART targets.

Introduction

This Overview Report is intended to provide an overview of the deliberations and recommendations of the Safeguarding Adult Review Panel drawing overall conclusions from the information and analysis contained in the individual management reviews and reports commissioned from any relevant parties.

Describe individual circumstances and reasons for the review being undertaken.

List contributors to the review and the nature of their contributions including from family.

The circumstances that led to a Safeguarding Adult Review being undertaken in this case

Provide an overview of the specific individual circumstances and outline the concerns to be addressed. Give the specific facts of the Safeguarding Adult Review. State when the Safeguarding Adult Review commenced, the commissioning arrangements details of the Independent Chairperson/Independent Overview Report Author.

Terms of Reference

Detail the agreed terms of reference (see Part A appendix 1)

Process of the Safeguarding Adult Review

Describe the process of the review that undertaken by the Safeguarding Adult Review Panel. The panel consisted of representatives from (list appropriate agencies).
List agencies that provided Individual Management Reports.
State whether family and/or others were included or involved in the process and if not provide an explanation for example criminal proceedings.

Facts of the Individual Case

Compile an integrated chronology of involvement with the vulnerable adult and family on the part of all relevant agencies, professionals and others who have contributed to the review process. A Chronolater can be used.

Important to include:

Relevant information relating to the vulnerable adult.
Critical and life incidents.
Features of professional activity over time which should include key events, for example a referral or services provided.

Give an overview which summarises what relevant information was known to the agencies and professionals involved.
Provide an explanation and exploration of ethnicity.

Analysis

This part of the Overview Report should look at how and why events occurred, decisions were made, actions taken or not.

Identify the key features of the case:
• Vulnerable adult's needs/characteristics/behaviour
• Wider family and environment
• Professional involvement

Analysis of interacting risk and protective factors to include:
• A clear summary and synthesis of the knowledge brought together by the assessment
• A description of the problem/concern
• A description of protective factors and support
• A hypothesis about the nature, origins and cause of the need/problem/concern, and
• A plan of the proposed decisions and/or interventions

This is the part of the Overview Report which can consider whether different decisions or actions may have led to an alternative course of events.

Communication between and within agencies
Was there a shared safeguarding agenda between or within agencies?
Was there evidence that the vulnerable adult's needs were paramount? Challenge of carer/care provider power.

Reference should be made to the quality of the Individual Management Reviews and how this assisted in analysing how and why events occurred and why some decisions were or were not taken. The Overview Report should challenge agency practice and comment on whether different decisions or actions may have led to an alternative course of events.

The analysis section is also where any examples of good practice should be highlighted.

This part of the Overview Report should take account of recent and well publicised major enquiries and government guidance pertinent to the case.

Conclusions and recommendations

This part of the Overview Report should summarise the lessons to be drawn are and how those lessons should be translated into recommendations for action.

The Overview Report should make reference to the single agency recommendations identified through the Individual Management Reviews and identify any further single agency recommendations.

Recommendations should be few in number, focused and specific (SMART) and capable of being implemented. View on how these could be achieved should be included. Consideration should be given to the resources required to implement the recommendations such as cost.
If there are lessons for national, as well as local, policy and practice these should also be highlighted.

Action plan

The overall action plan should identify the main cross cutting multi-agency themes.
The Learning and Review Sub Group will complete the Safeguarding Adult Review action plan based upon the multi-agency recommendations identified by the Independent Chair/Overview Report author.

Safeguarding Adult Review Multi-Agency Action Plan template

Recommendation: INSERT RECOMMENDATION

Agency	Lead Professional	Action (required or taken)	Timescale	Outcome of recommendation	Progress

Guidelines for completing Safeguarding Adult Review action plans

In the action column indicate what action has been taken to address the recommendation or what action will be taken.
In the timescale column provide the date action was completed and/or provide a realistic timescale for your agency to address outstanding action.
In the outcome of recommendation column provide a summary of the impact of the recommendation, how the agency has learnt lessons and identify source of evidence to demonstrate learning.
In the progress column state whether action arising from the recommendation is ‘compliant’ ‘progressing’ or ‘non-compliant’.

PART A APPENDIX 7

Template – Executive Summary

Content of report:

1. Front sheet with anonymised name of the vulnerable adult with date of birth and date of death or age at the time of the incident
2. Introduction
3. Circumstances that led to a Safeguarding Adult Review being undertaken in this case
4. Terms of reference
5. Case summary
6. Relatives/other relevant persons
7. Context of agencies involved
8. Conclusions and recommendations

Introduction

This document is intended to provide an overview of the deliberations and recommendations of the Safeguarding Adult Review Panel instigated by the Safeguarding Adults Board relating to xx.

A Safeguarding Adult Review is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change which will help to improve the safeguarding and wellbeing of vulnerable adult in the future.

Insert the circumstances that led to a review being undertaken in relation to individual cases.
.
The Overview Report brings together, and draws overall conclusions from, the information and analysis contained in the Individual Management Reviews, and reports commissioned from any relevant parties.

List contributors to the review and the nature of their contributions.

Cite contribution of family members and any others.

The circumstances that led to a Safeguarding Adult Review being undertaken

Provide a brief and anonymous overview of the specific individual circumstances that led to a Safeguarding Adult Review being undertaken.

Provide reasons for conducting the review and what Safeguarding Adult Review criteria were met (or if the criteria were not met the reason for conducting the review).

Terms of Reference

Detail the agreed terms of reference (see Part A appendix 1)

Summary

Provide a brief case summary including details of the incident

Relatives/other relevant persons

Provide brief and anonymous details of relatives/other relevant persons (as appropriate).

Conclusions and Recommendations

Cite the key themes and lessons arising from the Safeguarding Adult Review and how those lessons should be translated into recommendations for action.

Recommendations should be few in number, focused and specific (SMART) and capable of being implemented. Views on how these could be achieved should be included. Consideration should be given to the resources required to implement the recommendations such as cost.
If there are lessons for national, as well as local, policy and practice these should be highlighted.

Safeguarding Adult Review Multi-Agency Action Plan template

Recommendation: INSERT RECOMMENDATION

Agency	Lead Professional	Action (required or taken)	Timescale	Outcome of recommendation	Progress

Part B

Safeguarding Adult Reviews using Systems Methodology

Introduction

'Systems Learning' is a multi-agency systems approach which sets out to study the whole system and look closely at what influenced professionals practice. It does this by taking into account the many factors that interact and influence individual worker's practice in a more in depth way.

The premise of this process is to study the whole system and look closely at what influenced the performance of individuals. It does this by taking into account the many factors that interact and influence individual worker's practice in a more in depth way that is accommodated by the traditional Safeguarding Adult Review process and methodology. This methodology was supported by the Munro Report addressing Safeguarding Adult Reviews for child safeguarding but has now been piloted in adult cases.

The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The methodology requires rigorous analysis based on:-

1. Timeline
2. The story of how professionals involved saw the case as it unfolded
3. Analysis of Key Practice Episodes and their contributory factors
4. Identification and prioritisation of generic systemic issues

There are no specific Terms of Reference for the review to follow. Areas to focus on are determined as the review progresses.

The Final Report sets out system based findings in categories of working and human interaction around the vulnerable adult. This methodology brings to the fore underlying patterns and themes and these are presented as generic findings that the Safeguarding Adults Board.

It should be noted that those who lead the process should be trained individuals whether they are selected internally from within one of the agencies or independent personnel are used.

Process

Agreeing the Lead Reviewers and Review Panel

The Learning and Review Sub Group will decide on undertaking the Safeguarding Adult Review using "Learning Together" methodology and appoint two Lead Reviewers within 7 working days. The Chair of the Safeguarding Adults Board must endorse and approve the Lead Reviewers selection. Within 7 days the Lead Reviewers must have confirmed they can accept the commission and have capacity in which to fulfil the role.

The Lead Reviewers can be appropriately trained professionals working in one of the agencies who are not directly connected to the case or one internal/ one independent or two independent individuals to lead the process.

The key aspect is the ability to deploy the methodology to a requisite standard and work within the six month timeframe.

For quality control Social Care Institute for Excellence have trained and accredited a pool of individuals to be Lead Reviewers. Once appointed the Lead Reviewers will control the process with the assistance of the Board Manager.

The Lead Reviewers will obtain an initial understanding of the case from the Learning and Review Panel's understanding of what agencies were involved.
There will be an early consideration of whether a skeleton chronology will be required or early sharing of documentation.

One representative from each agency will be selected and agreed to be participate as a key member of the process.

The representatives from each agency form the Review Team. These are the multi-agency group of people conducting the review with the Lead Reviewers and are usually senior managers.

Meeting 1 (to be held within 4 weeks)

The Review Team will meet with the Lead Reviewers for Meeting 1 which is an initial planning meeting to review what relevant documentation may be required at this stage and to plan the rest of the process.

At this meeting the Lead Reviewers orientate the Review Team to the methodology. There is no requirement for Individual Management Reviews but each representative does need to attend with some knowledge of the case and who is involved at the frontline to assist in formulating the Case Group.

The Case Group is the staff and managers who were directly involved with the family in question (see Part B appendix 2 for invite letters).

At this planning meeting other considerations are included, such as whether there is an on-going criminal investigation, media management aspects and other aspects such as family. This needs to be considered on a case by case basis and taking into account the sensitivities that are often present.

Meeting 2 (to be held within 6 weeks)

This meeting is between the Case Group, the Lead Reviewers and the Review Team. The purpose of the meeting is to explain the methodology with an overview, what is entailed and their role. There should also further consideration of documentation required to include case notes, policies and procedures.

Meeting 2 is also to plan for the Conversations stage of collecting data for the review. The conversations are interviews of key professionals on a one to one basis. The Lead Reviewers with the Review Team will make a judgement as to how many professionals need to be seen and by whom. As a general rule those leading the conversation should not be with those from their own agency.

Conversations (to be held within 8 weeks)

It will be the usual approach for one Lead Reviewer and a member of the Review Team to conduct the conversations which should take place over 2-3 days. Each conversation is typed for approval by the professional as an accurate and true account of the conversation. One person will lead the conversation and the other person (observer) will make records. Each conversation is likely to take to 2 hours.

Where the vulnerable adult or family are involved in a conversation there needs to be a consensus on whom is best placed to conduct this conversation. Venue for this conversation needs to be considered with care and a neutral place is preferable. Also there needs to be consideration of whether the vulnerable adult has mental capacity.

The conversation structure includes:-

Introduction - purpose, confidentiality and outline

Overview - brief description of what happened and the role of professionals

Key Practice Episodes - what crucial moments or key actions/decisions were taken that in the view of the professional determine the direction of the case

Local Rationality - what was behind the professional's thinking; what were the factors, personal, or professionally that were influencing. This aspect is a deep reflection for the professional to convey professional and other influences, and considerations

Contributory Factors - aspects of the family; professional roles; conditions of work and work environment; personal aspects; team factors; inter-agency factors; culture; political context and any other contributory factors impacting upon the direction and management of the case

Things that went well

Suggested Changes - on reflection, are there any practice changes that would help you/ others

Summing Up - checking that the view of the case from the professionals' perspective is clear

Reflections - how did the professional find the conversation, any questions? How does the professional feel about the case and the role they played after the conversation.

The record of the conversations will be approved both by the observer and the person with whom the conversation was held.

Meeting 3 (to be held within 12 weeks)

Meeting 3 takes place with the Lead Reviewers and the Review Team and lasts one day. This meeting is to share data gathered thus far from the conversations and agree a draft narrative as the report starts to be formulated. This meeting should identify any gaps or further information required.

This meeting should also inform the first draft chronology, and start to identify the Key Practice Episodes (KPEs), that represent the "working out" of the case as to what happened and why.

Meeting 4 (to be held within 14 weeks)

This meeting is between the Review Team and the Case Group and lasts one day. Before this meeting takes place the Lead Reviewers will draft the Report to share with a meeting with the Review Team and the Case Group. The Lead Reviewers will decide upon the best approach for sharing the information but it is essential that the Case Group look closely at the emerging narrative, chronology and Key Practice Episodes to agree accuracy, direction and identify contributory factors that sit behind the Key Practice Episodes.

The Lead Reviewers facilitate the meeting in a workshop format ensuring that all agencies input at an in depth level.

Meeting 5 (to be held within 16 weeks)

This meeting is between the Lead Reviewers and the Review Team and lasts half a day. Both agree the narrative, timeline, chronology and consider the themes and patterns with considerations of practice. Considerations of practice include what went well and good practice to be captured.

Meeting 6 (to be held within 18 weeks)

This meeting is between the Lead Reviewers, the Review Team and the Case Group to confirm and consider in more depth the underlying themes, and patterns in the context of the emerging findings.

The Case Group actively feedback on any patterns to consider if there is resonance,

what is case specific and/or one off aspect of practice and what learning is developing on the way (learning on the fringes)?

The Lead Reviewers capture what may have happened in terms of practice changes already. This is also another key time for the Lead Reviewers to ensure that all agencies are able to put their perspectives across and will facilitate so this is done in a constructive and collaborative manner.

The Lead Reviewers take further data and information from the meetings to develop the final report, putting together the various components of the main report and the appendices which represent the "working out". The template as produced by SCIE is used. There is no executive summary in this process nor are there SMART recommendations but findings to be included for the Hampshire Safeguarding Adults Board so they can respond accordingly. The report contains a section specifically for the Board to insert their response plan and priorities.

Meeting 7 (to be held within 22 weeks)

This meeting is for the Lead Reviewers and the Review team to "sign off" the report. The proposed final report is circulated beforehand.

Hampshire Safeguarding Adults Board Presentation

The report is presented to the Hampshire Safeguarding Adults Board by the Lead Reviewers. The Board then develop the response and agree priorities.

The first part of the report (without appendices) is the publication element of the report and should be considered by the Board as such.

Using systems methodology there is no requirement to commission a Safeguarding Adult Review Panel.

Responsibilities of the Safeguarding Adults Board

Using systems methodology the Safeguarding Adults Board receives feedback from the Lead Reviewers in the form of a presentation and a Final Report. This will give a series of findings for the Board to consider.

Once the Final Report is presented the Hampshire Safeguarding Adults Board will:

- Consider each of the findings in depth
- Discuss and agree the necessary actions including priority
- Confirm the monitoring and implementation of the actions required
- Convene extra-ordinary meetings as needed
- Agree how key findings will be disseminated to interested parties
- Agree task and finish groups as necessary
- Clarify to whom the report or parts of the report should be made available and agree the means by which this will be carried out
- Come to an agreement in relation to sharing the report with the family

PART B APPENDIX 1

Template for Standard Letters
Letter to Review Team Representatives

Dear

Re:
Name:
DOB:
Address:

I am writing to inform you that the Hampshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death.

For this Safeguarding Adult Review the Board will be using "Systems Learning" methodology. This takes the focus away from individuals but looks at the systems that professionals work within and what can be improved about the system to enable professionals to work to best practice.

A systems approach looks in some depth at all the circumstances that may have made the management of the particular case go in one direction or another. It also highlights what is working well and patterns of good practice as well as capturing aspects of single and multi-agency systems that may need improving in the future.

An important part of the process is the formation of a Review Team. You are receiving this letter as you have been nominated as a senior professional for your agency to be part of the Review Team. The Review Team is responsible of much of the data collection and analysis of the review and the team typically includes a representative from each agency involved.

There are two Lead Reviewers who are trained in the process and it is their responsibility to conduct the review according to the methodology.

The Review team are also joined by a Case Group who are the group of frontline professionals involved. The process will require attendance to four meetings which take up to a day each. At the initial meeting of the Review Team an overview of the process will be given as well as much more detailed explanation of the process and methodology.

The details of the first meeting of the Review Team are as follows:

I would be grateful if you could confirm your attendance to xx Board Manager.

Yours sincerely

Chair of the Hampshire Safeguarding Adults Board

PART B APPENDIX 2

Template for Standard Letters
Letter to Case Group Representatives

Dear

Re:
Name:
DOB:
Address:

I am writing to inform you that the Hampshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death.

For this Safeguarding Adult Review the Board will be using "Systems Learning" methodology. This takes the focus away from individuals but looks at the systems that professionals work within and what can be improved about the system to enable professionals to work to best practice.

A systems approach looks in some depth at all the circumstances that may have made the management of the particular case go in one direction or another. It also highlights what is working well and patterns of good practice as well as capturing aspects of single and multi-agency systems that may need improving in the future.

An important part of the process is the formation of the Case Group. The Case Group is a group of professionals across the agencies who have had direct involvement with the vulnerable adult and his/her family. You are receiving this letter as you have been identified as a professional involved personally or to have managed staff who were closely involved.

The process is managed by two Lead Reviewers and a Review Team who are made up of a senior representative of each relevant agency. At the first meeting with the Lead Reviewers and the Review Team an overview of the whole process will be provided and more explanation of the process and your role within it. The experiences and perspectives of professionals like you, are central to a systems review. The Safeguarding Adults Review is therefore very much a collaboration which we hope you will take an active part in.

The details of the first meeting of the Case Group are as follows:

I would be grateful if you could confirm your attendance to xx Board Manager.

Yours sincerely

Chair of the Hampshire Safeguarding Adults Board

PART B APPENDIX 3

Guidance for agencies using the Systems Methodology

Agencies with knowledge or contact with the vulnerable adult subject to a Safeguarding Adult Review will be requested to be involved in the Review process. The methodology takes the focus away from individuals and seeks to evaluate the systems that professionals work within to enable improvements. The premise is that the evaluation of practice allows for consideration of a 'window on the system' if there are areas that can be generalised and improvements to be made across the system as a whole.

Role of the Review Group

The Review Team consists of senior professionals representing the key agencies and organisations who were directly involved in the case under review. Members of the Review Team need to be sufficiently senior within their organisations to be able to make recommendations and to influence change. They need to be conversant with the operational aspects of the work their agency provides. The Review Team play the central role in putting together the picture of what happened and analysing the data that is collected. They will also interview and liaise directly with relevant front line staff. Members of the Review Team should be analytical and willing to discuss the work of their own agency in a non-defensive way. They will need to commit time in order to attend approximately six meetings throughout the process.

Role of the Lead Reviewers

The Lead Reviewers are trained in systems methodology and are responsible for the facilitation and co-ordination of the review and the production of a Final Report. There are two Lead Reviewers who will lead the process undertaken by the Review Team. The Lead Reviewers are responsible for ensuring that each stage in the process is supported and works effectively, including the liaison with and interviews of front line staff, the analytical work undertaken by the Review Team and the production of the findings (final report).

Role of the Case Group

The Case Group are the frontline professionals who were involved in supporting the vulnerable adult. They are invited to a number of meetings in order that they can reflect on their practice and contribute. The Case Group consists of front line staff from each agency or organisation directly involved in the case. It would also sensually include their immediate line managers. Members of the Case Group are interviewed as a part of the process of gaining data direct from the front line staff. The Case Group will also participate in a small number of meetings to provide feedback to the Review Team about the findings as they develop.

PART A&B APPENDIX 1

Template for standard letters

Letter to agencies

Dear

Re:
Name:
DOB:
Address:

I am writing to inform you that the Hampshire Safeguarding Adults Board has decided that a Safeguarding Adult Review will be undertaken. It will investigate and review the involvement of agencies into the health and social care support received by xx prior to her/his death.

Safeguarding Adult Reviews are undertaken when a vulnerable adult dies or is seriously harmed and abuse or neglect is suspected and there are lessons to be learned about the way agencies have worked together to prevent similar deaths or injuries in the future. A Safeguarding Adult Review looks at how local agencies and organisations have worked together to provide services and is completely separate to any investigation being undertaken by the police or Coroner.

I would be grateful if you could confirm whether or not your agency had any contact with xxx.

If your agency has had involvement you are likely to be required to be involved in the Safeguarding Adult Review. Your agency may be required to complete an Individual Management Review and nominate a representative to sit on the Safeguarding Adult Review Panel or alternatively you may be asked to participate in a Case Group or Review Group. This will all be explained once we have the information.

I look forward to hearing from you shortly to enable the Safeguarding Adult Review Panel to be set up. Please could you contact xxx Board Manager to provide details of your agencies involvement.

Yours Sincerely

Chair of the Hampshire Safeguarding Adults Board

PART A&B APPENDIX 2

Template for standard letters

Letter to families

Dear

Re:
Name:
DOB:
Address:

I am writing to you as the Chair of the Hampshire Safeguarding Adults Board. I would like to offer my condolences to you and your family following the death of xx.

I am writing to let you know that it has decided that a Safeguarding Adult Review will be undertaken following the death of xx. Safeguarding Adult Reviews are multi-agency reviews undertaken when there has been the death of a vulnerable adult or a vulnerable adult has been seriously harmed and abuse or neglect is suspected. The purpose of a Safeguarding Adult Review is to learn lessons and prevent similar deaths or injuries in the future. A Safeguarding Adult Review looks at how local agencies and organisations have worked together to provide services and is completely separate to any investigation being undertaken by the Police or Coroner.

This review will investigate and review the involvement of agencies into the health and social care support received by xx prior to his/her death.

I would also like to offer you the opportunity of involvement in the review as it is very important that we hear from families to enable them to share their experiences in order that we develop services as a result.

If you do wish to be involved this can be in a manner and time that suits you.

Your involvement is very much welcomed and I would be grateful if you could contact xx Board Manager, if you wish to be involved. She will be happy to explain the process to you and answer any questions you may have.

We will also keep you updated on the progress of the review.

We look forward to hearing from you.

Yours sincerely

Chair of the Hampshire Safeguarding Adults Board

PART A&B APPENDIX 3

Safeguarding Adult Review Pathway

Commissioning a Safeguarding Adult Review

Written request for Safeguarding Adult Review submitted to Learning and Review Sub Group

Agencies requested to supply scoping information in the form of a chronology

Learning and Review Sub Group makes recommendations to Hampshire Safeguarding Adults Board Chair on decision to proceed

Learning and Review Sub Group decides on methodology and timescales

Chair notifies Hampshire Safeguarding Adults Board and Care Quality Commission if registered services involved

Hampshire Safeguarding Adult Board Chair contacts families

Undertaking a Safeguarding Adult Review

If traditional method

Chair of Hampshire Safeguarding Adults Board approves terms of reference, drawn up by Learning and Review Sub Group

Learning and Review Sub Group appoints Independent Chair and Author

Learning and Review Sub Group seeks Safeguarding Adult Review Panel Members and Individual Management Report Authors

Initial Safeguarding Adult Review Panel held

Further Safeguarding Adult Review Panels held to consider Individual Management Reviews

Overview Report produced by Independent Author and Recommendations presented to Safeguarding Adult Review Panel

Overview Report and Executive Summary presented to Hampshire Safeguarding Adults Board

If systems method

Safeguarding Adult Review Sub Group agrees Lead Reviews and Review Team

Meeting 1 – Lead Reviewers and Review Team agree Case Group

Meeting 2 – Lead Reviewers and Review Team meet with Case Group

Conversations with Case Group individually led by one Lead Reviewer and one Review Team member

Meeting 3 – Lead Reviewers and Review Team

Meeting 4 – Review Team, Lead Reviewers and Case Group

Meeting 5 – Lead Reviewers and Review Team

Meeting 6 – Lead Reviewers, Review Team and Case Group

Meeting 7 – Lead Reviewers and Review Team to 'sign off' the report

Findings presented to Hampshire Safeguarding Adults Board

Hampshire Safeguarding Adults Board extra-ordinary meeting held to agree actions arising

Task and Finish Groups established as needed

Publication

Feedback sessions with staff and family facilitated by Board Manager

Final Report (systems methodology) or Executive Summary (traditional methodology) published

Review and Monitoring

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

PART A&B APPENDIX 4

Referral Form for a Safeguarding Adult Review – to be sent to Safeguarding.account@hants.gcsx.gov.uk

Name of Vulnerable Adult:

Address:

Date of Birth:

Brief Details of the Circumstances:

Details of any meetings held under the Safeguarding Adults Procedures:

SAR Criteria considered to be met:

Agencies directly involved with the vulnerable adult:

Any other additional information:

Referrer:
Name:

Job Title:

Employed by:

Address:

Email:
Telephone:

PART A&B APPENDIX 5

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. A Safeguarding Adult Review looks 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 Board website, www.hampshiresab.org.uk